

*These notes refer to the Mental Health Act 2007  
(c.12) which received Royal Assent on 19 July 2007*

# **MENTAL HEALTH ACT 2007**

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## **EXPLANATORY NOTES**

### **INTRODUCTION**

1. These explanatory notes relate to the Mental Health Act 2007, which received Royal Assent on 19 July 2007. They have been prepared by the Department of Health and the Ministry of Justice, in consultation with the Welsh Assembly Government, in order to assist the reader in understanding the Act. They do not form part of the Act.
2. The notes need to be read in conjunction with the Act. They are not, and are not meant to be, a comprehensive description of the Act. So where a section or part of a section does not seem to require any explanation or comment, none is given.

### **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>The 2007 Act</b> – the Mental Health Act 2007
<b>AC</b> – approved clinician
<b>AMHP</b> – approved mental health professional
<b>ASW</b> – approved social worker
<b>CCfW</b> – Care Council for Wales
<b>CTO</b> – community treatment order
<b>ECHR</b> – European Convention on Human Rights
<b>ECT</b> – electro-convulsive therapy
<b>GSCC</b> – General Social Care Council
<b>IMCA</b> –independent mental capacity advocate
<b>IMHA</b> – independent mental health advocate
<b>LHB</b> – local health board
<b>LSSA</b> – local social services authority
<b>MCA</b> – Mental Capacity Act 2005
<b>MHAC</b> – Mental Health Act Commission
<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 the 2007 Act is to amend the 1983 Act. It is also being used to introduce “deprivation of liberty safeguards” through amending the Mental Capacity Act 2005 (MCA); and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004.
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. The changes in relation to the MCA are in response to the 2004 European Court of Human Rights judgment (*HL v UK (Application No.45508/99)*) (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).

### ***Summary***

7. The following are the main changes to the 1983 Act made by the 2007 Act:
  - **definition of mental disorder:** it changes the way the 1983 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 medical 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 functions currently performed by 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, the one in Wales remaining in being.
  - **age-appropriate services**: it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
  - **advocacy**: it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
  - **electro-convulsive therapy**: it introduces new safeguards for patients.
8. 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. 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 procedures.
9. The changes to the Domestic Violence, Crime and Victims Act 2004 introduce new rights for victims of mentally disordered offenders who are not subject to restrictions.

## **OVERVIEW OF THE STRUCTURE**

10. **Part 1** sets out the amendments to the 1983 Act. The commentary follows the order of the sections in Part 1. Part 2 is divided into Chapter 1 (for the amendments to the Domestic Violence, Crime and Victims Act 2004 and Chapter 2 (for the amendments to MCA). Part 3 sets out general provisions such as transitional and consequential amendments.

## **TERRITORIAL EXTENT**

11. Generally, the 2007 Act has the same extent as the provisions that it amends. It applies for the most part only to England and Wales.
12. 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 2007 Act 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***

13. **Section 38** 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.
14. Annex A provides further detail on the provisions in the 2007 Act 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*

##### *Section 1: Removal of categories of mental disorder*

15. **Section 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 disorder or disability of mind” to “any disorder or disability of the mind”.
16. 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.
17. 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.
18. The section 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*

19. *Subsection (4)* of section 1 introduces Schedule 1, Part I of which replaces references in the 1983 Act to the 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 would not be considered legally to be “mental illness” and 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 almost certainly 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.

##### *Section 2: Learning disability*

20. **Section 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.
21. 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 section 1. As well as criteria for detention they also include criteria for the use of guardianship in section 7 and the making of guardianship orders in section 37 of the 1983 Act.
22. The reference to association with abnormally aggressive or seriously irresponsible conduct is derived from the current definitions of “mental impairment” and “severe mental impairment” in the 1983 Act (which are removed by section 1). Accordingly, in those cases 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.

**Section 3: Changes to exclusions from operation of 1983 Act**

23. Section 1(3) of the 1983 Act 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.” Section 3 substitutes for this a single exclusion stating that dependence on alcohol or 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).
24. 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 might be considered “sexual deviance” in the terms of the current exclusion (for example paraphilias like fetishism or paedophilia.) On that basis, the amendment would bring such disorders within the scope of the 1983 Act.
25. The use of alcohol or drugs is not, by itself, regarded clinically as a disorder or disability of the mind (although the effects of such use may be). However, dependence on alcohol and drugs is regarded as a mental disorder.
26. The effect of the exclusion inserted by this section 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.
27. 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 section 7 below for the definition of medical treatment).

**Criteria for detention under the 1983 Act: overview**

28. **Sections 4 and 5** amend the criteria for detention in Parts 2 and 3 of the 1983 Act (see also the amendments made by section 7 *subsection (3)*). 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 (although in limited circumstances it can be extended under section 29 of the 1983 Act pending resolution of proceedings to appoint an acting nearest relative for a patient). 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 Secretary of State for Justice) to transfer prisoners to hospital for treatment. The criteria in each case are set out in the relevant section.
29. 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 of the 1983 Act.

***Section 4: Replacement of “treatability” and “care” tests with appropriate treatment test***

30. Section 4 introduces a new “appropriate medical treatment test” into the criteria for detention under section 3 of the 1983 Act, 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.
31. 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).
32. The appropriate medical 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) of the 1983 Act (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 section and replaced by the appropriate medical treatment test. Because of the removal of categories of disorder by section 1 the appropriate medical treatment test applies equally to all mental disorders.
33. As an illustration, the effect of sections 1 and 4 and paragraph 2 of Schedule 1 on the criteria for applications for admission for treatment under section 3 of the 1983 Act 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

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- 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.

### ***Section 5: Further cases in which appropriate treatment test is to apply***

34. **Section 5** also adds the appropriate medical 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 medical treatment test will be an additional requirement in these sections, rather than a replacement for an existing test.

### ***Section 6: Appropriate treatment test in Part 4 of 1983 Act***

35. **Section 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) of the 1983 Act authorising the giving of certain types of medical treatment for mental disorder.
36. Those sections of the 1983 Act provide procedural safeguards for patients in relation to particular types of treatment. They are summarised in the introductory material to the notes on sections 27 to 31 below.
37. As sections 57 and 58 of the 1983 Act 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 section of the 2007 Act 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 medical treatment" test to be added to the criteria for detention under the 1983 Act by sections 4 and 5 above.

### ***Section 7: Change in definition of "medical treatment"***

38. *Subsection (1)* of section 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 (but see also subsection (4) below”).

39. 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. Such services 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.
40. *Subsection (2)* inserts a new subsection (4) in section 145 of the 1983 Act (interpretation) to provide that references in the 1983 Act to medical treatment for mental disorder mean medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. This applies to all references in the 1983 Act to medical treatment in relation to mental disorder, including references to appropriate medical treatment to be inserted by sections 4 to 6 above.

SUMMARY OF EFFECT OF AMENDMENTS IN **CHAPTER 1 OF PART 1**

<i>Provision</i>	<i>Currently applies to</i>	<i>Will apply in future to</i>	<i>Learning disability provision to apply in future</i>	<i>“Treatability” test applies now</i>	<i>Appropriate medical treatment test to apply in future</i>
<b>Civil Patients (Part 2 of the Act)</b>					
Admission for assessment for up to 28 days (section 2)	Mental disorder	Mental disorder	#	#	#
Admission for treatment (s3)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
“Holding power” for patients already in hospital (s5)	Mental disorder	Mental disorder	#	#	#
Guardianship (s7)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
<b>Patients concerned in criminal proceedings (Part 3 of the Act)</b>					
Remand to hospital for report (s35)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
Key: MI = mental illness, MM = mental impairment, PD = psychopathic disorder, SMM = severe mental impairment					



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<i>Provision</i>	<i>Currently applies to</i>	<i>Will apply in future to</i>	<i>Learning disability provision to apply in future</i>	<i>“Treatability” test applies now</i>	<i>Appropriate medical treatment test to apply in future</i>
Remand to hospital for treatment (s36)	<b>Mi, Smm</b>	Mental disorder	#	#	#
Hospital order (s37)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
Hospital order without conviction (s37(3) & 51(5))	<b>Mi, Smm</b>	Mental disorder	#	#	#
Interim hospital order (s38)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
Hospital and limitation directions (s45A)	<b>Pd</b>	Mental disorder	#	#	#
Transfer direction – sentenced prisoner (s47)	<b>Mi, Mm, Pd, Smm</b>	Mental disorder	#	#	#
Transfer direction – other (s48)	<b>Mi, Smm</b>	Mental disorder	#	#	#
Key: MI = mental illness, MM = mental impairment, PD = psychopathic disorder, SMM = severe mental impairment					

### **Section 8: The fundamental principles**

41. **Section 8** amends section 118 of the 1983 Act to insert new subsections (2A) to (2D) into the existing provision regarding the requirement to have a Mental Health Act Code of Practice.
42. The new subsection (2A) requires the Secretary of State to include in the Code of Practice a statement of principles that he or she thinks should inform decisions made under the 1983 Act.
43. New subsection (2B) contains a list of issues that the Secretary of State must ensure are addressed in the statement of principles when preparing it. Under new subsection (2C) the Secretary of State must also have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services.
44. The responsibility for preparing and revising the Code of Practice in relation to Wales was transferred to the National Assembly for Wales, but, by virtue of the Government of Wales Act 2006, this function transferred to and is now exercisable by the Welsh Ministers.
45. New subsection (2D) provides that the people listed in section 118(1)(a) and (b) shall have regard to the Code of Practice. This is to confirm in statute the status of the Code of Practice, as elaborated on by the House of Lords in the case of *R v Ashworth*

*Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz* [2005] UKHL 58. Those people listed in section 118(1)(a) and (b) (as amended by the 2007 Act) are registered medical practitioners, approved clinicians, managers and staff of hospitals, independent hospitals and care homes, and approved mental health professionals dealing with patients admitted to hospital, or subject to guardianship or SCT under the 1983 Act; and registered medical practitioners and members of other professions dealing with patients suffering from a mental disorder.

## **Chapter 2 - Professional Roles**

### **Overview**

46. 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 role of the “approved social worker” (ASW) with that of the “approved mental health professional” (AMHP).
47. 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.
48. 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 section 32 below).
49. 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.
50. 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 section 32 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. The appropriate national authority will set out approval criteria in regulations (see section 18 below).

### **Section 9: Amendments to Part 2 of 1983 Act**

51. Section 9 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 defines the RC, where the patient is liable to be detained or a community patient, as the AC with overall responsibility for the patient's case. Where the patient is subject to guardianship, the RC is defined as the AC authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the RC.
52. The RC will be responsible for renewing a patient's detention. Section 9 will insert a provision into section 20 of the 1983 Act requiring the RC to gain the agreement of another person that the conditions for renewal are met before furnishing a renewal

report. The other person must have been professionally concerned with the patient's medical treatment and be of a different profession to the responsible clinician.

53. **Section 9** 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.

### ***Section 10: Amendments to Part 3 of 1983 Act***

54. **Section 10** makes similar amendments to Part 3 of the 1983 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 of the 1983 Act. Section 10 of the 2007 Act 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.

### ***Section 11: Further amendments to Part 3 of 1983 Act***

55. **Section 11** makes further similar amendments to Part 3 of the 1983 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 (in effect the Secretary of State for Justice) will be able to return a patient subject to a restricted transfer direction under section 47 to prison, or exercise certain powers in relation to the person's release, 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.

### ***Section 12: Amendments to Part 4 of 1983 Act***

56. **Section 12** makes similar amendments to Part 4 of the 1983 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).
57. The section amends the provisions of Part 4 so that the AC or other person 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 (e.g. medication if the RC is not a doctor or a nurse prescriber) then another appropriately qualified professional will be in charge of that treatment, with the RC continuing to retain overall responsibility for the patient's case.
58. **Section 12** also makes provision about who may perform functions under Part 4. In particular, it recognises that some patients receiving treatment under section 57 (e.g. informal patients) will not have a responsible clinician or an approved clinician in charge of their treatment. Section 12 also amends Part 4 of the 1983 Act so that the patient's RC (if they have one) and the person in charge of their treatment (if they are a different person) are excluded from being the registered medical practitioner to give the second opinion required by sections 57 and 58 (the SOAD). It also prevents these professionals from being one of the persons the SOAD has a statutory duty to consult. This is to ensure that there is an independent assessment of whether treatment should be given.

***Section 13: Amendments to Part 5 of 1983 Act***

59. **Section 13** 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.

***Section 14: Amendments to other provisions of 1983 Act***

60. **Section 14** makes related amendments to other provisions of the 1983 Act. It amends section 118 so that the Code of Practice will also be for the guidance of ACs. It also inserts into section 145 a definition of an AC. The Secretary of State and the Welsh Ministers will have the function of approving persons to be approved clinicians in relation to England and Wales respectively. It is expected 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 issued by the Secretary of State and the Welsh Ministers respectively.

***Section 15: Amendments to other Acts***

61. **Section 15** 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.

***Section 16: Certain registered medical practitioners to be treated as approved under section 12 of 1983 Act***

62. **Section 16** 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 (in relation to Wales the function of approving practitioners is exercisable by the Welsh Ministers). It is expected 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.

***Section 17: Regulations as to approvals in relation to England and Wales***

63. **Section 17** 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 1983 Act and approval as an AC should be considered to mean approval in Wales as well, and vice versa.

***Section 18: Approved mental health professionals***

64. **Section 18** substitutes section 114 of the 1983 Act. 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.

*These notes refer to the Mental Health Act 2007  
(c.12) which received Royal Assent on 19 July 2007*

65. The definition of an ASW in section 145(1) of the 1983 Act is replaced by the definition of an AMHP in section 114 (see paragraph 11 of Schedule 2). Unlike with ASWs, there is now no requirement that an AMHP be an officer (employee) of an LSSA.
66. LSSAs will approve AMHPs. Before doing so they must be satisfied that the individual has appropriate competence in dealing with persons who are suffering from mental disorder and complies with regulations setting out conditions for approval, factors as to competency, and requirements for training.
67. There will be separate regulations for England and Wales, which may contain different approval criteria. Therefore, 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.

***Section 19: Approval of courses etc for approved mental health professionals***

68. **Section 19** 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 (CCfW), 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 CCfW 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 CCfW's codes of practice do not apply to AMHPs who are not social workers.

***Section 20: Amendments to section 62 of Care Standards Act 2000***

69. Although AMHP functions are not to be considered "relevant social work" for the purposes of Part 4 of the Care Standards Act 2000, section 20 provides that the GSCC's and CCfW's codes of practice will continue to apply to social workers when carrying out AMHP functions.

***Section 21: Approved mental health professionals: further amendments and Schedule 2***

70. **Section 21** introduces Schedule 2 which makes further amendments to the 1983 Act in relation to ASWs.
71. ASWs are responsible for assessing whether an application for a patient's admission under Part 2 of the 1983 Act should be made (unless the application is made by the patient's nearest relative). 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 2007 Act 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.
72. **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 even where the patient is no longer in the area of that authority. 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 5(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 themselves or enter into agreements with other LSSAs and/or NHS organisations to do so.

73. Because AMHPs will no longer always be employed by a LSSA, section 145 of the 1983 Act is amended to provide in new subsection (1AC) that references to an AMHP in the 1983 Act are generally to be read as 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.

### **Section 22: Conflicts of interest**

74. **Section 22** introduces a power to enable regulations to be made by the Secretary of State in respect of England and the Welsh Ministers in respect of Wales setting out when, because of a potential conflict of interest:
- an AMHP may not make an application for admission to hospital or guardianship under section 2, 3 or 7 of the 1983 Act; or
  - a medical practitioner may not provide a medical recommendation accompanying such an application.
75. The power replaces the provisions of section 12(3) to (7) of the 1983 Act, which set out when a medical practitioner may not provide a medical recommendation in support of an application, because of their position either in relation to the applicant, the patient or the other practitioner providing a medical recommendation.

### **Chapter 3 – Safeguards for Patients**

#### **Sections 23-26: Patient's nearest relative**

76. Sections 26-29 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. **Section 23** introduces a new right for a patient to apply for an order displacing the NR on the same grounds available to other applicants under the 1983 Act as it stands, and on the additional ground that the NR is unsuitable to act as such. 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 a requirement that the person is, in the court's opinion, a "suitable" person to act. Section 23 also amends section 29 of the 1983 Act to provide that where the

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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”.

	<i>Possible grounds for an application</i>					
	<i>29(3)(a) – the patient has no NR</i>	<i>29(3)(b) – the NR is too ill to act</i>	<i>29(3)(c) – the NR unreasonably blocks admission</i>	<i>29(3)(d) – the NR has or is likely to discharge the patient without due regard</i>	<i>29(3)(e) – the NR is unsuitable to act as such</i>	
Possible applications displacing ASW	AMHP	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, for example, in the past subjected a patient to 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, another relative or anyone living with the patient (or if the patient is an in-patient in a hospital, anyone with whom the patient was living before he was admitted). 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 to act as such.
80. [Section 24](#) 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; section 24 will allow the court to make an appointment for an indefinite period.
81. A person who has been made the acting NR retains the right to apply 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. A NR displaced on the new grounds that he is unsuitable to act as such can apply for the discharge of the order which displaced him as NR. However, the application 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. [Section 25](#) 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) of the 1983 Act (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.

84. [Section 26](#) amends the list in sections 26 and 27 of the 1983 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.

[Sections 27-31](#): Consent to treatment

***Overview of consent to treatment provisions in the 1983 Act***

85. Part 4 of the 1983 Act deals with the medical treatment of patients, other than (for most purposes) patients subject to a community treatment order (a CTO) who have not been recalled to hospital. Treatment of such patients is generally dealt with under Part 4A. See section 32 below for an explanation of a CTO.
86. Section 57 of the 1983 Act 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 (MHAC) 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) of section 57, surgical implantation of hormones for the purpose of reducing male sex drive (a procedure which is no longer used).
87. Section 58 of the 1983 Act provides that patients who are liable to be detained under the 1983 Act (subject to certain exclusions set out in section 56) may not, in general, be given certain treatments unless they consent and that consent is certified by their RMO (in future the AC in charge of the treatment) or a SOAD, or alternatively, unless a SOAD certifies that they either cannot or will not consent to the treatment, but that it should nonetheless be given. Section 34 of the 2007 Act also applies section 58 to patients who are subject to a CTO and who have been recalled to hospital (subject to certain exceptions).
88. Section 58 of the 1983 Act also applies to the administration of 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. At present and by virtue of regulations under subsection (1)(a), it also applies to electro-convulsive therapy (ECT), without any initial period however this will be overtaken by the amendments made by section 27 of the 2007 Act (see below).
89. [Sections 57](#) and [58](#) are subject to the following sections of the 1983 Act:
- section 59, which provides that consent or a certificate under either of those sections may relate to a plan of treatment instead of an individual treatment
  - section 60, which provides that a patient who withdraws consent to treatment or to all or any part of a plan of treatment, is to be treated from that point onwards as being someone who does not consent to the treatment(s) in question
  - section 61, which imposes requirements on RMOs (in future the AC in charge of treatment) to report to the Secretary of State (in practice MHAC) on treatment given on the basis of a SOAD certificate and permits the Secretary of State (MHAC) to withdraw such a certificate
  - section 62, which dis-applies sections 57 and 58 where treatment is immediately necessary and meets certain criteria, and in certain cases where the discontinuance of treatment would cause the patient serious suffering.
90. Section 63 of the 1983 Act provides that patients liable to be detained (and not excluded by section 56) may be treated by or under the direction of their RMO (in future the AC

in charge of the treatment) without their consent, where the treatment concerned is not one to which sections 57 or 58 apply.

**Section 27: *Electro-convulsive therapy, etc***

91. **Section 27** inserts a new section 58A into the 1983 Act. That new section provides that ECT and any other treatment provided for by regulations made under subsection (1) (b), can only be given when the patient either gives consent, or is incapable of giving consent. This provision is subject to the provisions about emergency treatment in section 62 of the 1983 Act (as amended by section 28 of the 2007 Act). This is to ensure that a patient, including one who is not consenting, can still receive treatment in the urgent circumstances set out in section 62 if there is insufficient time to apply the requirements at section 58A.
92. Where a detained patient 18 years of age or older consents to treatment with ECT (or any other treatment provided for by regulations), that consent must be certified by either the AC in charge of the patient's treatment or a SOAD. Where a child patient under 18 years of age who is either a detained patient or an informal patient who is not subject to a CTO consents to such treatment, a SOAD must certify that consent and that it is appropriate for the treatment to be given.
93. Where a detained patient is incapable of consent, the SOAD must certify that the patient is not capable of understanding the nature, purpose and likely effects of the treatment and that it is appropriate for the patient to receive the treatment. Before doing so, the SOAD must first consult two other persons - one must be a nurse concerned with the patient's medical treatment and the second must be another person professionally concerned with the patient's medical treatment who is neither a nurse nor a doctor. The patient's RC (if they have one) and the person in charge of their treatment (if they are not the RC) are excluded from being a person the SOAD has a statutory duty to consult.
94. Where an informal child patient (who is not subject to a CTO) is incapable of consent and there is authority to treat such a patient, the SOAD must similarly certify that the patient is not capable of understanding the nature, purpose and likely effects of the treatment and that it is appropriate for the patient to receive the treatment. Before doing so, the SOAD must first consult two other persons - one must be a nurse concerned with the patient's medical treatment and the second must be another person professionally concerned with the patient's medical treatment who is neither a nurse nor a doctor. The person in charge of the patient's treatment is excluded from being a person the SOAD has a statutory duty to consult.
95. The SOAD is not able to give such a certificate if giving the treatment would conflict with:
  - a valid and applicable advance decision of the patient not to receive the treatment as provided for by the Mental Capacity Act 2005, or
  - a decision made by a deputy or donee as defined by the Mental Capacity Act 2005, where the deputy or donee has the authority to refuse such treatment on behalf of the patient, or
  - an order of the Court of Protection.
96. Before making regulations regarding section 58A, the Secretary of State for England and the Welsh Ministers for Wales shall consult any such bodies as appear to them to be concerned.

**Section 28: *Section 27: supplemental***

97. Section 28 of the 2007 Act amends section 62 of the 1983 Act (urgent treatment) so that, where the treatment is ECT, urgent treatment can only be given where it is immediately necessary to save life or to prevent a serious deterioration in the patient's

condition. Where the treatment is another form of section 58A type treatment (to be determined by regulations under section 58A), the Secretary of State for England and the Welsh Ministers for Wales, may make regulations regarding which of the criteria in section 62(1) of the 1983 Act for urgent treatment are to apply to that treatment. Section 28 of the 2007 Act also makes consequential amendments to sections 58, 59, 60, 61, 62 and 63 of the 1983 Act, and to section 28 of the MCA, to take account of the new section 58A.

### ***Section 29: Withdrawal of consent***

98. Section 29 of the 2007 Act amends section 60 of the 1983 Act (withdrawal of consent), which sets out the effect on a certificate issued under Part 4 of the 1983 Act by either the approved clinician in charge of the treatment or a SOAD when the patient, having given consent, withdraws that consent. The amendment clarifies the position when a patient who has been certified as unable to understand the nature, purpose and likely effects of the treatment becomes able to so understand. It also clarifies the position when a person, having consented, loses the ability to understand the nature, purpose and likely effects of the treatment. In both cases the certificate is no longer valid.

### ***Section 30: Independent Mental Health Advocates***

99. **Section 30** places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates (IMHAs). IMHAs must be made available to certain “qualifying patients” subject to the powers or safeguards in the 1983 Act as amended, to provide support in the ways specified in the provisions.
100. Qualifying patients will be informed that they are eligible for the services provided by an IMHA as soon as is practicable. An IMHA will meet with a patient on the request of the patient, the nearest relative, the responsible clinician or an AMHP.
101. Where a patient has the capacity to consent and does so, an IMHA has a right to see any hospital or local authority records relating to him. If a patient lacks the capacity to consent, the record holder can still allow access to such records if it is appropriate and relevant to the help the advocate will provide to the patient. IMHAs have a right to meet patients in private and to visit and interview anyone professionally concerned with the patient’s medical treatment.
102. The appropriate national authority can make regulations setting out, for example, the standards and qualifications that will need to be met by an individual in order to be approved as an IMHA. These regulations can make different provision for different cases. This will allow them to take account of the different needs of different groups of patients.
103. **Section 30** also amends section 134 of the 1983 Act, to ensure that hospital managers cannot withhold correspondence between patients and their advocates.

### ***Section 31: Accommodation etc***

104. **Section 31** adds new section 131A to the 1983 Act. This places hospital managers under a duty to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). In determining whether the environment is suitable, the managers must consult a person whom they consider to be suitable because of their experience in child and adolescent mental health services cases.
105. **Section 31** also amends section 39 of the 1983 Act (information as to hospitals) to provide that a court may request information from a primary care trust (PCT) (in England) or local health board (LHB) (in Wales) when dealing with a person aged under 18 in certain cases. Those cases are where the court is minded to make a hospital order or interim hospital order, to remand the person to hospital for a report on their mental

condition (section 35) or for treatment (section 36), or (in the case of a magistrates' court) to order detention in hospital when committing an offender to the crown court (section 44). The information will be about the availability of accommodation or facilities designed to be specially suitable for patients under 18. The purpose of this provision is to ensure that courts do not place a child in a prison setting when a suitable hospital bed would be a more appropriate option.

106. [Section 31](#) also amends section 140 of the 1983 Act (notification of hospitals having arrangements for reception of urgent cases) to place a duty on PCTs and LHBs to advise local social service authorities in their area of hospitals providing accommodation specially suitable for patients aged under 18.

## ***Chapter 4 – Supervised Community Treatment***

### **Overview**

107. The supervised community treatment (SCT) provisions will allow some patients with a mental disorder to live in the community whilst still being subject to powers under the 1983 Act. Only those patients who are detained in hospital for treatment will be eligible to be considered 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 subject to conditions whilst living in the community. Most conditions will depend on individual circumstances but must be for the purpose of ensuring the patient receives medical treatment, or to prevent risk of harm to the patient or others. Such conditions will form part of the patient's community treatment order (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 will remain in hospital for the time being.
108. 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 of absence 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.

### ***Section 32: Community treatment orders, etc***

109. [Section 32](#) inserts new sections 17A-17G which set out how CTOs are to be made, and how they will work.
110. Under new section 17A, the RC may make a CTO for a patient detained under section 3, or for a patient who is not subject to restrictions under Part 3 of the 1983 Act (i.e. to a restriction order, a restriction direction or a limitation direction), if they are satisfied that the relevant criteria are met. An AMHP must agree that the criteria are met and also that a CTO is appropriate for that patient. The CTO, and the AMHP's agreement to it, will be in writing.
111. 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 can be recalled to hospital for treatment should this become necessary. When deciding if it is necessary to be able to recall the patient to hospital, the RC must consider the risk that the patient's condition will deteriorate after discharge from hospital, as a result, for example, of their refusing or neglecting to receive the treatment they need. In considering that risk, the RC must have regard to the patient's history of mental disorder and any other relevant factors. Appropriate medical treatment

for the patient must be available in the community. Patients who are subject to a CTO are referred to in the legislation as “community patients”.

112. Section 17B requires that CTOs specify conditions to which a community patient will be subject. There are two mandatory conditions that the patient must be available for medical examinations, firstly as required for the purposes of determining whether the CTO should be extended, and secondly to allow a SOAD to make a Part 4A certificate. Otherwise, conditions must be necessary or appropriate to ensure that the patient receives medical treatment, or to prevent harm to the patient’s health or safety, or to protect others. The RC and an AMHP must agree the conditions. The RC may vary the conditions, or suspend any of them.
113. Other than the conditions about availability for examination, the conditions specified under section 17B 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)). See also section 17E.
114. 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 was time-specific and runs out.
115. 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.
116. 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 amended by the 2007 Act 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.
117. 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 were not to receive that treatment.
118. Under section 17E(2), there is also a power to recall a patient to hospital if the patient fails to comply with the condition under section 17B(3) 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 extended and also allows a SOAD to examine the patient in order to meet the certificate requirement in new sections 64B and 64E of the 1983 Act (see section 35 below).
119. 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 for treatment 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.

120. 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).
121. **Section 32** 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 for periods of one year at a time. For an order to be extended 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. The RC must apply exactly the same considerations as when the CTO was first made, so that the RC must again consider the risk that the patient's condition will deteriorate in the community, as a result, for example, of their refusing or neglecting to receive the treatment they need. In considering that risk, the RC must have regard to the patient's history of mental disorder and any other relevant factors. The RC can only make a report to extend the CTO if the grounds for the CTO still apply. An AMHP must agree that the criteria for extension of the CTO are satisfied, and that it is appropriate to extend the CTO, before the report can be made.

### ***Section 33: Relationship with leave of absence***

122. **Section 33** makes provision in respect of the relationship of SCT with other powers in the 1983 Act. It amends the provisions in the 1983 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.

### ***Section 34: Consent to treatment***

123. **Section 34** replaces section 56 of the 1983 Act which sets out the patients to whom Part 4 of that Act, which deals with consent to treatment, applies. In addition to detained patients, informal patients under 18 years of age will be subject to new section 58A of the 1983 Act (see section 27 above). A community patient is not subject to the provisions of Part 4 of the 1983 Act (except section 57 which applies to any patient) unless recalled to hospital for treatment.
124. On recall to hospital, a patient may be given treatment which would otherwise require a certificate under section 58 or 58A of the 1983 Act ("section 58-type treatment" and "section 58A-type treatment") on the basis of a certificate given by a SOAD under the new Part 4A of the 1983 Act (see section 35 below) if that certificate specifies the treatment as being appropriate in these circumstances. If the certificate does not specify any such treatment, then (if it is section 58-type or section 58A-type treatment) it cannot be given on recall unless or until its administration is permitted under Part 4 of the 1983 Act.
125. However, if a certificate covering section 58(1)(b) treatment was in place before the CTO was made, and covers the patient's current treatment needs, there is no need for a new section 58 certificate on recall. If the period from the time the patient first received medication is less than three months then a new certificate under section 58 will not be required until that three month period has elapsed.



126. If a patient's CTO is revoked, so that the patient is once again detained in hospital for treatment, treatment can be given on the basis of a Part 4A certificate only until a section 58 or section 58A certificate can be arranged.
127. A section 58 or section 58A 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(6);
  - the treatment is immediately necessary: immediately necessary treatment can be given under section 62 (which applies by virtue of the application of Part 4 of the Act);
  - in the case of administration of medicine, the patient is still within the period before which a certificate is required i.e. either one month has not elapsed from the time when the CTO was made or the three month period from when medication was first given to the patient, as provided for in section 58(1)(b) has not elapsed.
128. A Part 4A certificate will not provide authority to give section 58A type treatment to a patient who has capacity or competence to consent but who refuses consent when recalled or when the community treatment order is revoked.

### ***Section 35: Authority to treat***

129. **Section 35** introduces a new Part 4A into the 1983 Act to regulate the treatment of community patients whilst in the community i.e. when they are not recalled to hospital. New section 64B gives the authority to treat in the community adult patients who have the capacity to consent. Community patients aged 16 or over with capacity to consent to treatment can only be treated in the community if they do consent to their treatment.
130. Community patients aged 16 or over who lack the capacity to consent to treatment can be treated in the community provided that the treatment is authorised under new section 64D or, where relevant, a donee of a lasting power of attorney (an "attorney" or deputy appointed under the Mental Capacity Act 2005, or the Court of Protection, consents to treatment on their behalf. Section 64D also sets out that force cannot be used to administer treatment if the patient objects to that treatment. If the patient does not object to treatment, force is permitted and that may be in cases where, for example, the patient is suffering from tremor and physical force is needed as a practical measure to administer the treatment. The factors to be considered by a practitioner in determining whether a patient objects to treatment are outlined in new section 64J. If the treatment conflicts with a valid and applicable advance decision made under the MCA, it cannot be given to the patient.
131. 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 (although the conditions do not hinge on concepts in the MCA since powers under that Act cannot in general be exercised in relation to children under 16).
132. Only in emergencies can force be used to give treatment to patients who lack capacity or to children who lack competence against their objections. 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, needs to be given to prevent harm to the patient, and is a proportionate response to the likelihood of the patient suffering harm and to the seriousness of the harm. The emergency circumstances in which section 58A type treatment can be given to patients who lack capacity or children who lack competence are more limited than the circumstances in which other treatment can be given in emergencies.



*These notes refer to the Mental Health Act 2007  
(c.12) which received Royal Assent on 19 July 2007*

133. All community patients receiving the type of treatment which falls under section 58 or 58A 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), i.e. medication, a certificate is not required immediately, 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.
134. 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 could specify that a particular antipsychotic and dosage can only be given in the community if the patient retains capacity to 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.
135. Under new section 64B, 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.
136. 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 and section 58A type treatment:

	<i>Patients 16 and over with capacity to consent AND patients under 16 with competence</i>	<i>Patients 16 and over without capacity to consent</i>	<i>Patients under 16 without competence to consent</i>
SCT patient in the community PART 4A regulates treatment	<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 or s58A type treatment there must be a SOAD certificate in place before</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</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> </ul>
1 For medication (s58 1(b)) a SOAD certificate must be in place one month from when a patient leaves hospital or three months from when the medication was first given to the patient.			
2 Unlike section 58 type treatment, section 58A treatment cannot be given under section 62A to patients with capacity or competence to consent if they do not consent to that treatment.			
3 Where an SCT patient's CTO is revoked, treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58 or s58A			

	<i>Patients 16 and over with capacity to consent AND patients under 16 with competence</i>	<i>Patients 16 and over without capacity to consent</i>	<i>Patients under 16 without competence to consent</i>
	<p>treatment can be given<sup>1</sup>.</p> <ul style="list-style-type: none"> <li>But certificate requirement need not be complied with where treatment is immediately necessary</li> </ul>	<p>decision of an attorney, deputy or Court of Protection or advance decision)</p> <ul style="list-style-type: none"> <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 or s58A type treatment there must be a SOAD certificate in place before treatment can be given<sup>1</sup></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>For s58 or 58A type treatment there must be a SOAD certificate in place before treatment can be given<sup>1</sup></li> <li>But it is not necessary to comply with the certificate requirement where treatment is immediately necessary or under section s64G</li> </ul>
SCT patient on recall to hospital or where	<p>Section 58 or 58A<sup>1</sup> type treatment can be given 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<sup>1</sup></li> </ul>	<p>Section 58 or 58A type treatment can be given 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<sup>3</sup></li> </ul> <p>or</p>	<p>Section 58 or 58A type treatment can be given 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<sup>3</sup></li> </ul> <p>or</p>
<p><sup>1</sup> For medication (s58 1(b)) a SOAD certificate must be in place one month from when a patient leaves hospital or three months from when the medication was first given to the patient.</p>			
<p><sup>2</sup> Unlike section 58 type treatment, section 58A treatment cannot be given under section 62A to patients with capacity or competence to consent if they do not consent to that treatment.</p>			
<p><sup>3</sup> Where an SCT patient's CTO is revoked, treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58 or s58A</p>			

	<i>Patients 16 and over with capacity to consent AND patients under 16 with competence</i>	<i>Patients 16 and over without capacity to consent</i>	<i>Patients under 16 without competence to consent</i>
SCT is revoked PART 4 regulates treatment	<ul style="list-style-type: none"> <li>or</li> <li>• For medication regulated by s58 (1) (b) the patient is still within the period before which a certificate is required<sup>1</sup></li> <li>or</li> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A (5)</li> <li>or</li> <li>Treatment is immediately necessary under s62</li> <li>If none of the above is satisfied s58 or s58A requirements must be met</li> </ul>	<ul style="list-style-type: none"> <li>• For medication regulated by s58 (1) (b) the patient is still within the period before which a certificate is required<sup>1</sup></li> <li>or</li> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A (5)</li> <li>or</li> <li>Treatment is immediately necessary under s62</li> <li>If none of the above is satisfied s58 or s58A requirements must be met</li> </ul>	<ul style="list-style-type: none"> <li>• For medication regulated by s58 (1) (b) the patient is still within the period before which a certificate is required<sup>1</sup></li> <li>or</li> <li>• Discontinuing the treatment or plan of treatment would cause serious suffering to the patient under s62A (5)</li> <li>or</li> <li>Treatment is immediately necessary under s62</li> <li>If none of the above is satisfied s58 or s58A requirements must be met</li> </ul>
<p>1 For medication (s58 1(b)) a SOAD certificate must be in place one month from when a patient leaves hospital or three months from when the medication was first given to the patient.</p>			
<p>2 Unlike section 58 type treatment, section 58A treatment cannot be given under section 62A to patients with capacity or competence to consent if they do not consent to that treatment.</p>			
<p>3 Where an SCT patient's CTO is revoked, treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with s58 or s58A</p>			

***Section 36: Repeal of provisions for after-care under supervision***

137. SCT replaces the regime of supervised after-care. The supervised after-care provisions (sections 25A to 25J of the 1983 Act) are repealed by section 36. Section 57 of the 2007 Act allows the Secretary of State to make provision by order under section 56 for transitional arrangements for persons subject to after-care under supervision at the time of the repeal of sections 25A to 25J.

***Schedule 3: Supervised community treatment: further amendments to 1983 Act***

138. **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.
139. In relation to absence without leave, under a new subsection (2A) of section 18 of the 1983 Act a community patient who has been recalled to hospital can be taken into custody and returned to the hospital. 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. New subsection (7) of section 18 provides that a reference to a patient's being "returned" to a place where they are required to be means that the patient can be taken there for the first time as well as returned after absconding. This covers all patients under the 1983 Act, so that those subject to guardianship are covered in addition to community patients, rectifying a loophole in the guardianship provisions.
140. 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.
141. 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.
142. Sections 21, 21A and 21B are amended to make provision 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.
143. Section 22 of the 1983 Act 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.
144. Community patients can be absolutely discharged from SCT (and therefore liability to recall to hospital), under amended section 23 of the 1983 Act, by the RC, hospital managers of the responsible hospital or by the NR, in the same way as patients can be discharged from detention.
145. In order to advise a NR about making an order for the discharge of a community patient under amended section 24 of the 1983 Act, any registered medical practitioner can visit or examine the patient and access records relating to the patient, just as for detained patients.
146. 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.

147. A community patient may apply to the MHRT, under amended section 66 of the 1983 Act, 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 1983 Act. The hospital managers must refer a patient to the MHRT if a CTO is revoked.
148. In the case of community patients who were under a hospital order before being made subject to a CTO, the power under section 66 of the 1983 Act 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.
149. The MHRT must direct the discharge of a community patient under amended section 72(1) of the 1983 Act 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 responsible clinician to be able to recall the patient to hospital. (In determining this point the tribunal must consider the risk that the patient's condition will deteriorate in the community, as a result, for example, of their refusing or neglecting to receive the treatment they need. In considering that risk the tribunal must have regard to the patient's history of mental disorder and any other relevant factors.)
  - appropriate medical treatment is available for the patient.
150. The MHRT has a new power (section 72(3A) of the 1983 Act) in respect of a patient detained under section 3 of that 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 the MHRT thinks SCT might be appropriate for the patient.
151. 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.

#### ***Schedule 4: Supervised community treatment: amendments to other Acts***

152. Schedule 4 to the Act makes a number of amendments to the Administration of Justice Act 1960, the Criminal Appeal Act 1968, the Courts-Martial (Appeals) Act 1968 and the Juries Act 1974 that are necessary as a result of the introduction of SCT.

### ***Chapter 5 - Mental Health Review Tribunals***

#### ***Section 37: References***

153. 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 (which function in relation to

Wales is exercisable by the Welsh Ministers) 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. Section 37 of the 2007 Act 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).

154. Under the 1983 Act as it stands, 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/Welsh Ministers. As a result of amendments made by section 37, 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 new section 68A of the 1983 Act. The provision enables the order to include any consequential provisions 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.
155. **Section 37** 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). The requirement to refer a patient aged under 16 years after one year is extended to those aged under 18 years. 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 must be referred on their return to hospital.
156. 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.
157. Finally, section 37 amends Schedule 1 to the 1983 Act to ensure that the new provisions continue to apply where appropriate to unrestricted Part 3 patients (i.e. 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 detention, 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 (or one year) will extend to all Part 3 patients detained in hospital or on SCT and not subject to restrictions.

### **Section 38: Organisation**

158. **Section 38** replaces the existing multiple regional Tribunals in England with one Tribunal and continues the Tribunal 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**

### **Section 39: Cross-border arrangements**

159. **Section 39** covers the cross-border leave and transfer of patients. Section 39(1) adds two new subsections to section 17 of the 1983 Act. They will apply to patients from Scotland, Northern Ireland, the Isle of Man and the Channel Islands who are given leave of absence to visit England and Wales and whom the clinician has determined must (for the patient's own interests, or for the protection of others) remain in custody during the leave of absence. The new subsections will ensure that patients from these jurisdictions who visit England and Wales on escorted leave may be conveyed, kept in custody or detained by their escort while in England and Wales, and re-taken in the event that they escape.
160. **Section 39(2)** gives effect to Schedule 5. 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").
161. The amendments in Schedule 5 to the 2007 Act 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 revokes the relevant provisions in the Consequential Provisions Order dealing with transfers from Scotland.
162. 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.
163. 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.
164. 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 5 April, they will be treated as if they had been admitted to hospital in England or Wales on 5 April. A community patient transferred from Scotland to England or Wales and arriving at their place of residence in England or Wales on 10 April will be treated as though he had been admitted to hospital in England or Wales on 10 April, and then a community treatment order made on the same date, discharging him from hospital. The dates of 5 April and 10 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 of the 1983 Act as amended by section 37 of the 2007 Act).



165. No provision is made in the Act for the transfer of community patients from Northern Ireland as there is currently no provision for community patients in Northern Ireland.
166. **Schedule 5** also amends sections 83 and 85 of the 1983 Act (which provide for detained patients to be transferred from England and Wales to the Channel Islands and the Isle of Man and vice versa) 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 not, as things stand, have any effect in relation to the Channel Islands and the Isle of Man.
167. **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 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. In Scotland regulations can be made on such matters under section 309 (patients from other jurisdictions) of the Mental Health (Care and Treatment) (Scotland) Act 2003.

## ***Chapter 7 - Restricted Patients***

### ***Section 40: Restriction orders***

168. **Section 40** 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. As a result, restriction orders imposed by the Court will remain in force until they are discharged by the Secretary of State for Justice or the MHRT. The section also makes consequential changes to other provisions of the 1983 Act.

### ***Section 41: Conditionally discharged patients subject to limitation directions***

169. **Section 41** 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. The amendment brings the position of patients subject to limitation directions into line with other restricted patients, in that section 75(3) will now apply to both.

## ***Chapter 8 - Miscellaneous***

### ***Section 42: Offence of ill-treatment: increase in maximum penalty on conviction on indictment***

170. **Section 42** increases the maximum penalty for imprisonment on conviction on indictment for the offence of ill treatment of patients in section 127 in the 1983 Act. The maximum penalty on imprisonment on summary conviction for the same offence will increase from six months to one year on the commencement of sections 154 and 282 of the Criminal Justice Act 2003. The maximum penalties on summary conviction for the offences at sections 126 (forgery, false statements etc) and 128 (assisting patients to absent themselves without leave etc) of the 1983 Act will also increase on the commencement of those provisions of the 2003 Act.

***Section 43: Informal admission of patients aged 16 or 17***

171. **Section 43** amends section 131 (Informal admission of patients) of the 1983 Act so that in the case of patients aged 16 or 17 years who have the capacity to consent to the making of arrangements for their admittance to hospital or registered establishment for treatment for mental disorder on an informal basis, they may consent (or may not consent) to such arrangements and their decision cannot be overridden by a person with parental responsibility for them.
172. If the patient consents to the making of arrangements they can be informally admitted to hospital and their consent cannot be overridden by a person with parental responsibility for them. If the patient does not consent to the making of arrangements they cannot be informally admitted on the basis of consent from a person with parental responsibility for them but they could be admitted to hospital for compulsory treatment under the 1983 Act if they meet the relevant criteria.

***Section 44: Places of safety***

173. Under section 135(1) of the 1983 Act, the police can, on the authority of a magistrate, enter premises and remove to a place of safety a person who is thought to have a mental disorder and who has been or is being ill-treated or neglected or, if living alone, is unable to care for himself. Under section 136 of the 1983 Act, the police can remove from a public place to a place of safety a person who appears to have a mental disorder and to need immediate help. In both instances, the person can be detained at the place of safety for up to 72 hours. Section 44 amends sections 135 and 136 of the 1983 Act to enable a person detained at a place of safety to be transferred to another one, subject to the overall time limit for detention of 72 hours. A place of safety for this purpose is defined in section 135(6) of the 1983 Act and includes a hospital, a care home and a police station.

***Section 45: Delegation of powers of managers of NHS foundation trusts***

174. **Section 45** 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.
175. **Section 23** gives the managers of hospitals the power to discharge patients who are liable to be detained. (In the case of patients subject to special restrictions under Part 3 of the 1983 Act this power is only exercisable with the consent of the Secretary of State (in practice the Secretary of State for Justice).) 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.
176. The 1983 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 of the 1983 Act 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.
177. Section 145 of the 1983 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. (Section 46 below adds Local Health Boards (LHBs) in Wales to this list.)
178. These bodies do not have to take discharge decisions themselves. Section 23 of the 1983 Act 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) of the 1983 Act currently permits NHSFTs to delegate discharge decisions only to non-executive directors of the trust. Accordingly they cannot delegate to associate hospital managers.

179. *Subsection (1)* of this section 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 of the 1983 Act, 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 section 23(6) (as amended).
180. *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 to 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.
181. 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.

#### ***Section 46: Local Health Boards***

182. **Section 46** 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.
183. LHBs are statutory NHS bodies established by Welsh Ministers under section 11 of the National Health Service (Wales) Act 2006.
184. Most hospitals in Wales are vested in NHS trusts, but in Powys they are vested in the LHB established for that area. In the 1983 Act, LHBs are not specifically mentioned in the definition of “the managers”. *Subsection (1)* of section 46 accordingly provides that, for the purposes of the 1983 Act, LHBs are the managers of hospitals vested in those Boards.
185. *Subsection (2)* makes an equivalent addition to section 19(3) of the 1983 Act clarifying that LHBs may also move such patients liable to be detained in one of their hospitals to another.

#### ***Section 47: Welsh Ministers: procedure for instruments***

186. **Section 47** 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 Other Acts**

### ***Chapter 1 – Amendments to the Domestic Violence, Crime and Victims Act 2004***

#### ***Section 48: Victims’ rights and Schedule 6***

187. **Section 48** introduces Schedule 6 which extends, with modifications, the rights of victims under the Domestic Violence, Crime and Victims Act 2004 (“the 2004 Act”) to victims of persons convicted of a sexual or violent offence, where (a) the person is made subject to a hospital order without restrictions; (b) the person is made subject to a hospital and limitation direction and the limitation direction subsequently ceases to have effect; and (c) the person is transferred from prison to hospital under a transfer direction without a restriction direction, or where the restriction direction is removed.
188. As under the existing provisions of the 2004 Act, the local probation board must take reasonable steps to establish (a) if the victim of the offence wishes to make representations as to whether the patient should be subject to conditions in the event of discharge from hospital; and (b) whether the victim wishes to receive information about those conditions in the event of his discharge.
189. As the local probation board has no remit in relation to non-restricted mentally disordered offenders detained in hospital, the board must, at the appropriate point, notify the hospital managers of the hospital in which that offender (“the patient”) is detained of the victim’s wish to receive information and make representations. The hospital managers then have responsibility for forwarding the victim’s representations to the relevant persons and bodies responsible for making decisions on discharge or community treatment orders and for passing any information received from those persons or bodies to the victim.
190. Hospital managers must inform the victim if the patient’s discharge is being considered or if the patient is to be discharged. Because unrestricted patients cannot be conditionally discharged, hospital managers must inform the victim who has requested to receive information whether the patient is to be subject to a community treatment order; and, if so, to inform him of any conditions relating to contact with the victim or his family; any variation of the conditions and the date on which the order will cease. Victims also have the right to make representations about the conditions to be attached to a community treatment order, which hospital managers must forward to the responsible clinician.
191. So that hospital managers are in a position to comply with these obligations, the responsible clinician and the MHRT are required to inform hospital managers if the patient is to be discharged. Responsible clinicians must also inform hospital managers whether they are to make a community treatment order and give the managers information regarding the imposition or variation of any conditions and when the order will end.

### ***Chapter 2 - Amendments to Mental Capacity Act 2005***

#### ***Section 49: Independent mental capacity advocates: exceptions***

192. Under the MCA an independent mental capacity advocate (IMCA) must be appointed in specified situations to support and represent particularly vulnerable people who have no family or friends or others whom it would be appropriate to consult. Section 40 of the MCA provides some limited exceptions to the requirement to appoint an IMCA in these circumstances.
193. **Section 49** substitutes a new version of section 40, to limit the exceptions to the duty to instruct an IMCA. The amendment ensures that there will still be a duty to instruct an IMCA (for health and social care issues) for someone who lacks capacity even if they

have someone to represent them on different issues, for example financial issues. There is no such duty if they already have someone to represent them on the same issue.

***Section 50: Mental Capacity Act 2005: deprivation of liberty and Schedules 7 to 9***

194. **Section 50** inserts new sections 4A, 4B and 16A into the MCA. This makes it lawful to deprive a person of their liberty in a hospital or care home only if a standard or urgent authorisation under Schedule A1 to the MCA is in force or if it is 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 deprivation 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.
195. New Schedule A1 to the MCA (inserted by Schedule 7) 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 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.
196. Deprivation of liberty is defined as having the same meaning as in Article 5(1) of the ECHR (see paragraph 10(4) of Schedule 9 to the Act which amends section 64 of the MCA). In its judgment in *HL v UK*, 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 for example 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.
197. 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.
198. Part 3 of the new Schedule A1 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.
199. 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) .
200. 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

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(c.12) which received Royal Assent on 19 July 2007*

- a proportionate response to the likelihood of suffering harm and the seriousness of that harm (the best interests requirement).
201. 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 set out in new Schedule 1A to the MCA (inserted by Schedule 8). 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 be subject to an authorisation under these new provisions. 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 authorisation cannot be used as an alternative to the procedures for recall in the 1983 Act.
202. 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 the 1983 Act and the person objects to being detained in the hospital or to some or all of the treatment.
203. 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.
204. 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.
205. 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.
206. 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 the new Schedule 1A.
207. 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 advance 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



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- 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).
208. 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.
209. Part 4 of the new 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 reason for placing this duty with the managing authority is 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. 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.
210. Provision is also made for a third party to seek to initiate the standard authorisation assessment process. Where anybody is concerned that a person may be deprived of their liberty without the protection of the safeguards, and they have asked the managing authority to apply for an authorisation but the managing authority have not done so, they can make application to the supervisory body. The supervisory body must appoint somebody who would be suitable and eligible to be a best interests assessor in the case to assess whether the person is deprived of liberty. If there is nobody to consult among family and friends, an IMCA (section 39A IMCA) would also be appointed to support and represent the person.
211. If the outcome of the assessment is that there is an unauthorised deprivation of liberty, then the full assessment process would be completed as if an authorisation had been applied for. If the managing authority consider that the care regime should continue while the assessments are carried out, they will be required to issue an urgent authorisation and to obtain a standard authorisation within seven days.
212. In any case where a standard authorisation is requested, 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.
213. 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 Standards 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 .
214. 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 new Schedule A1 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 assessors who are eligible and who are suitable, having regard to the person to be assessed.

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215. The best interests assessment must take account of any relevant needs assessment or care plan, and of 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.
216. The best interests assessor will also be required, under section 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.
217. 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. Regulations may reduce the maximum authorisation period to less than 12 months if at a future date there is evidence that 12 month authorisations are granted inappropriately. The best interests assessor may recommend conditions to be attached to the authorisation.
218. 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. The supervisory body are then required to notify the managing authority of the relevant hospital or care home, the relevant person, any section 39A IMCA and any interested person consulted by the best interests assessor.
219. 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, a section 39A IMCA will be appointed to support and represent them during the assessment process.
220. 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 section 39A 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.
221. 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

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- appoint someone to act as the person's representative during the authorisation
  - provide a copy of the 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.
222. 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).
223. 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 of the new Schedule A1). 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 a review or applying to the Court of Protection on their behalf.
224. The person concerned and their representative have right of access to the Court of Protection to challenge an authorisation. Any other person with a concern may apply to the Court for permission to be heard.
225. 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.
226. If there is a section 39C IMCA appointed for a person who is the subject of an 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.
227. If there is a both a section 39A IMCA and a representative appointed, the duties and powers of the section 39A IMCA do not apply except for the right to apply for permission to bring a case to the Court of Protection. However, the section 39A IMCA must take the views of the person's representative into account before applying to the Court of Protection.
228. Anyone who is deprived of their liberty and subject to a standard authorisation under the MCA, or their representative, has the right of access to advocacy support, in the form of a section 39D IMCA. This support will be available to help them to understand

the authorisation, its purpose and effect and to understand and exercise the review and Court of Protection safeguards. The section 39D IMCA can help and support the person or their representative to trigger a review and can make representations to the review assessors. The section 39D IMCA can help and support the person or their representative to make an application to the Court of Protection on a question regarding the authorisation.

229. When an authorisation is granted the care home or hospital must inform the person and their representative of the statutory right to a section 39D IMCA and how to obtain this support. A section 39D IMCA will be instructed if they request one or if in the opinion of the supervisory body the support of an advocate is necessary in order for them to exercise the review or appeal safeguards. If a person already has a paid representative appointed because there was no one suitable among family and friends to act as representative, they will not also be able to receive a section 39D IMCA.
230. Urgent authorisations (Part 5 of the new Schedule A1) 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 of the new Schedule A1 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 apply to the Court of Protection and to notify any IMCA when an urgent authorisation is given.
231. 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 continues. 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 judgment 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.
232. The purpose of Part 6 of the new Schedule A1 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.
233. 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.
234. If the person does not move but the supervisory body changes, for example because of changes in a local authority boundary, the managing authority must apply for a variation of the authorisation, provided that none of the grounds for review are met (Part 7 of the new Schedule A1). The new supervisory body must make the variation if it is satisfied that there are no grounds for review 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.
235. The supervisory body may review (Part 8 of the new Schedule A1) 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).

236. 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.
237. The supervisory body must first decide if any of the qualifying requirements appear to be reviewable. If not, no further action is required. 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.
238. 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, in which case it can vary the conditions as appropriate. 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.
239. 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.
240. 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.
241. The Secretary of State and the Welsh Ministers may make regulations conferring a duty on a body to monitor the operation of the new safeguards.
242. It is for the Secretary of State to make regulations under the new 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 the Welsh Ministers or a local authority in Wales) and for the Welsh Ministers to direct a Local Health Board to exercise the functions of a supervisory body (Part 12 of the new Schedule A1).

### ***Section 51: Amendment to section 20(11) of Mental Capacity Act 2005***

243. **Section 51** amends section 20(11)(a) of the MCA. It replaces the word "or" with "and". The amendment corrects a drafting error.

## **Part 3 - General**

### ***Sections 52-59***

244. This Part sets out general provisions for the 2007 Act. Particular points to note are set out below.

***Section 53 and Schedule 10: Transitional provision and savings***

245. **Section 53** introduces Schedule 10, which contains a number of transitional provisions. These transitional provisions provide a bridge from the system as it operates at present under the 1983 Act to the one that will operate under the amendments made to the 1983 Act by the 2007 Act. They stipulate the extent to which an amendment to the 1983 Act applies to or has an impact on a patient who is subject to the 1983 Act when the amendments come into force. The transitional provisions in Schedule 10 relate to provisions in the 2007 Act concerning:

- the authority to detain a patient
- consent to treatment
- the reclassification of a patient's mental disorder
- the patient's nearest relative
- the rules governing applications and referrals to the MHRT
- independent mental health advocates.

***Section 54: Consequential provisions***

246. **Section 54** 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 the 2007 Act. The Secretary of State will require the agreement of the Welsh Ministers to make these amendments, to the extent that they relate to matters in respect of which functions are exercised by the Welsh Ministers.

***Section 56: Commencement***

247. **Section 56** (commencement) provides that the provisions of the 2007 Act (other than sections 51-53 and Schedule 10, section 56 itself and sections 57- 59) are to be brought into force on a day appointed for the purpose by the Secretary of State by order made by statutory instrument. In accordance with subsection (4)(a), provisions may be commenced separately in England and Wales. They may also be commenced separately for different groups of patients, e.g. those subject to Part 2 or Part 3 of the 1983 Act and, where relevant, informal patients.

248. **Section 51**, which amends the MCA, will be brought into force on a day appointed by order made by the Lord Chancellor. Sections 52 (meaning of "1983 Act"), 53 and Schedule 10 (transitional provisions and savings), 56 (commencement), 57 (commencement of section 36), 58 (extent) and 59 (short title) will come into effect immediately. Orders made under section 56 are to be made by statutory instrument and, by virtue of subsection (6), are subject to the negative resolution procedure if they include transitional or saving provision.

249. The power in subsections (4)(b) and (5) to make transitional provision to modify the application of the 2007 Act pending the commencement of a provision of another enactment will be used to make temporary modifications to the amendments made by 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 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. They will also be necessary to 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 they will be necessary to 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.

### ***Section 57: Commencement of section 36***

250. **Section 57** gives the Secretary of State the power to make provision in an order made under section 56 for the commencement of section 36 (repeal of provisions for after-care under supervision) for transitional arrangements for persons subject to after-care under supervision when it ends. The intention is to retain after-care under supervision for a brief period after its abolition so that a decision can be made about what should happen to a person subject to it at that time. PCTs in England and LHBs in Wales will be required to ensure that a registered medical practitioner examines each person subject to after-care under supervision within the transitional period so that such a decision can be made.

### ***Section 58: Extent***

251. **Section 58** provides that the amendments contained in the 2007 Act will have the same extent as the enactments they amend (subject to subsection (2)).
252. 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 Act 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. *Subsection (2)* sets out a handful of qualifications to the general proposition in *subsection (1)*.
253. Paragraph (a) of subsection (2) refers to paragraph 35 of Schedule 3. Paragraph 35 amends section 146 of the 1983 Act so as to provide that section 128 does not extend to Scotland. Paragraph (b) refers to paragraph 20 of Schedule 5. Paragraph 20 amends section 146 of the 1983 Act so as to provide that section 88 (and so far as applied by that section sections 18, 22 and 138) does not extend to Scotland. Both sections 88 and 128 will no longer apply in Scotland as a result of their repeal by the Adult Support and Protection (Scotland) Act 2007.
254. **Section 88** (patients absent from hospitals in England and Wales) currently provides for the taking into custody in Scotland of persons who are subject to measures in England and Wales in the 1983 Act and who escape from hospital there, fail to return at the end of a period of leave of absence or escape in other specified circumstances. Provision is made in the Mental Health (Care and Treatment) (Scotland) Act 2003 to deal with such matters in regulations made under section 309 (Patients from other jurisdictions) and so it is no longer necessary to have provision in the 1983 Act which extends to Scotland about this matter.
255. **Section 128** (Assisting patients to absent themselves without leave etc) of the 1983 Act makes provision for the offence of assisting patients subject to measures under the Mental Health Act 1983 to escape from custody or absent themselves without leave. This has been replaced in Scotland by the application of section 316 (Inducing and assisting absconding etc) of the Mental Health (Care and Treatment) (Scotland) Act 2003 to such patients, so again it is no longer necessary to have provision in the 1983 Act.
256. **Section 146** (Application to Scotland) of the 1983 Act lists the provisions of the 1983 Act which extend to Scotland. Sections 88 and 128 are at present included in section 146 as provisions which do extend to Scotland, and thus require amendment now this is no longer to be the case.
257. Paragraph (b) of subsection (2) of section 58 also refers to paragraphs 3 and 4 of Schedule 5. Those paragraphs insert new sections 80ZA, 80B, 80C and 80D, which

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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.

258. Paragraph (c) of subsection (2) of section 58 refers to paragraph 12 of Schedule 8. Paragraph 12 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 Act to the MCA. Section 47 of the National Assistance Act will no longer apply in Scotland as a result of its repeal by Schedule 2 to the Adult Support and Protection (Scotland) Act 2007. As such, the amendment to section 47 does not need to extend to Scotland. *Sub-paragraph (3)* of paragraph 12 makes provision for this.
259. Subsection (3) provides that section 54 (consequential provisions) 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.

### TRANSPOSITION NOTES

260. None of the measures in this Act has any effect on or is affected by any European Directive.

### HANSARD REFERENCES

261. The following table sets out the dates and Hansard references for each stage of this Act's passage through Parliament.

<i>Stage</i>	<i>Date</i>	<i>Hansard reference</i>
<b>House of Lords</b>		
Introduction	16 November 2006	Vol. 687 Cols. 19
Second Reading	28 November 2006	Vol. 687 Cols. 654-667 & 679-732
Committee	08 January 2007	Vol. 688 Cols. 11
	10 January 2007	Vol. 688 Cols. 228-251, 263-280, 296-324
	15 January 2007	Vol. 688 Cols. 439-502, 517-562
	17 January 2007	Vol. 688 Cols. 649-713, 727-770
	29 January 2007	Vol. 689 Cols. 98-120
Report	19 February 2007	Vol. 689 Cols. 885-900, 903-950, 967-996
	26 February 2007	Vol. 689 Cols. 1366-1378, 1392-1433, 1449-1484
	27 February 2007	Vol. 689 Cols. 1561-1590
Third Reading	06 March 2007	Vol.690 Cols. 117-137
<b>House of Commons</b>		
Introduction	No debate	

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<i>Stage</i>	<i>Date</i>	<i>Hansard reference</i>
Second Reading	16 April 2007	Vol. 459 Cols. 52-132
Committee	24 April 2007 (am)	1 <sup>st</sup> sitting Cols. 3-40
	24 April 2007 (pm)	2 <sup>nd</sup> sitting Cols. 43-76
Hansard Public Bill Committee, 2006-2007  session	26 April 2007 (am)	3 <sup>rd</sup> sitting Cols. 79-94
	26 April 2007 (pm)	4 <sup>th</sup> sitting Cols. 97-134
	01 May 2007 (am)	5 <sup>th</sup> sitting Cols. 137-174
	01 May 2007 (pm)	6 <sup>th</sup> sitting Cols. 177-210
	08 May 2007 (am)	7 <sup>th</sup> sitting Cols. 213-250
	08 May 2007 (pm)	8 <sup>th</sup> sitting Cols. 253-284
	10 May 2007 (am)	9 <sup>th</sup> sitting Cols. 287-302
	10 May 2007 (pm)	10 <sup>th</sup> sitting Cols. 305-358
	15 May 2007 (am)	11 <sup>th</sup> sitting Cols. 361-398
	15 May 2007 (pm)	12 <sup>th</sup> sitting Cols. 401-440
Report and Third Reading	18 June 2007	Vol. 461 Cols. 1088-1210
	19 June 2007	Vol. 461 Cols. 1275-1350
House of Lords/Commons		
Lords consideration of Commons amendments	02 July 2007	Vol. 693 Cols. 811-850
Comms consideration of Lords message	04 July 2007	Vol. 462 Cols. 1040-1055
Lords consideration	04 July 2007	Vol. 693 Cols. 1124
Royal Assent - 19 July 2007		House of Commons Hansard Vol. 463, Col 429
		House of Lords Hansard Vol. 694, Col 363

**ANNEX A:**

**FUNCTIONS OF THE WELSH MINISTERS**

<b>Section in MHA 2007 / Section in MHA 1983</b>	<b>Function Description</b>
<b>8 / 118(2a)</b>	To include within the Code of Practice for Wales a statement of principles which should inform decisions under the Act
14 / 145(1)	The function of approving persons to act as ACs for the purposes of the Act.
<b>17 / 142a</b>	Power, exercisable jointly with the Secretary of State, to make regulations as to the territorial extent of approval for s12 doctors and approved clinicians
18 / 114(4) & (5)	Power to prescribe by regulations matters relating to the approval of Approved Mental Health Professionals. The regulations 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.
<b>22 / 12a</b>	Power to prescribe by regulations as to the circumstances in which there would be a conflict of interests in respect of applications made by AMHPs and medical recommendations given by registered medical practitioners
<b>27 / 58A(1)(b)</b>	Power to specify by regulation other forms of treatment to which the safeguards of s58A should apply
<b>130a(2) &amp; (3)</b>	Power by way of regulations to make provision for the appointment of persons as independent mental health advocates (IMHAs). The regulations may make provision for the circumstances and any conditions in which an IMHA may act as such, and for the appointment of IMHAs
<b>30 / 134(3a)</b>	Power to prescribe by regulations descriptions of arrangements relating to independent advocacy services which may be included for the purposes of section 134(3).
<b>32 / 17f(2)</b>	Power to prescribe by regulations the circumstances in which and conditions subject to which a recalled patient may be transferred to any hospital.
<b>Section in MHA 2007 / Section in MHA 1983</b>	<b>Function Description</b>
<b>32 / 20A(4)(b)</b>	Power to prescribe by regulations the form of the report which a RC must furnish to hospital managers, where it appears to that RC that the conditions in section 20A(6) have been met.
<b>35 / 64h(2)</b>	Power to prescribe by regulations the form of the "Part 4A certificate".
<b>35 / 64h(4)</b>	Power to require a report on a patient's treatment and condition where that treatment is given in accordance with a Part 4A certificate.
<b>35 / 64h(5)</b>	Power to give notice directing that a Part 4A certificate shall not apply after a specific date.

<b>Section in MHA 2007 / Section in MHA 1983</b>	<b>Function Description</b>
<b>37 / 68a(1)</b>	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.
<b>37 / 68a(2)</b>	Power to include in any order made under section 68A(1) such transitional, consequential, incidental or supplemental provision as the Assembly thinks fit.
<b>37 / 68a(7)</b>	Power by order to make provision in consequence of any order made by the Secretary of State under section 68A(1) reducing time periods for referral to the MHRT for England.
<b>Schedule 3 / 19A(1)</b>	Power to prescribe by regulations the circumstances in which and conditions subject to which a community patient may be assigned to any hospital.
<b>Schedule 3 / 67(1)</b>	Power to refer the case of any community patient to the MHRT.
<b>Schedule 5 / 80ZA(1)</b>	If it appears that specified conditions are met, power to authorise the transfer of responsibility for a community patient to a hospital in Scotland.
<b>Schedule 5 / 81ZA</b>	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.
<b>Schedule 5 / 83ZA(3)</b>	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.

#### DEPRIVATION OF LIBERTY SAFEGUARDS

<b>Paragraph in Schedule A1 MCA 2005 (inserted by Schedule 7 in the Mental Health Act 2007)</b>	<b>Function Description</b>
<b>Para 21</b>	The function of supervisory body in relation to hospitals, with power to give standard authorisation to deprive persons of liberty.
<b>Para 31</b>	Power to prescribe in regulations information required in requests for standard authorisations.
<b>Para 33</b>	Power to prescribe in regulations the timescales for assessors to carry out assessments for standard authorisations.
<b>Para 47</b>	Power to provide in regulations a requirement that eligibility assessors must require best interests assessors to provide relevant eligibility information.
<b>Para 77</b>	Power to extend the period of urgent authorisation
<b>Para 95</b>	The function of reviewing standard authorisations.
<b>Para 129</b>	Power to prescribe in regulations as to the number and kind of persons that may carry out assessments, including their qualifications,

<b>Paragraph in Schedule A1 MCA 2005 (inserted by Schedule 7 in the Mental Health Act 2007)</b>	<b>Function Description</b>
	experience and independence. The regulations may also require assessors to hold liability insurance.
<b>Paras 138 and 142 to 152</b>	Power to make regulations about the selection and appointment of representatives and provision regarding the monitoring of contact between representatives and relevant persons.
<b>Paras 163</b>	Power to make regulations to enable monitoring and reporting on the operation of provisions under Schedule 7 and to direct one or more persons or bodies to monitor and report on the operation of the provisions.
<b>Para 164</b>	Power to make regulations requiring the supervisory body and managing authority to disclose information.
<b>Para 165</b>	Power to direct LHBs to exercise supervisory functions.
<b>Paras 166 to 168</b>	Power to make further provision about the exercise of supervisory functions, including power to vary or revoke directions.
<b>Para 173</b>	Power to determine questions arising as to residence and to make regulations about the determination of residence (as set out in paragraph 183).
<b>Para 184</b>	Power to make regulations about the carrying out of functions where the supervisory body and managing authority are the same body.