Department
of Health &
Social Care

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

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A. Introduction

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

2. The Bill is currently in draft and will be subject to detailed scrutiny by a pre-legislative parliamentary committee (the "PLS Committee") before the final version is drawn up by the Government and introduced into Parliament. This memorandum identifies the provisions of the draft Bill that confer powers to make delegated legislation. It explains why the power has been taken and explains the nature of, the reason for, and the procedure selected.

B. Purpose and effect of the Bill

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

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

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

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

6. The Government's Response to the Independent Review was published in its White Paper, Reforming the Mental Health Act[2], on 13th January 2021. In the response, the Government accepted the majority of the Independent Review's recommendations. The

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf.

[2] https://www.gov.uk/government/consultations/reforming-the-mental-health-act.

subsequent consultation on the White Paper reported in July 2021, with respondents supportive of the reform proposals.

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

8. The purpose of the draft Bill is to reform and modernise the MHA to provide an effective framework for services to support people experiencing the most serious mental health conditions. These reforms will ensure that patients are more empowered, have more choice and influence over their treatment and receive the dignity and respect they deserve. The measures within the draft Bill will strengthen patient voice and, together with the non-legislative reforms we are bringing forward to address poor patient experience among people from ethic minority backgrounds, will help to tackle significant disparities in the number of people from these backgrounds detained under the MHA. The draft Bill will also make it easier for people with a learning disability and autistic people (LDA) to be discharged from hospital.

C. Delegated powers

9. The draft Bill contains 11 delegated powers. There are two amendments to existing powers to make broader provision and a power to issue guidance. The draft Bill also repeals a delegated power. There are five Henry VIII powers, including the power to make consequential amendments, and a power which, although not technically a Henry VIII power as it does not give power to amend or repeal the MHA provisions, will apply a primary legislative provision to certain transfers and the operation can be modified for this purpose (as explained below). The powers are as follows:

- a. Clause 2 – People with autism or learning disability– duty and power to make regulations regarding a new duty on integrated care boards (ICBs) to establish risk registers in respect of people with LDA. This is a power for the Secretary of State to make regulations regarding the establishment and maintenance of risk registers, the information to be included in them and the disclosure of that information.

- b. Clause 2 – People with autism or learning disability– duty to publish guidance regarding the exercise by certain bodies of functions in respect of persons with autism and learning disability. This is a power for the Secretary of State to issue guidance regarding reviews into the care, treatment, and in certain cases, education, of certain detained patients, guidance regarding the above risk registers and the commissioning functions of certain bodies.

- c. Clause 16 – Urgent electro-convulsive therapy etc - Certificates under section 62ZA: powers of appropriate national authority. A power to make regulations regarding the new requirement that a second opinion appointed doctor (SOAD) must provide a certificate before emergency electro-convulsive therapy (ECT) may be given. The regulations can set a time limit for the certificate and amend the MHA by specifying circumstances in which the certificate can be given by the approved clinician, or the SOAD.

- d. Clause 18 - Care and treatment plans. A power to make regulations regarding the new duty on appropriate practitioners to prepare care and treatment plans for certain detained patients. This is a power for the Secretary of State to make regulations setting out the content of a care and treatment plan, and other provision, for example, when such a plan must be prepared by.

- e. Clause 28(5) - Repeal of delegated power to reduce periods under section 68 of the MHA.

- f. Clause 29(2)(b) - References to tribunals for patients concerned in criminal proceedings etc. In the existing power to vary the automatic referral periods at which the Secretary of State must refer a restricted patient to the Tribunal to be considered for discharge, adding power to make provision subject to specified exceptions, and different provision for different cases and areas.

- g. Clause 29(3)(a) - References to tribunals for patients concerned in criminal proceedings etc. A new power to vary the periods at which the Secretary of State must refer a conditionally discharged restricted patient (either with or without deprivation of liberty conditions) to the Tribunal for variation of their conditions or absolute discharge.

- h. Clause 31(3) and 44 - Hospital treatment for prisoners: 28 day transfer period. A power to, by draft affirmative regulations:

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

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

  - iii. Alter the list of notified authorities prescribed in new section 47A.

- i. Clause 31(4)(b) and 44 - A power to apply new section 47A in relation to the 28-day transfer limit to transfers under section 48, subject to any necessary modifications, by regulations.

- j. Clause 45 - Power to make consequential provision.

- k. Clause 48(4) - Power to commence provision.
- l. Clause 48(7) - Power to make transitional provision.

Clause 2 – People in England with autism or learning disability– risk register

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: Negative

Context and purpose

10. Clause 2 inserts a new Part 8A into the MHA which makes provision in respect of persons with LDA. The new section 125D requires an ICB to create and maintain a register of individuals with LDA who may be at risk of detention under the MHA. Section 125D(1)(b) creates a duty on the Secretary of State to make regulations specifying what factors should be taken into account when considering whether an individual is “at risk” of detention. Section 125D(3) provides the Secretary of State with a general power to make further provision about the information which must be included in the register, the establishment and maintenance of the register under section 125D and a power to obtain and collect personal information for the purposes of the register.

Justification for taking the power

11. Clinical commissioning groups (CCGs) (soon to be replaced with ICBs on 1 July 2022) already maintain registers but there is no statutory basis underpinning them. This has led to CCGs taking divergent approaches to the form and content of these registers. The purpose of taking the power in section 125D(3) is to set down in regulations certain standards pertaining to the register which the ICBs are required to comply with. This includes the minimum data set which should be included about individuals on the register, the format of the register, the process for moving individuals between registers, and a power to obtain and disclose information in relation to the register (which will not override existing legislative and common law duties of confidentiality). This will ensure that the registers maintained by the ICBs are consistent and will increase the effectiveness of information sharing across the country, leading to better outcomes for those with LDA. It is not appropriate for this level of detail to be placed on the face of primary legislation and instead is a matter for regulations.

12. In addition to the power, there is also the duty in section 125D(1)(b) to set out in regulations the factors which determine whether an individual is “at risk” of detention.

Similar to the power in s 125D(3), the aim of the duty is to ensure that ICBs are as consistent as possible when assessing an individual's eligibility for inclusion on the register. These factors may include (but are not limited to) previous admissions, living situation and mental health diagnosis. By cross referencing against criteria set out in regulations, ICBs can make informed assessments about an individual's eligibility for inclusion on the register. The reason for taking a power (as opposed to listing factors out on the face of the draft Bill), is that the Government considers it important to be afforded the flexibility of regulations to ensure that risk factors are up to date and captures all those who would benefit from being included in a register especially given the role of risk registers in preventing individuals from being admitted to hospital under the MHA (which is particularly detrimental to persons with LDA). Additionally, given concerns from some stakeholders over the paternalistic aspect of risk registers, the Government would not want to include factors on the face of the draft Bill, which could lead to individuals being added to, or kept on a register, where new evidence suggests it is no longer appropriate.

Justification for taking the procedure

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

14. The Government considers that this procedure is appropriate and proportionate for regulations of this nature because they relate to mostly operational matters. The power will relate to finer points of process detail such as the structure of the register and how ICBs are to operate it in practice. Further, there will be no additional obligations which would involve civil or criminal liability.

15. We are aware that the duty to make regulations which sets out the risk factors for detention has the potential to impact individual's rights because changes in the detention criteria may alter an individual's eligibility for the register. However, the Government does not consider this to be a controversial area requiring an affirmative procedure. The Government's belief is that such factors have been well established for some time, as is apparent in policy guidance, 'Care and Treatment Reviews (CTRs): Policy and Guidance'[3] issued by the NHS Commissioning Board, which sets out the risk factors professionals ought to consider when deciding whether to add individuals to a register. (The NHS Commissioning Board is a non-departmental public body established in 2012, with broad duties, in conjunction with the Secretary of State, to promote a comprehensive health service and to arrange and secure the provision of services for the purposes of the health service. On 1st July 2022 the NHS Commissioning Board will merge with other bodies

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[3] ctr-policy-v2.pdf (england.nhs.uk).

(Monitor and the NHS Trust Development Authority) and shall be renamed NHS England'[4].)

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

17. Additionally, the data sharing gateway provided for in section 125D(3)(c) and (d) will not override existing obligations of confidentiality which currently exist in legislation so the power will not create additional obligations which would involve civil or criminal liability.

18. Parliament will also have scrutinised the power during the passage of the Bill following introduction and this procedure will afford Parliament appropriate scrutiny of the policy proposals. Therefore, the Government considers the negative procedure to be appropriate.

Clause 2 – People in England with autism or learning disability - Guidance

Power conferred on: Secretary of State

Power exercised by: Guidance

Parliamentary Procedure: None

Context and purpose

19. Clause 2 (new section 125F) confers a duty on the Secretary of State to publish guidance to a number of public bodies, about the exercise of functions under this new Part 8A. Those bodies will be under a duty to have regard to that guidance.

20. These are functions in respect of persons with LDA. The guidance will apply to the new duty on the ICBs specified in the Bill, to make arrangements for the holding of reviews into the care, treatment and, in respect of children and certain adults with educational, health and care plans, education, of certain detained patients. In addition the guidance will relate to the new duties in respect of commissioning and risk registers. Clinicians, Commissioners and ICBs will have a duty to have regard to the guidance.

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[4] See sections 1, 33 and 36 of the Health and Care Act 2022.

Justification for taking the power

21. The purpose of the guidance is to give practical advice to the various bodies regarding how to exercise these functions. For example, in respect of reviews into care, education (where relevant), and treatment of certain detained patients, it is anticipated that the guidance will set out expectations on best practice regarding the holding of the review, including future reviews, in line with the current guidance referred to in paragraph 15 above, which has been established for some time. The statute will provide when reviews must be held by, but certain circumstances may mean that earlier reviews would be advisable and the guidance will set out examples of best practice. It is not intended that these earlier reviews must take place on each and every occasion, but individual circumstances and concerns may mean that a different approach is advisable and the guidance will assist the public bodies in determining when this might be. Therefore, the guidance will assist in how those bodies exercise their functions, through practical examples based on clinical understanding of persons with LDA which may adapt over time. The purpose of the guidance is not to seek new duties, but to provide operational detail, based on evolving clinical understanding that has been pre-established for some time.

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

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

24. The matters which will therefore be dealt with via the guidance will accordingly be targeted and operational in nature. They will be aimed at a number of differing scenarios and will seek to address, by way of examples and case studies, the myriad of problems, issues and differing circumstances that may apply in practice. This is to offer assistance to those bodies exercising functions under these provisions, but will not be legislative in

nature. It should also be noted, that, as referred to above, policy documents covering these reviews, and dynamic support registers already exist, and are in the process of being updated. The guidance to be issued by the Secretary of State will largely reflect these and will be produced following engagement with NHS England to ensure it reflects the latest position.

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

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

27. Further, the Code of Practice (CoP) prepared under section 118 of the MHA is not considered appropriate for the provisions of guidance of this nature. This is because the guidance will be aimed at ICBs and other commissioners of services (as well as certain clinicians). These bodies do not have a statutory duty to have regard to the CoP. In addition, it is likely that the guidance will be updated frequently and possibly at speed as what is considered best practice changes, for example. The CoP however is subject to Parliamentary procedure which means it cannot be updated so readily to deal with changing needs, circumstances and what is considered best practice.

Justification for the Procedure

28. Mindful of the Delegated Powers and Regulatory Reform Committee's 12th Report of Session 2021-22[5] published on 24th November 2021, and in particular paragraphs 91 to 100 in Chapter 4 of that Report, it is not considered that a Parliamentary procedure is necessary for guidance issued under this clause.

29. This is because the guidance will supplement the legislative provision and aid policy implementation, for example, by providing examples of best practice. The statute provides for when the duty to hold care, education and treatment reviews is to be discharged. And it is clear from the statute when that duty is to be discharged. The guidance will however set out issues to consider which might mean an earlier review is advisable depending on the specific circumstances of those who will have such a review. This will not make legislative or quasi legislative provision but rather assist in an already prescriptive landscape and

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

help those subject to the duties determine how best to discharge them in varying circumstances, by reference to examples, case studies, and scenarios and how the duties work in practice.

30. Further, the provision regarding the LDA register, does contain a regulation making power (clause 2) which gives power to the Secretary of State to make regulations regarding the content of the register, such as data, information sharing, factors which determine who is eligible to be included on the register. It is considered that Parliamentary scrutiny is appropriate in respect of these provisions. The guidance, on the other hand, will deal with more administrative aspects of the register and accordingly Parliamentary scrutiny is not considered necessary.

Clause 16 - Urgent electro-convulsive therapy etc - Certificates under section 62ZA: powers of appropriate national authority.

Power conferred on: Secretary of State and Welsh Ministers

Power exercised by: Regulations and Code

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

Context and purpose

31. The Government proposes a new requirement through the draft Bill (clause 16), that a SOAD must provide a certificate before urgent ECT(and the associated medicines) can be given to a patient who has refused ECT with capacity, either at the time or in an Advance Decision or has a Lasting Power of Attorney/Deputy appointed by the Court of Protection/Court of Protection decision that refuses ECT. This is intended to be an important safeguard for those refusing ECT.

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

33. The regulations would also provide for circumstances in which the SOAD requirement can be dispensed with and instead the certificate can be given by the approved clinician in charge of the treatment.

Justification for taking the power

34. The current policy intention in England is to apply a 48 -hour maximum time limit for the certificate. However, the Government wants to keep this maximum time limit under review on the basis that it may need to be reviewed subject to how it works in practice. This may require the extension or reduction of the deadline, and it is therefore

necessary to do so by delegated power rather than include the deadline on the face of the draft Bill. In addition, the Government would want flexibility to be able to, for example, vary the deadline for different types of cases and extend this to other forms of treatments that might fall within section 58A (which sets the special rules for ECT and other treatment).

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

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

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

38. The Government also intend to specify in regulations circumstances in which it would be appropriate to dispense with the requirement to obtain a SOAD certificate and instead for the approved clinician in charge of the ECT to provide the relevant certificate. This is intended to deal with cases which are of such urgency that the delay caused in obtaining the SOAD would place the patient at very serious risk. The precise criteria is something that the Government wishes to test in practice and keep under review, as it should only ever be needed in a very small number of cases. It might be the case that certain cohorts of patients can be identified or that a set of circumstances would be more appropriate. It

should be noted that the scope of this power is expressly limited to cases which already require urgent ECT under the relevant criteria already specified in section62 of the MHA. Therefore the power could only be applied in very limited circumstances.

Justification for the procedure

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

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

Clause 18 Care and treatment plans

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: Negative procedure

Context and purpose

41. An appropriate practitioner will, under proposed provisions in the draft Bill, (clause 18 at new section 130ZA) be under a duty to prepare a care and treatment plan which is a plan for meeting the current and future needs of certain detained patients (both civil patients under Part II and Part III patients) arising from or connected with their mental disorder. The Government proposes through the draft Bill (new section 130ZA(3) of the MHA), that such a plan is a document made in accordance with regulations made by the Secretary of State. The regulations may also provide other information is to be contained in the plan. The care and treatment plan may include information about persons with whom the patient has a relationship or other connection or to whom the plan is relevant for certain purposes. It is also proposed, that the Secretary of State may also make regulations specifying, in relation to the cases when a care and treatment plan must be prepared, reviewed and revised by, when that is to be done, and requiring a plan to be

revised in specified purposes. Provision regarding disclosure of information in the care and treatment plan or of other information for the purposes related to the care and treatment plan may also be made. In addition, the power provides that the regulations may make transitional, consequential, supplemental and incidental provision, as well as different provision for different cases and provisions subject to exceptions.

Justification for taking the power

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

43. It is expected that the regulations will require certain information to be included in a care and treatment plan in respect of both Part II and Part III patients. At this point, this is expected to include information about the reasons for a patient's detention, outcomes which the assessment and/or provision of medical treatment for mental disorder during detention are designed to achieve and a care and treatment plan for achieving those outcomes, and information about a patient's wishes and feelings which may impact on their care and treatment. It is anticipated that regulations may also provide that other information is to be included in the care and treatment plan, for example it is anticipated the clinician will be required to set out in the care and treatment plan the reasons behind any decision to give the patient compulsory treatment (if applicable) under the MHA, or the reasons for any use of force for example under the Mental Health Units (Use of Force) Act 2018 and also details of any services the patient may need on discharge. It is possible that the care and treatment plan must also contain details of other persons with a relationship to, or other connection with, the patient or to whom the care and treatment plan is relevant, for certain purposes. This may be details of those to be consulted about the care and treatment plan, other than the patient or who have requested a review of the care and treatment plan for example.

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

45. Further, it is expected that the regulations may make provision regarding disclosure of the information to be contained in the care and treatment plan or other information for purposes related to the care and treatment plan. This may be to the persons who are to be

consulted about the care and treatment plan, or other persons associated with the patient’s detention, for example the clinical supervisor. This will ensure that persons who need to know certain information about the patient’s care and treatment may receive that information where that would be appropriate. The ability to create powers to share data is subject to existing statutory and common law protections relating to the use and sharing of data with the result that any impact on individual rights through use of these powers will necessarily be limited.

46. Care planning is an important aspect of ensuring that relevant mental health patients receive access to timely and high-quality care. The National Institute for Health and Care Excellence has published numerous pieces of guidance on care and treatment planning, which it reviews and updates, to align with the research literature on the subject. It is not expected that what may be considered appropriate to include in a care and treatment plan currently will remain static – some aspects may become obsolete and others may become important and this may happen regularly. By taking a delegated power, the Government aims to ensure that the care and treatment plan requirements can be adjusted to reflect the latest in best practice around care and treatment planning, where appropriate.

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

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

49. Further, regulations will provide when aspects of the care and treatment plan must be prepared, reviewed and revised by. It is expected that the regulations will provide that certain aspects must be completed, for example, earlier than others. This is because certain information may not be known at the same time as other information. For example, in respect of patients in the criminal justice system, it is likely that some information, such as the conditions the patient is subject to on discharge, will not be known until much later than say the reasons for the patient’s detention. However, the intention is that that should not delay preparation of the care and treatment plan in respect of information that is known at an earlier point.

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

Justification for the procedure

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

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

Clause 28(5) Repeal of delegated power to reduce periods under section 68

Context, purpose and justification

53. Clause 28(5) of the draft Bill amends section 68 of the MHA, to increase the frequency of automatic referrals to the tribunal by hospital managers in respect of Part II patients and unrestricted Part III patients. These changes ensure that patients benefit from more regular tribunal reviews during their detention.

54. Clause 28(5) repeals the power conferred on the Secretary of State and Welsh Ministers to reduce the referral periods under section 68. This power has not been previously exercised. It is considered, in light of the increase to the number of automatic referrals and their occurrences at earlier periods in a patient's detention, that this delegated power is now no longer necessary and should therefore be removed.

Clause 29(2)(b) References to tribunals for patients concerned in criminal proceedings etc – change of order-making power to make provision subject to specified exceptions, and different provision for different cases and areas, where an order is made varying the automatic referral period in section 71

Power conferred on: Secretary of State

Power exercisable by: Order made by Statutory Instrument

Parliamentary Procedure: Affirmative Resolution

Context and purpose

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

56. There is already a power in section 71 to vary, by affirmative order, the length of the prescribed period in section 71. This power is currently subject to the power to make transitional, consequential, incidental or supplemental provision as the Secretary of State thinks fit. This power is being adjusted by clause 29 to include the ability to make provision subject to specified exceptions, and for different provision for different cases and areas.

Justification for taking the Power

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

58. Parliament has already determined that the power to change the referral periods is suitable to be delegated. This measure builds on that power by adding flexibility for specified cases. The detained restricted patient cohort is small and has specific needs (as

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

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

Justification for the procedure

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

Clause 29(3)(a)- power to vary the periods at which the Secretary of State must refer a conditionally discharged restricted patient, or a conditionally discharged restricted patient subject to conditions

which amount to a deprivation of liberty, to the Tribunal for variation of their conditions or absolute discharge under section 75

Power conferred on: Secretary of State

Power exercisable by: Order made by Statutory Instrument

Parliamentary Procedure: Draft Affirmative Resolution

Context and purpose

61. Restricted patients can be subject to conditions when discharged by the Tribunal or the Secretary of State if they no longer require detention for treatment, but there are continuing risks to the public that cannot otherwise safely be managed. This is known as conditional discharge. The Government proposes a new measure in the draft Bill via clause 30 (known as 'supervised discharge') as the result of the decision in Secretary of State for Justice v MM [2018] UKSC 60. The clause enables patients with specialist needs who require conditions which amount to a deprivation of liberty to be imposed to ensure they are safe to be discharged into the community, either by the Secretary of State or the Tribunal.

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

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

Justification for taking the Power

64. These patients are in the community in much less restrictive conditions than patients detained in hospital. As with detained patients, the automatic referral is only one of a suite

of safeguards in place in the MHA to provide for review of restrictions placed on patients. A conditionally discharged patient can apply to the Tribunal between six months and two years, and thereafter every two years, to have their conditions and discharge reviewed. The Secretary of State can at any time discharge all restrictions on a patient, either by their own volition or on application by the patient, and can at any time refer the patient to the Tribunal to consider conditions or whether to absolutely discharge.

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

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

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

Justification for the procedure

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

Clause 31(3) and clause 44- power to amend the prescribed period for responsible parties to facilitate the removal of a prisoner from prison to hospital for treatment under section 47 by regulations

Power conferred on: Secretary of State

Power exercisable by: Regulations made by Secretary of State

Parliamentary Procedure: Draft Affirmative Resolution

Context and purpose

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

70. Clause 31 introduces a 28 -day time limit within which parties involved in the transfer of offenders (both adults and children) suffering with severe mental health conditions from prison to hospital for treatment (the relevant referring body and the notified authorities) must seek to ensure that the transfer is executed. This power allows the Secretary of State to amend the time period of 28 days in 47A(4) by regulations and the power is therefore a Henry VIII power. Clause 44 provides for draft affirmative procedure for this measure.

Justification for the power

71. Following the consultation held after the White Paper published after the Independent Review, some stakeholders emphasised that 28 days is considered in some cases too long for a prisoner or Immigration Removal Centre (IRC) detainee to wait for treatment. Given this appetite for a shorter time limit in the future, supported by ongoing work by the NHS,([6]) the Government has determined it is appropriate to take a power to enable the Secretary of State to change the time limit in the future. It is expected that any changes to the limit would be for it to be decreased, to further reduce the time taken for a prisoner to access treatment, however it may also be used to increase the time limit where appropriate. This ability to vary the limit is considered important to retain as the new time limit is bedded in, for example, where insufficient beds are available to meet demand over a sustained period of time. The Ministry of Justice is committed to ensuring an equivalence of care for people in prison when compared to people in the community. This power will also allow the Secretary of State to amend the time limit to keep standards in line with practice for civil patients admitted under Part II. These changes are suitable for secondary legislation rather than primary, because of the flexibility and potential speed required.

Justification for the procedure

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

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

Clause 31 and clause 44 Hospital treatment for prisoners: 28-day transfer period - power to alter the relevant referring body and notified authorities by regulations

Power conferred on: Secretary of State

Power exercisable by: Regulations made by Statutory Instrument

Parliamentary Procedure: Draft Affirmative Resolution

Context and purpose:

73. The power allows for the 'relevant referring body' (defined in section 47A(2)(c)) and the 'notified authorities' (defined in section 47A(3)) to be amended via secondary legislation, to be able to add to or remove from the list of these bodies where responsibilities for components of a transfer change. This is a Henry VIII power. Clause 44 provides for draft affirmative procedure for this measure.

Justification for the power

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

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

76. As well as the risk above, which makes it appropriate to delegate the power in the event a body's function changes or moves to ensure all relevant parties remain notifiable and accountable, the power is considered to be comparable with other delegated powers

Parliament has granted to change applicable bodies, such as the Public Bodies Act 2011, and section 5 of the Freedom of Information Act 2000.

Justification for the procedure

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

Clause 31(4)(b) and clause 44 – Power to apply new section 47A in relation to 28 day transfer limit to transfers under section 48, subject to any necessary modifications, by regulations

Power conferred on: Secretary of State

Power exercisable by: Regulations made by Secretary of State made by Statutory Instrument

Parliamentary Procedure: Draft Affirmative Resolution

Context and purpose

78. Section 48 of the MHA provides for the same transfer provision for other detainees in prison or custody, and immigration detainees, as provided for prisoners in section 47, to enable them to be transferred to hospital for inpatient treatment for mental disorder where it is urgently required. As with section 47, this provision also applies to adults and children. These individuals are in the same vulnerable position as prisoners suffering with severe mental health conditions, but are in a slightly different position at law, as they are either un-convicted defendants, civil prisoners, or immigration detainees. They are still the responsibility of the State in relation to facilitating treatment for mental disorder and the 28-day transfer limit is intended to apply to them in kind; however, contracting requirements as entered into by the Home Office for persons in immigration detention mean this provision needs further consideration with the Ministry of Justice post scrutiny by the PLS Committee, in order to place the correct duties on the correct bodies.

79. This power allows the Secretary of State to provide that new section 47A, which implements the new 28-day time limit, applies to transferees under section 48 as it applies to those under section 47, subject to any modifications prescribed. In practice, this will allow regulations which extend the introduction of a 28-day statutory time limit to patients under section 48, and allow for adjustments to accurately prescribe relevant referring bodies in the prison or IRCs, as well as other places of detention such as residential short-term holding facilities and pre-departure accommodation and relevant notified authorities,

tailored to IRC needs and any external contracting. Although this is not technically a Henry VIII power as it does not give power to amend or repeal the MHA provisions, it will apply a primary legislative provision to section 48 transfers and the operation can be modified for this purpose. Clause 44 provides for draft affirmative procedure for this measure.

Justification for the power

80. In the White Paper, the Government committed to introduce the statutory time limit for all prisoners and immigration detainees. This power mirrors that introduced and scrutinised under section 47A as it applies to section 47 prisoners. The power therefore only gives the ability to apply and modify a primary power whose parameters have already been scrutinised and approved by Parliament in primary legislation. IRCs have different contractual and sub-contractual arrangements in place for the commissioning and provision of mental health services. The power is necessary to apply the 28-day time limit in an equivocal manner, until the Ministry of Justice can undertake further work with the Home Office to prescribe a list of relevant referring bodies and notified authorities post scrutiny by the PLS Committee.

Justification for the procedure

81. It is considered that exercise of this power requires scrutiny by both Houses and the Government is thus taking the approach of draft affirmative regulations. The duties imposed on relevant bodies under the section are onerous and will raise a litigation risk in private and public law for any bodies prescribed. It is considered essential therefore to give Parliament an opportunity to consider these regulations, and how the impacts of the duties introduced in this power may need to differ for patients under section 48.

Clause 45 Power to make consequential provision

Power conferred on: the Secretary of State

Power exercised by: Regulations

Parliamentary procedure: Negative procedure. This is a Henry VIII power. 23

Context and Purpose

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

Justification for taking the power

83. A power to make consequential provision is a power commonly taken in Bills to deal with any minor and technical changes necessary in consequence of the changes contained in the Bill, to ensure the effect of the existing provision is preserved. The draft Bill contains such consequential provisions the Government has identified so far on the face of the draft Bill, but it is only prudent that the draft Bill includes a power to deal with consequential amendments or modifications that are identified at a later date, particularly as the draft Bill is to have pre-legislative scrutiny by the PLS Committee, so will not be introduced imminently. Consequential amendments will, for example, need to be made to the Armed Forces Act 2006.

Justification for the procedure

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

Clause 48(4)- Commencement

Power conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary Procedure: None

Context and purpose

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

Justification for taking the power

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

Justification for the procedure

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

Clause 48(7) -Transitional arrangements

Power Conferred on: Secretary of State

Power exercised by: Regulations

Parliamentary procedure: None

Context and purpose

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

Justification for taking the power

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

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

Justification for the procedure

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

Department of Health and Social Care

Ministry of Justice

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