

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Tuesday 18 October 2022

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Written evidence from witnesses:

- [National Autistic Society \(MHB0038\)](#)
- [Inclusion London \(MHB0067\)](#)
- [Mencap \(MHB0078\)](#)

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Members present: Baroness Buscombe (The Chair); Dr Rosena Allin-Khan; Baroness Barker; Baroness Berridge; Lord Bradley; Marsha de Cordova; Baroness Hollins; Baroness McIntosh of Hudnall; Dr Dan Poulter; Dr Ben Spencer.

Questions 29-41

Witnesses: **Tim Nicholls**, Head of Influencing, National Autistic Society; **Dan Scorer**, Policy, Public Affairs, Information and Advice, Mencap Society; **Gail Petty**, Advocacy Lead, National Development Team for Inclusion (NDTi); and **Simone Aspis**, Free Our People Now Project Manager, Inclusion London.

Q29 The Chair: Good afternoon, everyone. This is the second session of the Joint Committee's inquiry into the Draft Mental Health Bill. This session will explore one of the most pressing themes that has come out of the written evidence submissions, which is the treatment of people with learning disabilities and autism. Panel 1 contains charities that advocate for people with learning disabilities and/or autistic people. Panel 2 will bring in clinical perspectives.

I have the pleasure of welcoming the first panel. We have three witnesses present with us and one witness online. First of all, could I ask the three witnesses who are present with us today to kindly introduce themselves and say who they represent? We will keep the opening quite short because we have a lot of questions we want to ask you and we want to hear what you have to say.

Dan Scorer: I am head of policy, public affairs and information and advice at Mencap, the learning disability charity.

Tim Nicholls: I am the head of influencing and research at the National Autistic Society.

Gail Petty: I lead the advocacy programme at the National Development Team for Inclusion.

The Chair: Simone, thank you for joining us remotely. Please introduce yourself.

Simone Aspis: I am the Free Our People campaign project manager and I am part of Inclusion London, which is a disabled people-led organisation.

Q30 **The Chair:** I will put the first question to you all on behalf of the committee. What are your views on the draft Bill's proposals to remove learning disabilities and autism as a condition for which people can be detained under Part II, Section 3 of the Mental Health Act?

Gail Petty: Overall, we view this as a really positive move, although our view is that it would feel appropriate for that change to be consistently applied across the legislation. We are concerned that there may be a risk of confusion in how and when the Act could be applied to people with a learning disability and autistic people, leaving potential opportunity for misuse or misinterpretation and then unintended consequences.

Tim Nicholls: Similarly, at the National Autistic Society we view this as a really positive step. It is one we have been calling for for very many years, at least since the last review of the Act.

It is also just part of the picture. Changing the definition on its own will not end the crisis of autistic people and people with a learning disability being stuck in mental health hospitals for a long time. That will take the right services in the community, be those mental health community services or social care services. Although the definition change is indeed a very good step in the right direction, it is very important to shore up other parts of the Bill and make sure that they are stronger, so that we enable that change in the definition to make the difference that it is aiming to.

The Chair: I should say at this point that we will have further questions, as you know, that will dig a bit deeper into some of those issues that you are raising.

Dan Scorer: We welcome it. It was a measure that was consulted on back in 2014 in the "Right to Be Heard" consultation. Norman Lamb was the relevant Minister then, and the Government did not move forward with the proposal because opinion was very divided on it. It is incredibly welcome that we now have a fairly broad consensus that this is a positive step that can be taken, but, taking my colleagues' points, it very much means that we need to have a strong focus throughout the Bill on preventive and forensic services in the community, given that the provisions are remaining in place throughout Part III.

Simone Aspis: From our position, we need to take a step back and ask the question about the Mental Health Bill and compulsory detention. The Bill, from our perspective, assumes that there is a right and wrong way of being, feeling, thinking and seeing the world. The Mental Health Bill starts from the position that people who do not conform to western ideas about personhood can be detained against their wishes. This is particularly important for people who are autistic, who describe themselves as often thinking, feeling and seeing the world differently from non-disabled people. Therefore, we need to ask the question right from the start about the Mental Health Bill per se, in terms of the presumption that we should start from compulsory treatment of people, including those who are labelled as autistic and people with learning difficulties.

Although taking people with learning difficulties out of the treatment section and the criminal justice section appears to be a good way forward, we have concerns about whether this alone will decrease the number of people being detained under the Mental Health Act. We start from the UNCRPD perspective, on which I expect there will be some questions, which we can answer more fully at the appropriate time.

Q31 Baroness Berridge: I find it surprising that you are saying that there is now a clear consensus, because the review did not actually recommend this. Our briefing said that there is no clear consensus on this and viewed the risks of taking people outside the scope of the Act as being too high. Can you just explain that? People will end up being detained, will they not? It just will not be under the Mental Health Act.

Dan Scorer: Were you referring to the *Wessely* review?

The Chair: The *Wessely* review, yes.

Dan Scorer: Sir Simon was quite clear that it was not within his remit to make recommendations on that issue. Although a number of us met with him on a number of occasions and very much pressed him on this issue, he was clear that it was not within the remit of his review to make a recommendation, but he very much acknowledged it in the review as an issue that needed to be looked into.

Q32 Marsha De Cordova: Simone picked up on the UNCRPD. We know that some user-led groups said that the draft Bill was not compliant with the legislation and that it needed a complete overhaul. I would be interested to unpack a little more about what the view is in relation to this draft Bill and the UNCRPD.

Simone Aspis: The UNCRPD committee made some fundamental observations and recommendations around why the Bill is not compliant with the UNCRPD. We must remember that the UNCRPD is about supporting disabled people's human rights in all areas of life, on par with non-disabled people. It is really important that we start from this point.

The first point that the UNCRPD monitoring committee made was that disabled people were not treated equally with non-disabled people under the law. People who are autistic and people with learning difficulties can be detained just because they are disabled, have a perceived impairment, or are perceived to be a risk to other people or need protection from other people. Disabled people are the only group of people that can be detained against their wishes. No other group can be detained. For example, people who may be at risk of causing criminal activity cannot be detained until something actually happens.

Secondly, disabled people are compelled to have treatment against their wishes. Again, the UNCRPD makes it quite clear that everybody must have the right to self-determination and autonomy, including over their body. The UNCRPD made a clear recommendation that the Mental Health Act needs to start from the point of no compulsory detention and no compulsory treatment of disabled people.

For people who lack capacity, we need to make a distinction between legal capacity and mental capacity. Everybody has a legal standing and right to have their human rights respected, regardless of their ability or mental capacity. Again, the UNCRPD made recommendations that the Mental Health Act needs to be overhauled to start from a point of

what is needed to stop the compulsory detention of disabled people. It starts from a point of disabled people's rights to live independently in the community under Article 19. Again, I assume we are going to cover that later.

Q33 **Baroness Barker:** Given that you are not alone in thinking that there are deficiencies in this Bill, the question we want to ask you, which we have asked others, is whether, on balance, you would prefer to see this Bill go ahead?

Simone Aspis: We would like to see the Bill start from an alternative position, which you asked in one of your questions. We would like to start from the point of what is needed to support disabled people with mental health conditions to live independently in the community and for the right support to be given.

The problem we have at the moment is that we keep starting from the wrong position: how do we make detention more equitable? How do we make it more humane? We are focusing on the wrong question. We need to be focusing on a different question: what do we need to do to support disabled people to live in the community with the relevant support that they need? Too often, people come into the mental health system on a crisis basis, where it can be avoided if we absolutely focus on an alternative. At the moment we have a focus on how to make the mental health system better under the existing provisions, as opposed to starting from what an alternative might look like.

Tim Nicholls: Simone has made some really powerful points there. I agree entirely with her about the inequality that disabled people face in terms of this Act at the moment. Autism is not a mental health condition. You should not be detained because you are autistic. That is the crux of this issue.

However, in direct answer to Baroness Barker's question, we have been calling specifically for this change to the Act, in the recognition that progress will take a long time. For a long time when we said that the definition should be changed we faced a response of, "The social care system is broken, and this means we can help people in an emergency". Although that is true, we are in a situation where we are allowing the state to deprive people of their liberty because the state is not meeting their needs effectively in the community. We at the National Autistic Society feel that is untenable. It is a human rights issue.

Although we agree that progress needs to be made around issues of detention—and perhaps there is a better system to be had—we are in a crisis right now. We have 2,000 autistic people and people with a learning disability in units for far longer than they should be. We know, and we all accept, that it is not the best place for them, so we have to do something now. We would like to see this change go forward, with some tightening and strengthening of other parts of the Bill, but for it not to be the last step.

Gail Petty: I agree that Simone has raised some really important points, and I absolutely agree with Tim. This Bill has made some really positive steps forward. There is scope for tightening and strengthening some particular areas, but we would not want to see this Bill halted while we wait. We need to be heading towards that wholesale reform, but those two things need to happen in parallel. We must carry on with the reforms in this Bill.

Dan Scorer: The draft Bill is far from perfect. In a lot of key areas it has moved back significantly from quite positive strong positions that were set out in the White Paper across a

number of key areas, which I am sure we will discuss in due course. Like Tim, we are looking at this in the round. We have a situation where nearly 2,000 people with a learning disability and/or autism are detained in in-patient units. We have seen the horrific recent exposes around alleged abuse in these settings.

This work started, in many ways, after the Winterbourne View abuse scandal in 2011. We have had repeated government commitments to close in-patient beds and develop community support. Target after target has been missed. This piece of legislation provides us with an opportunity, on a number of fronts, to drive forward that stalled programme and make vital changes that we hope can reinvigorate those ambitions that have not been delivered over the last decade.

Q34 **Baroness McIntosh of Hudnall:** I do not think anybody would want to argue with what you are describing in terms of the unsustainability and injustice of people being confined in mental hospitals who should not be there. We can all agree about that. Do you have any concerns that, by saying what you do not want to happen, you may expose people to risk? I am not suggesting that what is happening now is in any way satisfactory, but do you have any concerns that if you stop people from being detained under the Mental Health Act, if that is the right thing to do, they will then be exposed to further risk because there will be no way of helping them in crisis?

Tim Nicholls: Yes, of course there are concerns around what some of the consequences could be, but the point that we are making in saying that is that those are also consequences we need to deal with. This is not to say that you will fix everything by changing this definition. The Government will need to make sure that there is strong guidance about when the Mental Capacity Act should and should not be used. I am sure we will come on to that topic.

There is also the question of when forensic services or liaison and diversion services need to be bolstered, or when there needs to be better understanding in the adult social care system of what autistic people's needs will be. There are any number of different things. We are saying that, because we believe this is fundamentally a human rights issue, we should not allow the consequences of other bits of the state failing to lead to a denial of the principle.

The Chair: Simone, do you have something to say? We have to be quite quick, because we have covered only the first question of 10.

Simone Aspis: Very quickly, surely our job must be to work out how we can support people in a crisis before they go into hospital. Everything involves a risk, but I believe that this might be a much less risky situation, because people will not be detained and therefore their risks to liberty are much more enhanced than they would be if they were in the community. Yes, there is going to be risk but, if crisis management can happen within the community in more appropriate settings, there would be a lot less risk to individuals and people around them.

Dr Rosena Allin-Khan: I just want to get to the nub of this. The crux of what we are talking about—please correct me if I am wrong—is that currently you can be detained just for the fact that you are autistic.

Tim Nicholls: Yes, or have a learning disability.



Dr Rosena Allin-Khan: That is not to say that, in the rest of the population, there are not people who have both, but we have an absolute duty to fix, in what we are doing now, the fact that, by sheer fact of you having a neurodiverse label, you can be detained. We heard very powerfully last week from witnesses where that can go horribly wrong. I totally see where Dan is coming from. We absolutely have an opportunity now to fix this. That is what we have to focus on.

Dan Scorer: Section 2 is still there, so people can still be sectioned for 28 days for assessment to find out, in what can be a very complex situation, whether there is an underlying mental health problem or whether it is actually a physical health issue. Is it that someone has had a traumatic experience? Have there been recent changes in their life that have been highly disruptive or changes to their support team? That 28-day period is there to assess what is actually going on. It may be that an underlying mental health condition is found, and then a judgment can be made about whether there is therapeutic benefit from that person then moving on to Section 3.

On what I said earlier, and as Tim has touched on, the changes set out in the draft Bill are so important in driving forward this programme that has been government policy for over a decade. Everyone agrees on what the vision should be. We want to have high-quality community support services for people. We want to prevent future admissions. We want to discharge large numbers of people from in-patient settings and support them in the community. This legislative change around Section 3 is so important to driving that work forward.

Q35 **Lord Bradley:** You have started to answer parts of this question, quite rightly, because it is about what other reforms in the system you would like to come forward to ensure that your support for the separation is for the benefit of people with learning disabilities and autism. It is another chance to elaborate on those changes that you would like to see come forward at the same time.

Gail Petty: We absolutely need to see developments and investment in the types of community support that are available to people. That is in terms of both the physical and sensory environment that people are living within and the support that people receive. We know that there is a real dearth of appropriate community support. That is one of the reasons why people are ending up in hospital, so that has to be a primary area of focus, including ensuring our workforce is autism-aware and has a really good understanding of learning disability.

We also need to ensure that our criminal justice system can respond appropriately to people with a learning disability and autistic people. We can make an easy assumption, potentially, that hospital is a better place. It often might not be a better place for people. If our criminal justice system was also able to respond to people with a learning disability and autistic people and make the reasonable adjustments that they need, we may find ourselves in a better position and with fewer people facing those significant restrictions.

Tim Nicholls: Gail has touched on a lot of things that I would say. Social care is the absolute linchpin. When we spoke to autistic adults back in 2019, when we did our survey around this, more than 70% told us they did not get the support they need. We have here an example of what happens when people's needs continue to develop and they hit a crisis: they can end up

in a mental health hospital. If you get in there nice and early you will prevent an awful lot of these admissions happening. That is why strengthening the community support duties from their current state will be absolutely pivotal to making the change in definition work.

You also need to increase funding and autism understanding, in particular among community mental health services. This may well be a case of autistic people presenting to general community mental health services currently and facing a lack of understanding of what adaptations can be made to talking therapies to make them accessible, what the implications of certain medications would be or any number of different things.

There is a particular need to focus, as Gail was saying, on the criminal justice workforce. Mandatory police training is something we have been calling for for an awfully long time, but it is the difference between someone being sectioned on the street or actually helped to come down from a meltdown and supported to go home, go on and live the rest of their lives, rather than being criminalised, either by way of criminal justice section or being arrested.

Lord Bradley: What is amendable within the draft Bill to put in these additional safeguards for this group that are not included in the Act?

Tim Nicholls: It would be a few things. One is around what will be new Section 125 on the provision of community services. There needs to be a stronger compulsion to look at, maintain and use that local risk register. There also needs to be very clear guidance about who should be included in that risk register. We should look quite expansively at the list, because if we look at the consequences of a school exclusion, for example, several years down the line, it could be interaction with some of these parts of the system.

There also needs to be clear guidance and a clear statement from Government that the Mental Capacity Act should not be used to detain people in a mental health hospital if they are autistic or have a learning disability, so that we do not see reliance on the Mental Capacity Act in informal admissions. Those would be two of the key things to inject into the Bill to make those duties work.

Simone Aspis: At the moment, the only way people with learning difficulties and autistic people get some kind of “state support” is when they are detained under the Mental Health Act. There is no corresponding absolute right for disabled people to get the support that they need and to live in the community. There really needs to be an absolute right to community care and support within the community.

Clearly, we would be looking for implementation of UNCRPD Article 19, the right to independent living. That independent living is not simply about providing the minimum amount of support for people to function in their own homes. It takes a more rounded view in terms of the rights of disabled people to access the opportunities that non-disabled people take for granted: health, social care services, education, employment, social and leisure opportunities, et cetera.

Support around mental health is often not provided for people who are living in the community. I had a recent example of somebody who I was supporting to advocate to live in the community, and one of the questions I asked was, “What support will be provided if this person has a mental health crisis?” Of course, I did not really get a satisfactory answer. There needs to be a much better incorporation of crisis management and health management in the

community itself. What often happens when people with learning difficulties and autistic people are coping well in the community is that, all of a sudden, the support gets taken away from them or reduces. There seems to be no recognition whatever that disabled people need that support to maintain good well-being throughout their lives.

There needs to be a clear understanding that the focus has to be on disabled people living in the community, the right to a house of their own choice, the people they live with and the interests they pursue. We all recognise that having autonomy and control of your life enhances well-being, so there needs to be much more focus on that with regard to supporting independent living.

We need to focus on what we mean by “independent living”, the right to independent living in statute and recognising the role that support has in continuing to benefit people’s well-being. We should be very clear that the institutionalisation of people with learning difficulties and autistic people, in care home settings as well as in psychiatric hospitals, needs to end. There needs to be a programme very clearly setting out what will happen to move these people out of institutional care into living in the community.

I hear what people say: “Things need to be done now”. Yes, they need to be done now, but sometimes we need to ask the right questions at the same time, and the focus has to be on what needs to happen to ensure that people with learning difficulties and autistic people do not go into hospitals and instead remain in the communities.

We are not really convinced about the registers either. Why would anybody want to go on a register to say, “I might be at risk of being detained under the Mental Health Act”? Many more questions need to be asked about that. Earlier support for people with learning difficulties or autistic people is needed right from the beginning, throughout childhood. A lot of the experiences that people with learning difficulties have start from the experiences that they have in childhood and the struggles that they have in accessing the appropriate education, health and social care support. That is very appropriate now, given the doubling of disabled children who are going into psychiatric care today.

Q36 **Baroness Hollins:** You have spoken about the importance of better social care, crisis care and workforce training, but I wonder whether you think there is adequate community mental health support for assessment and treatment in the community for this group of people. What could be done about that?

Gail Petty: Can I respond to that secondly? There are some other things in response to that last question about areas that we might want to focus on in terms of improvements to community care. One is strengthening commissioning responsibilities. At the moment, the duties on local authorities could be strengthened within the Bill and with ICBs.

We might also want to consider extending rights to advocacy for people who are living in the community and might be at risk of detention so that there is a recognised right to advocacy for people before they get to hospital, ensuring that there is some independent support and representation.

It is fantastic that CTRs are being introduced and will have that statutory footing. It would be great if community CTRs had a similar status. Those are some areas that we could focus on.

I absolutely agree that we really need to focus on strengthening community mental health services. Tim has already spoken about ensuring that there is improved diagnostics and autism awareness within those community mental health teams. We know that people wait for incredibly long times to get support and are often on a revolving door of a very short intervention or interaction and then back to trying to manage. It is just not working as it needs to at the moment if we are going to keep people out of hospital.

Dan Scorer: Building on the point that Simone raised, the wider strategic environment in which this Bill is situated is the “building the right support” action plan that the Government released just before the summer recess. We have been waiting about two years for that action plan to be released. It is very important, but in the same way that the draft Bill falls short in a number of areas, so does the action plan. The key building blocks that we can improve on in the draft Bill would make a fundamental difference to the issues my colleagues have raised around things such as the duties to actually invest in and deliver the community support that is needed. The duty is currently too strongly focused on health; local authority social care support is not included strongly enough.

The Bill could be instrumental in plugging some of the gaps in that action plan, which the department’s own work, through the independent evaluation that RedQuadrant undertook for it around funding flows, showed up around the lack of monitoring and evaluation of what has been happening in the community. What has money been spent on over the last 10 years to try to build the community support services that we need? We need much stronger duties and much more monitoring and accountability to make sure these services are put in place.

Q37 **Dr Dan Poulter:** On that, are you suggesting that there should be not just some duty but some sort of mandation or some recourse that someone can go to if their health and care needs were not adequately met?

Dan Scorer: This also takes us to the issue around care and treatment reviews and the lack of enforceability of recommendations, which potentially is exactly that kind of situation. What is in the draft Bill is certainly not strong enough. It is very welcome that we have the care and treatment reviews in the recommendations being put on a statutory basis.

Gail is absolutely right to raise the omission of community CTRs, which are incredibly important in preventing admission, but we absolutely want much stronger rights for people to be able to challenge failures to act on those recommendations where there is no therapeutic benefit from them being in an in-patient unit, they are ready for discharge, the CTRs are saying they are ready for discharge, but commissioners are not acting on those recommendations locally. That is not an acceptable position. We are in a situation where every month the NHS Digital data gives us the two biggest reasons for delayed discharge: lack of appropriate social care support and lack of appropriate housing. We have to address that.

Dr Dan Poulter: Simone, you mentioned that you felt the Bill had come from the wrong presumption, and that this should be about how we support people with learning disabilities to live in the community more effectively. What are your thoughts on having stronger sanctions or mandation if people’s health needs are not met by the local health and care system?

Simone Aspis: At the moment, it is not good, because there is no statutory right to provide the support that people need to live in the community. You are starting off with the right to be detained, and then you have the right to hospital healthcare within a detention, but you do not have a corresponding right to live in the community or a right to have the support that you need in the community. As long as you have that inequality in legislative provision there will always be bias towards not providing the support.

As you have highlighted, local authorities know this. The longer you do not provide the support, the longer the NHS continues to provide the funding for people who are detained under the Mental Health Act, because it is required to do so by law, which is why you need to have the reassumption. You cannot have a parallel system of compulsory treatment and the alternative running at the same time. We do not have the resources and the funding to do this.

We do not need to look much further than what is happening in the education system. We try to fund a mainstream school system and a special school system together, and none of the children gets the education, health and social care that they need to thrive in education provision.

It is the same here, so let us focus on getting one system right, which is the community care system. Let us put all our resources in there to ensure that there is minimal chance of people ending up in hospital, because all our resources and our strategic thinking is going to support people to be in the community.

Regarding CTRs, we are concerned about the lack of independence there. At the moment, CTRs are chaired by somebody who is part of the system—the NHS transforming team, or CCG in those days—and there is a selection of independent people. We question how independent they can be if the chair is having their own work and decisions evaluated. They do not really have the time to get to know the patients themselves, so there is sometimes, to a certain extent, a bias towards listening to why people need to continue being detained under the Mental Health Act. Although we support CTRs per se, there is definitely a lack of independence. We would say the same issue arises around advocacy support and services.

Q38 **Baroness McIntosh of Hudnall:** You have touched on this very briefly already, but this is the issue about people who cannot be detained under the Mental Health Act. Is it more likely, in your view, that the Mental Capacity Act will be used as an alternative method of detaining them? Of course, there is the issue about the criminal justice system, but that is to one side of it. Do you have concerns about the Mental Capacity Act? Should we have concerns about it and, if so, what should be done about it?

Tim Nicholls: Yes, it is right to be concerned, but, again, it is so that you can tackle those other concerns. If community provision does not increase, could we see a situation where a system that is still unable to find the right places for people would be struggling and looking, as a last resort, to keep someone safe by putting them in the hospital? That could happen, but if you have the right community support and the right understanding, which is what the Bill aims to do, then you would do that.

However, the National Autistic Society is saying that there should be a clear statement from Government within this that the Mental Capacity Act should not be used to detain people in hospital. The reason for this is quite simple: who do we think would not meet the detention

criteria set out in the Mental Health Act but would still benefit from being detained in a mental health hospital? We have kicked that question around a lot and we cannot think of anyone. If we cannot think of anyone, that presumably is starting to mean that it should not be used.

Baroness McIntosh of Hudnall: Can I interrupt you just for a moment? You put a huge caveat on the front end of what you have just said by saying, “If there is no improvement in social care and community care”. Of course you wish to see social care and community care improved—so do we and so would any right-thinking person—but we live in the world as it is today. We cannot avoid the realisation that resources are under enormous pressure. It might get better, and let us hope that it does, but that is the state of the world. Given that, what are the dangers?

Tim Nicholls: I completely see your point and certainly would never be glib about any of these challenges. They are huge, but there are three things that mitigate here. One is time. This Bill is not coming in tomorrow. It will take years to come into force and there will be preparatory work to do for that. We also have the “Building the Right Support” action plan that Dan talked about. If this can help strengthen the performance of some of those things, we will be going an awfully long way. There are also the Government’s proposals around improving funding for adult social care, which we desperately need to see. Those things can come in.

The final thing is that these things can sometimes act as a catalyst for change. What exists at the moment is a backstop for system failure. If you remove the backstop, you can change the way that the system is currently operating towards relying on it.

Gail Petty: I do not disagree. We do not quite know how liberty protection safeguards are going to play out, do we? We do not know quite how those two pieces of legislation are going to align and interact with each other. We know that people are already in hospital under a deprivation of liberty safeguard. It is happening now. We also know that, in some instances, people report that, under a deprivation of liberty safeguard, they are better able to get out of hospital using the Court of Protection than they are via a mental health tribunal.

Regardless of those issues, there is something about ensuring that there is no loss of rights, either to independent advocacy in representation, whether you are under the Mental Health Act or the Mental Capacity Act, and no loss of ability to appeal, whether, again, that is under the Mental Capacity Act or the Mental Health Act. It is already happening. People are in hospital informally, people are in hospital under the Mental Capacity Act and people are in hospital under the Mental Health Act.

I agree: we would be in a much better position if the Mental Capacity Act was not able to be used within a mental health setting. It makes no sense. It is not designed for mental health settings.

Q39 **Dr Ben Spencer:** Just on that, in terms of the scope of what you are suggesting, you have said clearly that you would not want the MCA to be used to deprive people of their liberty in a mental health setting. Would that also include a physical hospital setting where someone is there for treatment of a mental disorder and physical disorder at the same time? Would it also include care home settings where people

might be under the LPS or DoLS?

In terms of consequences, is there a danger that, by removing the ability to deprive people of liberty under the MCA in a hospital setting, you would inadvertently lead to more use of Section 5 of the MCA in a domestic setting? What would happen if there would be more restraint on the use of force in people's homes to manage situations where, unfortunately, that may have to be used. There might be a danger that doing it in a hospital setting, although best avoided, is safer with the staff, back-up and resources you have, as opposed to in people's homes.

Tim Nicholls: I am only saying not to use the Mental Capacity Act in in-patient mental health hospitals for exactly the reason that Gail just ended on: it is not what it is designed for. If you look even at the liberty protection safeguards, predominantly that is around care arrangements for someone to live their day-to-day life. It has a clear role around residential care and when someone is needing physical health treatment in hospital and they lack capacity. When looking at whether we use the Mental Capacity Act or not, it is limiting its non-applicability, if you see what I mean, to an in-patient mental health hospital rather than restricting its other use.

Dr Ben Spencer: Just to be clear, that is specifically in the context of autistic spectrum disorders and LDs. To follow up on that point, just so I can understand, what makes LD and ASD different from conditions such as dementia, which is why you would say the MCA should be exceptional to those conditions? Do you think it should also apply to conditions such as uncomplicated dementia, for example?

Tim Nicholls: I am not an expert on dementia, but some of these issues we are talking about would clearly need an awful lot of thought. It is not something I would ever want to draw up on the back of a crisp packet. The fundamental difference when it comes to autism and learning disabilities, compared with most of the other conditions we are talking about today, is that autism is not treatable. It is a lifelong disability. It requires care and support in the community from professionals. It is about how you see, hear and understand the world. That is fundamentally different from a lot of the other conditions that we are talking about.

Simone Aspis: We agree that the Mental Capacity Act should not be used to detain people who are autistic or have learning difficulties. The main reason is because the UNCRPD monitoring committee said that should not be done. It is clearly against people's rights to liberty.

We also need to ask ourselves the question of whether it is ever in someone's best interests to be detained in a mental health hospital and institutionalised. When we look at children, for example, we do not think that a children's home is the first place in terms of best interests. By no means am I comparing children to adults, but it is an example of where we need to be starting from.

There might be less need for restraint in people's homes. If you are supporting people in a crisis at home, you hope the sensory environment will be much more conducive to de-escalation in supporting a person through a meltdown than being pulled into a psychiatric hospital, where everything is going on. You might find that supporting people in the community might actually be a better place for them, because people's sensory environment will be more supportive than a psychiatric hospital.



Q40 Dr Ben Spencer: On your proposals to exclude the use of the MCA under deprivation of liberty or LPS in a mental health setting, there will, of course, be people with autistic spectrum disorders or learning disabilities who will be voluntary patients in these settings, who may need urgent physical health treatment that they lack capacity for that requires deprivation of liberty. For example, a complication of diabetes might require a life-saving physical health treatment that would need to be authorised under the powers of the MCA, and may need a deprivation of liberty to do that. How would you envisage scoping, or how would you legislate for how the use of the MCA depends on this context?

Gail Petty: You have clearly described it: somebody is being deprived of their liberty in order to support them with a physical health need, which is quite different from keeping somebody in hospital for a mental health need. It is not complex.

On your other questions about restrictive practice, we might want to think about how we regulate and monitor restrictive practice, whether that is taking place within a hospital, a residential care facility or somebody's own home. There is a different question about how we might want to monitor and regulate any kind of restrictive practice in whatever setting that might be, but in terms of the Mental Capacity Act, if there is a physical health need, that is quite clear.

Dr Dan Poulter: I understood initially that you were saying there should be a blanket exclusion of application of the Mental Capacity Act in mental health hospitals. Of course, you are now saying that is not the case and that, if there was a physical health need, you would still think that is perfectly appropriate for that to be treated.

Gail Petty: It needs to be spelled out really carefully within the legislation, but I do not see an issue there.

Dr Dan Poulter: Yes, indeed. That was just important to clarify.

Q41 Baroness Berridge: What is your perspective on the fact that there are different provisions, not only for learning disabilities and autism but for civil patients, in terms of a test and those coming in through the criminal justice system? We have heard previously from witnesses that the world might not be ideal and that therefore there is a risk, from what other witnesses said, that we will see more learning disabilities and autism come in through the criminal justice system. There is also a disproportionality there in terms of BAME that is important. What is your perspective on having two tests running for civil patients and criminal patients?

Dan Scorer: Can I just clarify? The concern you are expressing is that, through the removal of Section 3, people will not get support in the community and potentially will end up in contact with the criminal justice system.

Baroness Berridge: Yes, that is what witnesses have said to us. They are worried about being criminalised. Being in hospital is not ideal when you have autism and no other mental health condition, but then they would be criminalised in order to access this.

Dan Scorer: From Mencap’s point of view, it is a risk that we recognise. If we do not get the community support services right, and if we do not also look at the services we need in the community in terms of outreach and support for people who may come into contact with the criminal justice system, that risk is undoubtedly there.

There is also a second risk—this is something that is happening now—which is the criminalisation of people already in the in-patient unit system. With a number of families that we have worked with, loved ones are experiencing distress and are subject to restrictive interventions in units. They have physical contact with staff and are then criminalised on the basis of reacting to those restrictive practices. We also see that escalation of people through the forensic side as well when they are in units.

I fully understand the point you are making. Everything that we have touched on has emphasised the importance of the development of those community services, but we have the time before the provisions of the Bill coming in to do that. I know there are serious questions around resources, but certainly the Government, with the “Building the Right Support” strategy that they have set out, have made their intentions very clear. You have a huge opportunity with the draft Bill to strengthen its provisions around the duties to commission those community support services, including the services that will support people who could be at risk of coming into contact with the criminal justice system.

The Chair: The vote is literally about to start. Unfortunately, we have to break for about half an hour, so we have to end the session early in terms of the number of questions we have, although we have spent a good hour and have had so much really helpful information from you. Thank you very much to all four of you for coming. I know that you have the remaining questions, so if you would like to respond to them in writing, we would be incredibly grateful. This has been a very helpful session. Thank you all.