

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Wednesday 26 October 2022

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Members present: Baroness Buscombe (The Chair); Dr Rosena Allin-Khan MP; Baroness Barker; Baroness Berridge; Lord Bradley; Marsha De Cordova MP; Jonathan Gullis MP; Baroness Hollins; Baroness McIntosh of Hudnall; Dr Dan Poulter MP; Dr Ben Spencer MP; Sir Charles Walker MP.

Questions 66-76

Witnesses: **Professor Sir Simon Wessely**, Former Chair, Independent Review of the Mental Health Act, Past President of the Royal Society of Psychiatrists and the Royal Society of Medicine; **Rabbi the Baroness (Julia) Neuberger DBE**, Former vice-Chair, Independent Review of the Mental Health Act, Vice-President of the Centre for Mental Health; **Steven Gilbert OBE**, Former Vice-Chair, Independent Review of the Mental Health Act, Trustee for the Association of Mental Health Providers and Mind; **Sir Mark Hedley**, Former Vice-Chair, Independent Review of the Mental Health Act, Visiting Professor of Law, Liverpool Hope University.

Q66 The Chair: This is the fifth session of the Joint Committee scrutinising the draft Mental Health Bill. We have before us today eminent members of the inquiry, who spent a considerable amount of time looking in depth at all the issues connected with the Mental Health Act. We thank you so much for coming. It is hugely important to learn your thoughts in relation to where we are now post the inquiry, which was published in 2018.

We have a dozen questions, which we have given to you in advance, but we are a dozen people all dying to ask you questions, so please bear with us. We want to make the most of you, as it were. I invite you to say quickly who you are, perhaps starting with the chair, Professor Sir Simon Wessely.

Professor Sir Simon Wessely: That is who I am. Thank you very much. I am a psychiatrist and academic, and at the moment I am dean of the Institute of Psychiatry.

Steven Gilbert: I was one of Simon's vice-chairs. I am a service user by trade. I am a trustee for the Association of Mental Health Providers, an adviser to Kooth plc and Thalamos, a consultant to Student Minds, a co-applicant on a programme called Ariadne and AdStAC, and I co-chair the mental health working group for the RHOB.

Baroness Neuberger: I am a Cross-Bench Peer. I was a Lib Dem Peer when we looked at the Mental Health Act before, as Baroness Barker will remember only too well. I spent a great deal of time on it then. I was chief executive at the King's Fund when the Mental Health Alliance was set up and we tried to bring together all the various voluntary organisations involved in mental health. That was probably my main thing. I have also been involved in the Centre for Mental Health for many years. I chair two NHS hospitals: UCLH and Whittington Health. Whittington Health has a CAMHS provision, so it does have mental health involvement.

Sir Mark Hedley: I am a retired High Court judge from the Family Division. I was also one of the foundation judges when the statutory Court of Protection was set up, so I have done a lot of mental capacity work. In retirement, I am visiting professor of law.

Q67 **The Chair:** Thank you very much indeed. Two members of the committee are appearing remotely today. We want to crack on, so I will ask the first question. Will you briefly summarise how far you feel the draft Bill reflects the recommendations and findings of the independent review? I will kick off with two supplementaries straightaway. Have there been developments since the independent review that you think might have changed your conclusions? When we come to some of the recommendations in more detail, are you particularly concerned about any of those not accepted by the Government?

Professor Sir Simon Wessely: I will kick off by fielding the question and pass it on to people who know better.

Overall, we were very satisfied. Overall, when we finished the whole process, which was an incredibly long one—compared with some inquiries, it was not so long—the majority of the recommendations made were on the basis of very big engagement with service users, focus groups, stakeholders, public workshops and round tables, you name it. I believe that the civil servants involved won an award for that—deservedly so.

We went to great effort to ensure that the recommendations we made were consensus recommendations not just of the four of us but of the key people involved. We say in the report where it is not a consensus and where maybe, in my world, we would say that it is not quite right for this world and that more work is needed, et cetera.

Most of the key recommendations were accepted when we finished the report. At that point, to a certain extent we stepped back, because our job is to make recommendations, not to implement them or to decide which are to be accepted, but we are pleased with the majority of them. Mental health legislation has been very problematic in the past and has often proved very divisive and difficult to get through and reach a consensus upon, but unusually that was not the case here. We had clear terms of reference, support from all the main parties, and support in the end from all the major stakeholders.

There were some who said that we had not gone far enough. Fair enough. One or two said that we might have gone a bit too far, some asked who was going to pay for this, others asked where the workforce was. You always expect that kind of response. Nobody said that it was the wrong decision. We found that good, and by and large that consensus has remained, but obviously the devil is in the detail, and that was always the case. I have forgotten your second question.

The Chair: My second question was about developments since then that might have changed things.

Professor Sir Simon Wessely: In terms of developments in knowledge, not a lot. The work has gone on in the area of mental capacity, as Ben would obviously know. It has clarified some points, but not others. There has not been much change in other legislation that might have helped in testing out some of the things that we said. If we were doing it today, I do not think we would say anything very different on the basis of new knowledge that we did not have. Would you say that is reasonably fair?

Baroness Neuberger: Yes.

Professor Sir Simon Wessely: I would say no. There is not something we have done and then we have said, “Oh, my God, we didn’t know about that. Had we known that, we would’ve done that”. I would not say there is much in that field. It is only four years.

The Chair: Which of the areas not accepted by the Government really concern you? Then we will get more into the detail.

Professor Sir Simon Wessely: One of our recommendations, which was not actually a recommendation for change, was about learning disability and autism. Clearly, that recommendation was not accepted. The bit where we said very clearly that we would like statutory principles at the start of the Act itself was not accepted. Obviously, we disagree with that, because we would not have put it in if we had not agreed to it. I think that the role of the tribunal and treatment challenge is misunderstood a little bit. It is an obvious area to discuss. The Mental Health Act and the Mental Capacity Act interface was a mess before. I think it is still a mess for various reasons, so again there is confusion there.

It is fair to say that we were disappointed that the recommendations on CTOs had been watered down, so we could come back to that. In addition, not enough recognition is given, as we did. We had, I thought, quite an elegant way of pushing advance treatment decisions through the whole of the Act from start to finish in various different ways: statutory, nudging and all sorts of things. I think that has been a bit lost as well.

Those are the areas. One of them is a straightforward difference of opinion on learning difficulty and autism; the others are more complicated, but I think that things have been lost.

The Chair: Would any other of you like to come in at that point?

Sir Mark Hedley: Can I talk a little about the statutory principles? At the back of it, I think, was a desire on our part to see culture change in the whole field of mental health. Part of the role of the statute is not to produce culture change but to encourage, support and consolidate it. The Mental Capacity Act opens with a set of principles. Speaking as a judge of the Court of Protection and as a law teacher, I think they are extremely helpful in focusing the mind every time somebody looks at the Act.

We produced a set of principles that you will find on page 67 of our report, or in whatever form you have it, which would sit perfectly easily, even in an amended Act as opposed to a new one. Principle No. 1 could easily be elided with Section 1(1) of the Act; that does not present any problems. The four principles themselves would sit perfectly easily as Section

1(1)(a) of the Act, setting the tone, as it were, for the whole way in which the Act is subsequently read.

We have the precedent of the Mental Capacity Act. I dare say that there have been complaints about principles in the Mental Capacity Act. If so, I have never heard them, and certainly I have not encountered them in practice. It has always been something on which to focus minds. There is that to be said about the principles. Shall I pause there?

The Chair: We have another opportunity a little later to talk about the principles.

Sir Mark Hedley: I was going to say something about the tribunal challenges, but that can wait, if you prefer.

The Chair: We have a question on tribunal challenges, so it would be helpful to come back to that.

The second question, which I will ask Ben Spencer to put, in a way follows that. Ben, ask the question and we will take it from there.

Steven Gilbert: Can I just say that one of the important things just to frame the whole discussion is the deep and meaningful involvement of service users and carers? Again, arguments can always be made that one should have done more; one should have had deeper engagement. You will have in your notes that we did a phenomenal amount. One of the things that I want to draw attention to is the setting up and successful exploration with our service user and carer group. These are 12 individuals. They include holders of PhDs, medical professionals, artists, a published poet, trustees for charities, volunteers, disability activists and exercise enthusiasts. It was such a wide range of individuals.

At the beginning of the report is a letter that we wrote to the Prime Minister. They endorsed the recommendations that we made, but it was not at all easy. In addition to the intensity of the four of us working together, the working group and all the other people we had around us, we were driven so hard by this group of 12 people, who in turn represented other people as well.

What is really challenging is that there is no such thing as a service user or carer; there are people who find themselves in those positions, either detained because of poor mental health or caring for somebody. We come from all different walks of life. Of course, there are things that I really wanted and got and things that I did not really want but got. This speaks to the need across the board to have compromise and pragmatism. There were times when certain service user groups did not agree with what we did. That is not to say that we did not do the right thing. I just want to provide context and pay tribute to their contributions.

The Chair: You listened to so many people. One cannot overestimate the degree to which you listened, which is so important. That also helps us to reflect, and that is why our role to look again at the draft legislation is important. This is a good opportunity for us to say that maybe in certain areas we have to think again, but again pragmatism and maybe some compromise to make things the best for everyone, to the best of our ability, is probably where we will end up. We welcome this opportunity to scrutinise the Bill properly.

Turning to fundamental reform versus what we have in front of us, I ask Ben to put his question.

Q68 Dr Ben Spencer: Professor Wessely, when you took on the review, surely there were just two options. One was to propose amendment of the 1983 Act, and the other was to rip it up and start again from square one. Why did you go down the amending route?

Professor Sir Simon Wessely: By the way, call me Simon; we have known each other long enough.

First, like most of the decisions, it was pragmatic; it was timing. We were told that it would have taken perhaps 10 years to start again and look at other jurisdictions. That is sometimes a conservative estimate. We wanted to get some changes through much quicker than that. The first thing was the practicality of it.

The next question—if you are not going to ask it now, I am sure you will—is why we did not then say that we needed a fusion Act. The first answer, as I have just said, is that that would have taken a very large amount of time, which was not available and still is not, and there are changes that we can make now much quicker than that.

Secondly, as the report says, there was no consensus on that. We debated it long and hard. There may be in the future, but at the moment there is not, certainly not sufficient for us to get over the hurdle that we set. For a recommendation, it would have to be a consensus recommendation, and it definitely would not have been.

The main argument there was from service users. I know that there is a very strong case for a fusion Act, and I accept that in many respects it makes a lot of sense. It ought to be simpler and easier, but the biggest pushback came from people who said that it was already being used in effect as a way of not giving care. A lot of service users, including those on our various panels, said that they had had experience where professionals had said, “I realise you are in great distress and you may be contemplating harming yourself”, or whatever, “but you have capacity, so I can’t stop you”. It was that type of argument. That was quite compelling. More has been written about it. I am sure you know that our colleague Chloe Beale has written about that a lot. That was the second argument we had.

The third one, going back to “pragmatic”, was that it seemed to us quite sensible to see where other jurisdictions smaller than ours were going down this route. It seemed rather sensible to wait and see what that did and whether or not that worked. I remain a little sceptical that it will work, but we shall see. That was the third reason.

Baroness Neuberger: There is a fourth reason. Although it seems to me that there is a very strong argument for a complete, fundamental review and a new Act—I do not doubt that—it is not only a question of the length of time it would take to get it; it is about the effect on people who use the services if we do not do something more quickly. There has been a four-year delay since we published the review. There are some things that we are recommending that will make a great deal of difference to service users. I think we should get them through. That is a pretty strong reason.

It would be wonderful if you as a scrutiny committee—I am not sure you are allowed to do it, but let us suggest it anyway—were able to say at the end of whatever you do say, “Ultimately, there needs to be a fundamental review. It will take a very long time, and as soon as this stuff has gone through can we please start?”

Dr Ben Spencer: I cannot remember whether this was in the original review on the White Paper, but it seems to me that there are a few areas where a bit of leg is being shown to fusion in terms of extra strengths regarding protections for people who have intact decision-making capacity and rights to refuse or appeal treatment. Do you think there are more opportunities to bring in principles and best interests?

There are also some very gnarly, problematic areas where the review has said, “This is a problem and we are not quite sure what to do”. The Government's White Paper said, “We're not quite sure what to do about these problems”. The A&E stuff is a good example. It strikes me that many of these gnarly areas can be fixed by fusion. Would you agree?

Professor Sir Simon Wessely: I think that some of them could be fixed by fusion, but it creates other problems as well. If it was entirely self-evident and everybody agreed, we would have said that, but it was not entirely self-evident. There are swings and roundabouts, and some of it will still have to be decided by case law.

Sir Mark Hedley: In one sense, although the Mental Capacity Act and the Mental Health Act express themselves as being mutually exclusive one with the other—in terms of jurisdiction, you cannot be subject to both at the same time—nevertheless we have imported into mental health a whole lot of competence from the Mental Capacity Act, including advance directives, donees of powers of attorney and all those kinds of things that rumble around in the mental health area as well.

There are arguments about this, but I subscribe strongly to the views that have just been expressed that the delay is not worth the price. We just need to get on with some of these things that need doing, and there will be space for overhauls in due course.

One of the problems of thinking about a new Act is that you have to solve the fusion issue at the same time. There is no point in having a new Act if you are also thinking of having a fusion. If you look at the Act as it is proposed to be amended, you see that the enumeration is almost incomprehensible now, which is a good indication that it is time that something was done.

I strongly subscribe to the view that the need to do something now trumps all those other matters, at least for the time being.

Steven Gilbert: It is interesting that you raise the A&E part. I know it is one of the areas since the review that has just proved impossible to resolve. We debated whether you have any holding power. It is interesting to look at it through a different lens. Somebody arrives in A&E in distress and crisis. That is a fixed point in time. If you view it from that fixed point in time you are looking only at the law, or you are looking at the law plus something like liaison psychiatry.

The bigger question is: why are they ending up there? Often, it is because A&E at that time is the only place where the lights are on, so again, trying not to draw us directly into a

conversation around community resourcing, with so much of this you cannot legislate your way out of it because you create different problems. I have had multiple suicidal periods. I would not have wanted to be held under any sort of power, because that is not appropriate. What I needed was something different. It is really muddy. I have had on and off conversations with NHS England on A&E. We could not work it out, because we did not want to do something different that made things worse. Even though it is inaction, it does not mean that thought was not given to that inaction, if that makes any sense.

Dr Ben Spencer: I have some questions about the interaction between MHA and MCA that I will come to a bit later. I will save those. What do you think of UNCRDP and the proposals on compatibility, or does it matter?

Professor Sir Simon Wessely: A lot of what we have said is entirely in keeping with UNCRDP. We think we have taken it a lot further than we did before, particularly around the whole thing on treatment decisions and how they should be respected.

That is totally in keeping with CRDP, but, to be fair, we also made a clear statement that we did not agree, not so much with CRDP but with the interpretation of it by various UN committees. It turns out that most people in this world do not agree with it either, but at least we have said so. Some of it is not what we want—for example, the complete elimination of all mental health legislation, which includes the Mental Capacity Act. I cannot believe that Parliament, the public or most people with severe mental illness would want that, but at least we said it.

It is still unclear what is meant by it, and the various committees themselves seem not to have a consensus on that. We think that we have taken the best bits that are implementable and should be implemented and have pushed those strongly, but have stopped short of saying, “In the end, we’d like to implement the whole of CRDP”, because I do not think we would like to implement all of it, and we do not think it would be a very nice society in which to have severe mental illness or dementia. Does that answer your question?

Dr Ben Spencer: Very clearly.

Dr Rosena Allin-Khan: I want to dig a little on the A&E point, because I am an A&E doctor and have been for 17 years.

For me, it is the greatest source of upset to see someone undergoing a psychiatric crisis in A&E, for days sometimes, and the difficulty that that poses, particularly if someone is in an acute crisis and they are in the middle of a very noisy and well-lit department because there is not the infrastructure in place to put people in a place of greater safety. When security is called there are all these horrible scenes in front of everybody, with somebody saying, “I want to leave”. Security are trained to the best of their ability, but essentially they are just told to come to A&E to deal with someone who wants to leave. They do not know all the details behind it, so we end up with very horrible, often violent, scenes in A&Es up and down the country.

I would like to know how this Bill can improve that for people. I am happy to be political about it. I think we need more resourced community psychiatrists to stop people going in in the first place. I will happily say that all day long, but ultimately it is one of the most inhumane scenes. You go to work and you see more and more of

that. It is not just adults; it is children in crisis in A&E. In some parts of the country, it is over 60 hours. I would like a bit more on that.

Professor Sir Simon Wessely: The over 60 hours is not to do with the Mental Health Act. In all our engagements with service users up and down the country, I would always begin by saying, “Eighty per cent of what you want is nothing to do with mental health legislation. It’s to do with the absence of alternatives to detention, failures in resources and so on”.

We could say that it is illegal to have someone in A&E for more than four hours. It will make no difference if there is nowhere else, or hospitals just game it, as they do. You and I know that is what would happen. I do not think that the Mental Health Act is the right way to address the question you have put. That is the first point, and I think that is my point.

Sir Mark Hedley: My eldest son is an A&E consultant, so I have heard this from time to time. Their hospital is fortunate in that it has a distinctive unit for mental health crisis.

Dr Rosena Allin-Khan: Some do. It is the luck of the draw, is it not?

Sir Mark Hedley: It seems to be the only place to make this work. It is the place to which the police will take people; they will not bring them to A&E. It is a place to which people are encouraged to take people and not bring them to A&D. We are back to your problem of trying to keep people out of A&E.

I rather agree with Simon. I am not quite sure that the Mental Health Act can deal with this, because it is the provision of those alternative resources that is of fundamental significance, much though we should draw attention to it.

Dr Rosena Allin-Khan: In a way, you are saying that there is nothing we can do in legislation to improve the situation.

Sir Mark Hedley: Not in this legislation.

Dr Rosena Allin-Khan: In this legislation, there is nothing further we can do to improve the situation for people who find themselves in that position.

Sir Mark Hedley: We had a dispute on the use of holding power in A&E, which is not part of the hospital, as you know. We lost that dispute, but even if we had won it and had a holding power, the person would still be held somewhere waiting for somewhere else. Although I agree that that is a loophole, I do not see how closing it would make much difference.

Dr Rosena Allin-Khan: I am trying to understand that. That is why I am asking.

Sir Mark Hedley: We are not disagreeing. We have at least kept people out of custody in this legislation. That is a bonus, but we acknowledge that it is not the whole answer.

Baroness Neuberger: That was the point I wanted to make. We have kept people out of custody. At UCLH we have separate rooms for people. We are lucky; we are well resourced compared with others, but, apart from keeping people out of custody, I do not think it is for the legislation. However, were you to recommend doing a greater dig, there are ways of thinking about that in a different piece of legislation.

Dr Rosena Allin-Khan: That is understood.

Steven Gilbert: I have a slightly different view on this. You come to that point in time and all these arguments are key. It is worth looking at who ends up in A&E time and time again. It is typically the same people, or they end up with the fire department or other emergency services.

A crisis is not a single event. In a crisis of any kind, even if it is for days, you are popping up at different places. With the legislation, we are making changes. In all likelihood, if you are having a crisis to that degree you will probably be sectioned at some point. Something has gone wrong there. We are saying that detention should be the start of recovery, not just warehousing people for a period of time and then chucking them out because they have had six months.

When you look at all the different details of the detention criteria and then the principles, the treatment must be beneficial. That is significant in making sure that when someone is in hospital they are not just getting good-quality nursing care, but we need to think about the environment.

A really simple one, which really fits into culture, is that even in some of the hospitals in Birmingham friends and others, when detained, could not get access to a black barber. If you have black hair, that is key. You have to think about the fact that you are there, arguably for a minimum of 28 days, with no liberty and access to all the things you need.

All these changes are littered throughout the piece, but if we get even 25% of these things it will make a difference to those people. We are going to push hard on ACDs. ACDs are not just about the legal right. That means you must have clinicians and staff engaging better with service users. Part of the biggest issue is: how do you get services to engage meaningfully with service users? It is often a special effort. This becomes the norm and you get the learning, but over time it means you should not have as many people going to A&E. But all these points still exist and the point about resourcing is key.

Q69 Marsha De Cordova: Can I go back to the question of UNPRPD and the response that was given? We heard from individuals who shared their concerns about the legislation not going far enough. This relates particularly to those with the lived experience. I would like to understand a little more about whether the current draft legislation goes far enough in acknowledging the UNCRDP, not in its extreme form—to get rid of all mental health legislation—but around detention, treatment, advocacy, support and, I suppose, co-production and that kind of independent living for disabled people, because for this group we need to ensure that this legislation is done right. I would like to hear a bit more about that from the professor or anyone else.

Professor Sir Simon Wessely: The principles that we endorse and wish to see on the front of the Act, which we will come back to, are basically the ones that use the least coercive measures for the shortest possible time and with the least possible interference in choice and autonomy, which are all CRPD principles as well. All of that is what we endorse, but we do not endorse changing the word “least” to “none”. That is where we are drawing the line. I think that goes for most people and, from what you have just said, you agree with that as well. The principles are fine, but we think that some of the interpretations made go too far.

There is no getting round it. It is an intellectually tenable position to say that we should have no mental health or capacity legislation at all, but I just do not think it is a good idea. I cannot put it any better than that.

Sir Mark Hedley: It is quite interesting to compare this with our experience of dealing with the United Nations Convention on the Rights of the Child. There are endless complaints that we are not compliant. If you read the convention, I think that English law is compliant, but there are lots of different ways of reading the convention.

I spent my life being chewed up by academics for not having read the convention properly. I suspect that we have a similar problem here. Conventions are living instruments and are not intended to be legislation and all the rest of it, so they are capable of very wide readings. We need to be very careful to be as compliant as we can with the fundamental principles, but we get ourselves into trouble if we treat them as though they are legislation with which we are trying to comply.

Marsha De Cordova: The key here is: how do we ensure that those with the lived experience truly grasp and understand that in relation to this Bill? That will be important. Based on some of the evidence sessions we have had, it is mainly those with lived experience who are sharing their concerns about the draft Bill. How do we bridge that?

Steven Gilbert: It is a very good question. Thousands of people with lived experience engaged in the review, and we had a real split on certain issues. This was one of them. I am always slightly careful when I hear “the lived experience says”, because I have lived experience and I do not agree with the position that the UNCRDP takes. I have colleagues with lived experience who absolutely do.

What is key is whether, at the end of the process in which you are involved, we have a new or amended Mental Health Act in the form of the Mental Health Bill that will deliver change. It will not go far enough, but it will go so much further than where we are at the moment. Not only will it save lives; it will dramatically allow for those to be different experiences of detention and being discharged in a way that is manageable and with a plan.

I cannot give you an answer to that, because unless you have mind control, I do not know how it can be done. When we talk about people with lived experience, it is potentially all of us. I know so many people who have had their lives touched by the Act. It is the most extraordinary piece of law, because it touches so many areas of life from young people all the way through to people who are incredibly old. My own grandmother was sectioned when I was a child. There are all sorts of issues around race, sexuality, gender and poverty. We have people who are high-ranking professionals and people who are unemployed. That is not to disregard the testimony you have heard. Our job was to make the best recommendations in the time we were given.

Professor Sir Simon Wessely: The first service user I spoke to as part of the committee said that she would be perfectly happy to say that the Mental Health Act had saved her life, and then she said, “But why was it such an effing terrible experience?” That stuck with me all the way through. I used it at the launch. That encapsulates the dilemma.

Q70 **Lord Bradley:** The A&E example is the first one where provision and resources hit



against ambitions and the Bill. I accept entirely that the Act cannot in itself produce resources, but it has to be a driver for change.

You have answered a lot of what I was going to ask about the alternatives to A&E with crisis care assessment units sitting alongside, which I have visited around the country. They are good examples of a better provision—they are not the complete answer—than the environment in which mental health people in crisis find themselves in A&E departments. They often sit alongside them; sometimes they are separate, as in Birmingham. It is the pathways out of those units that are important—again, robustly and properly resourced, to ensure that the point Steven made about the continuing crisis leading ultimately to mental health may be mitigated if the pathways are in place out of the crisis care unit.

I hope that you accept that that sort of provision ought to be driven out of reform, the Mental Health Bill, as part of the solution and part of the change that is needed in the community to ensure, as far as possible, that people do not go into custody.

Professor Sir Simon Wessely: Exactly. You know very well that we were asked whether a prison should be a place of safety under the Mental Health Act. I think we said that you can torture the English language so far, but there is a bit where you cannot go any further, so that was rejected—but you are right.

Baroness Neuberger: And police stations.

Professor Sir Simon Wessely: Do you want to say more on that, Mark?

Sir Mark Hedley: No. I agree entirely.

Baroness Neuberger: You are clearly right. I do not think that there is any disagreement between us. The question is: how do you use the legislation in some way to drive this? But clearly that is right.

Baroness Hollins: That was my question as well. How do you use the legislation to drive that? I had exactly the same point to make as Lord Bradley, although I would have wanted to say that we heard evidence from autistic witnesses, for example, who explained that A&E was noisy, very bright and not a peaceful, quiet, calm place. This just exacerbates their situation and makes it inevitable that they will be admitted. Having a quiet, calm place without bright lights and with skilled staff might avert admission. How can legislation be used? Do you have a view on that?

Professor Sir Simon Wessely: Honestly, I do not have a view. The way to avoid that is to have more investment in crisis teams—that is what they are there for—and home treatment services, as we do have. I do not like the idea of people going to A&E just because the lights are on, in the same way as it means they do not go to see their GP and things like that.

We did the best we could. There was one bit we got stuck on. I have forgotten the details. What was it about? We wanted 136 to be usable in A&E, but it is not possible. Anyway, that was the only suggestion we had. That was dropped for legal reasons. To be honest with you, I have now forgotten what the reasons were, but there were reasons.

Q71 **Baroness McIntosh of Hudnall:** I am sorry if this is a terrible Janet and John question. I am not an expert. Listening to you, what I think I am hearing is that, even if nothing else changes, you have contextualised your recommendations both in your report and today within a much wider assessment of the social fabric. We might be talking about housing; we might be talking about a number of other kinds of influences that bring people to crisis. We are living in particularly difficult times. Am I right in thinking that, if nothing else changes and there are no further resources and there is continued pressure on all the services that are currently available, you still take the view that the recommendations you have made as now incorporated in the Bill—leave out the ones that are not—are still worth fighting for?

Professor Sir Simon Wessely: God, yes.

Baroness McIntosh of Hudnall: Thank you. I assumed you would say that, but we keep coming back over and over with all our witnesses to the question of implementation and the question of resources needed to provide the alternatives to the way things are, which you say should be changed.

Professor Sir Simon Wessely: To reverse your question, if we start with the premise that some people are going to need admission, it could be that, in a wonderful new society, that is prevented because everything is done without any recourse to coercion, which is what we are talking about. I do not think that is ever going to be possible.

Assuming that there is still a role for admission as short as possible with the least restriction and so on, most of our recommendations will make that better. Your voice will be heard. Your choice of whether you want an injection or medication will be better respected. There will be people to advocate for you better. Your nearest relative can be someone you actually trust and who is not just imposed by law. All those things will make the process better, shorter and more therapeutic.

Baroness McIntosh of Hudnall: Sir Simon, I am really sorry to challenge you on that, but I have to say that, of all the things that you have just enumerated, I could not agree with you more. What could I possibly disagree with?

Professor Sir Simon Wessely: Good. But you are going to.

Baroness McIntosh of Hudnall: But they all require investment, they all require resource, and they all require extension of what is currently available, do they not? Tell me I am wrong.

Steven Gilbert: I am looking at Lord Bradley, because you face the same argument with criminal justice. We know the evidence suggests that there are approaches where for £1 you get £10 back. The arguments are overwhelming. The problem—this is where it gets slightly political—is that society does not want to fund healthcare for people who have a criminal justice background.

At the time of the review, we said that a voluntary admission was £12,535, basic detention under the Act was £18,315 for an average 45-day admission, a secure admission was £165,000 per year not including additional nursing and escort costs, and admission to medium secure services cost in the region of £320,000 just to prevent people going into

detention. You have to fund some of this up front. We cannot afford to keep doing this. Currently, people are coming out of hospital and they are not better; they have just been warehoused.

I was sectioned for 21 days. My friend got me out. I was well enough to leave hospital, but I was not well, and the problem was that there was absolutely no support for me to rebuild my life until I got very specialist care. I landed with a phenomenal community psychiatric nurse, from whom I was only just discharged after 12 years. I had consistency there. I have bipolar disorder, and the trust I was in had a course called Mood on Track, which basically was a class for 10 weeks that taught you how to live with bipolar disorder.

The problem is that is not standard. We are spending all this money not to get into an argument, which is quite complicated, about the importance of work, but it is really important for people to work. They become taxpayers, which is where we get money back. When you have a life that you are building and you have all the right support around you, you are less likely to become unwell.

I am simplifying a very difficult argument. I just push back against the notion that it is costly.

Baroness McIntosh of Hudnall: For the avoidance of doubt, may I say that I am entirely on the side of all the arguments that you have put forward? Of course, I understand exactly what you say. It is really the same question as the one that was put to you before about how the legislation can drive some of the changes that will be required, and I am struggling to understand that at the moment.

Baroness Neuberger: I will give you two examples. One is the named relative. Baroness Barker will remember that we battled and battled on that back in 2008 when the Government refused to say that somebody who was under a section could choose who their nearest relative was. If you allow somebody to choose who their nearest relative is who can help make decisions with them or, if necessary, on their behalf, you probably take one flashpoint out of the system, and that probably—not always—could reduce cost.

The other thing I would say is that if you go along with these changes—clearly, it is not enough, and a lot of this is about resources—you should have people in hospital for a shorter period, which is in itself—

Sir Mark Hedley: And fewer people.

Baroness Neuberger: And with any luck—that is why the principles are so important, in my view—you would get fewer people, as Mark says, and you would get them in for a shorter period. Those things in themselves are good. Whether that frees up resource for other things is another matter.

Dr Rosena Allin-Khan: Due to unforeseen circumstances, I need to leave early today. I was going to ask a question about patient choice around treatment. I will not be able to ask that now. Dr Poulter will do that for me. I just want to leave you with one thing that I have not been able to stop thinking about since yesterday. I was in a subgroup with Dr Spencer when we talked to people with lived experience of autism and learning disabilities. I promised myself that I would raise something that I heard yesterday. I will feed that in, and I am sure you will cover it at some point today.



On the issue of being able to name a family member, a gentleman who has been in the system for decades said to us—and we went very quiet—“I don’t have any family”. I feel a responsibility to raise this person’s experience. I am not going to name him because I do not know whether I am allowed to today. I want to raise the case of people such as him who very bravely spoke about the fact that he felt he had had all choice removed from him—he had no one to advocate for him and no family member to be called on. I just want to leave that with you before I depart. Thank you very much for your time.

Sir Charles Walker: If this was about money at the highest end of service users, we would have the most well people imaginable, given the financial numbers that have just been described to the committee. Resource is important. We spend a huge amount of money on the high-end service users, and they often come out as ill as they went in. It has to be about all the things that Sir Simon and you all have put in your report.

Who is going to drive the changes? It is great. This is the utopian committee. We love all this stuff. But who actually is going to drive it? There are hundreds of hospitals out there, there are thousands of clinicians and there is a culture, and they do the very best that they can in almost all cases. Who is going to drive the fantastic changes in this report? Who are going to be the drivers of change?

Professor Sir Simon Wessely: It will not be any one group, but it is the groups that were massively involved in this—part of Mind, Rethink and the Centre for Mental Health. My royal college is onside. We had tremendous support from the two major social work associations. Then there are the service user groups.

The coalition that came together as part of this, which some years ago was a bit fractured, is definitely not fractured at all. I have not followed your other hearings—I have not been able to because of the day job—but I would be amazed if they were not saying they are onside with this. They are very powerful and their support will also push it.

Sir Mark Hedley: I also want to add that the judiciary has a role. If the MHRT judges and the higher tribunals are on board with this, they will hold people to it. That is a way—only a small way—of percolating into the culture.

Sir Charles Walker: The NHS has only so much capacity for change at any one time because it is hugely overstretched. Between the changes coming into force, being approved by both Houses and your seeing that cultural change in mental health services, are we talking six months, a year, two years, and how will we measure the success of those changes?

Steven Gilbert: The other two groups that are key to mention are AMHPs and Section 12 doctors. Thinking about that specific point in time, and just thinking about how crucial the assessment is, we have had multiple discussions about how, despite the assessment taking quite a while, decisions are made quite quickly, rightly or wrongly, and then are justified. Actually, you only have to influence a relatively small number of AMPHs and Section 12 doctors in each location to start to drive some of that change. You are not looking at a whole group of NHS staff in the first instance.

Baroness Neuberger: We know that cultural change takes a very long time in a whole lot of areas: look at sex discrimination and stuff like that. It is not hard to see. That is one of the reasons I feel so strongly about principles on the face of the Bill.

If you have legislation that is based on some principles that everybody can see—all the professional groups read the legislation because they have to—it will not happen quickly, but it will happen, because they will have to read the stuff, and I think that is really important.

Sir Mark Hedley: If we draw on our experience of the Mental Capacity Act more recently or the Children Act further back, both were major cultural changes—it is a gradual process—but they bit very quickly. It started quickly, albeit that it took a long time to see the matter through because you uncover all sorts of problems that were not foreseen when you started implementing it, inevitably. I would not be pessimistic about initiating culture change, but the maintenance of it is an ongoing task. I quite agree.

Professor Sir Simon Wessely: Relatively simple things do not have much cost—for example, if our recommendations are implemented, saying that when you fill in the legislation, which will be electronic in the future, you have to write your capacity assessment—at the moment, you do not—and therefore everyone is suddenly getting trained properly in it. Ben, you will know that and will be thinking partly of it.

Baroness Neuberger: And you know that it can be looked at.

Professor Sir Simon Wessely: And it can be looked at. Then if you say, “You have to ask, ‘Is there an advanced directive? Yes or no?’”, you just say yes. “Are you going to follow it? If not, why not?”—that is completely new. It does not have any cost, but it means that you can at least mark their homework, and then people will start to take it seriously. That is how these things change. I am sure they are not cost-free—

Baroness Neuberger: Nothing is cost-free.

Professor Sir Simon Wessely: Nothing is cost-free, but they are not far off it. That is how you change behaviour. All you do is mandate that you have to fill that bit of the form in, and then people can challenge it.

The Chair: That is incredibly helpful.

Q72 **Baroness Berridge:** Shall we go back to the beginning, which I think is where Prime Minister Theresa May began, with addressing inequalities for black and minority-ethnic communities?

To what extent do you think this is now reflected in the draft Bill? We have heard from witnesses—and it has been my concern—that not enough is directly in the legislation to address the inequalities of experience. What practically could we do to put that on the face of the Bill? We have heard a lot about the lack of available data. If there is a post-legislative scrutiny committee, how will we ever know whether the legislation has been effective? There seems to be very little data on BAME in LDA settings.

Professor Sir Simon Wessely: I am an epidemiologist, so I will do the boring boffin question, which is the second bit.

It is by quite clearly making sure that data is captured that is not at the moment. I was very surprised to see where the big gaps were. They are in the report, and there is a recommendation that that be sorted. I think that is easy to do once you realise that it is not there.

The second point before I hand over to Steve is that nearly every recommendation will improve the discrimination that we now know exists against people from black Afro-Caribbean heritage. If you take the CTOs, where that discrepancy is the biggest and getting larger, clearly anything that we do to reduce the use of CTOs—hopefully quite dramatically to make them harder to get on and easier to get off—will improve those discrepancies most.

There is hardly any provision that does not have that effect, even though it does not mention the words “Afro-Caribbean community”. It is clearly and explicitly there to do that. That does not mean that it will not have a benefit on those who are not of black Afro-Caribbean heritage, but it will. If we halve the number of CTOs, that is proportionately going to make a huge difference to the statistics because of the tenfold overrepresentation. That is the first answer. The second one?

Steven Gilbert: The simple part. This is key, and we really battled with it during the review. Our society is acutely aware of it since the events of the murder of George Floyd and the overrepresentation of deaths due to Covid.

Part of the challenge—I get the frustration—is why we did not just write, “Don’t be racist”. That is effectively what people wanted us to write, but you already have that in law. You already have the Equality Act. You already have the public sector equality duty. It could not be clearer.

What is quite concerning is that in the time after the review I see lots of different professionals from lots of different areas, and they all have duties under the public sector equality duty, but a lot of them do not know what they are.

We already have laws. This is not about having more legislation. If legislation were to fix it, we would have done that already.

The points that Simon made are key: specifically, that advance choice documents are absolutely crucial. I mentioned at the beginning all the long lists of things I am involved in, and one of them is called AdStAC. I cannot remember what it stands for, but basically it is a piece of work that has been led by Dr Shubulade Smith. She was heavily involved in the review. She co-chaired the group on the experiences of black African and Caribbean people. They are doing a pilot at the moment looking at how you implement the actual practice behind advance choice documents focused on black people.

She is really excited. I know that she is coming to the committee on the 2nd, and she will talk much more about it. She said that she has never seen engagement like this from clinicians, professionals, service users and carers—not just that they are having a say, but that there is a tool and a function that will have legal status, which means they have to be listened to and their views have to be taken into account. We really believe that that will help not just at the point of crisis but in how you avert crisis.

The detention criteria are also massively crucial—the elephant in the room. We are dealing with perceptions of dangerousness. If you look back at some of the reports that have come out in previous years, there is language that is tongue-in-cheek about big, black and dangerous. I cannot tell you how to legislate against people not viewing me as scary. The train down was really busy, and I was one of the last people to be sat next to on the train. You can pass it off as being just on that given day. These experiences happen all the time.

What we are doing with the detention criteria—I know there are different thoughts on how we have rephrased them—is really about trying to say that you cannot view people as scary and that that is no reason to detain them. Do they have a genuine need that can only be met in hospital?

I know that you are thinking about abolishing CTOs. They are disproportionately used. That is a massive coercion in the community.

Checks through SOADs and easier access to tribunals are key. It is not just having access to the tribunal; it is seeing the pathway all the way through. Ideally, if someone has an advance choice directive or an advance choice document, you follow their wishes all the way through. It is not just a clinician versus a patient saying, “I didn’t like what they did to me”. If it gets to that point, it is because something has really gone wrong and the patient has not been listened to.

Baroness Berridge: From what you are saying, you want ACDs back in the Bill in the way you put them in the review.

It may be an aside, but I have a strategy of sitting next to black people on the Tube, and they often look at me really oddly because every other seat is empty and they wonder why I have sat with them. It is quite an odd strategy.

The reasoning in the review was that there is a small group of patients that CTOs might still be useful for. Maybe it is a question for us as legislators.

Steven Gilbert: We have an answer for that.

Baroness Berridge: I just want to put what I as a legislator would think of that reasoning: the harm on the other side, and, from the point of view of community engagement, the brand is gone—they are toxic. Am I right that it would be a very good action to say, “That’s it. We’re not having any more trials on this. They were predicted to be a disaster. They were a disaster”? It is time to use the clause around the community, once someone is released, which could have a similar function, and we get rid of them altogether.

Professor Sir Simon Wessely: We discussed all of that at great length, and it was a fine-grained decision.

The first thing I want to say is something that we did not put in but has been raised since. I easily see how you could put in a clause, “Lack of capacity. Cannot be established merely by reference to someone’s age, appearance or aspects of behaviour”. You could put that kind of thing into an Act, which we did not consider, but I think is quite reasonable to add.

Sir Mark Hedley: But it is in the Mental Capacity Act.

Professor Sir Simon Wessely: On the second question, when doing the review we saw some units and so on, particularly those who were dealing with people who had been moved from high security or medium security into supported housing, where the people working in those projects, much to my surprise, expressed a strong preference to have CTOs. They said that without them the people who were still ill would end up back in high security or medium security. That was a specific thing. I tried to avoid the awful clichés such as “last chance saloon”, but we wrote that in.

Dr Ben Spencer: Was that not supervised condition discharges, though, and not CTOs?

Professor Sir Simon Wessely: No, definitely CTOs.

Dr Ben Spencer: Forensic patients and CTOs.

Professor Sir Simon Wessely: Yes. You could say that CTOs should only be kept for Part 3, which I know you, Dan, are in favour of. I cannot really think of a counterargument to that.

Dr Dan Poulter: It is interesting, because CTOs were used in that context of forensic patients. You say there are other parts of mental health legislation that specifically deal with high-risk forensic patients. Is there a way in which you could see that CTOs’ generality could be abolished but there could be some specific additional clauses put in about forensic patients that work similarly to CTOs?

Baroness Neuberger: Possibly, yes.

Professor Sir Simon Wessely: Yes, it is quite a good idea. Like I said, I cannot think of a counterargument. Yes, possibly.

The Chair: We are straying into CTOs, and that is no bad thing, but we need to come back to the nub of the question—racial inequalities. Liz, was your question in relation to that?

Q73 **Baroness Barker:** It is. On the day we debate CTOs, I may well come to work wearing a T-shirt that says, “We told you so”, because we did. The members of the committee who listened to people with lived experience from the black and minority-ethnic community came away very strongly with the view that they should be taken away. My view is exactly yours. If they are to remain, they have to be highly circumscribed and restricted.

In the Bill committee we asked about the research evidence base, not just here but around the world, and were told that it is very sparse. It is not around. We are subjecting people to stuff that is not evidence-based at all. We want to know from the people who have been abused by the CTO process how they think they could be sufficiently restricted in order to not be incompatible with the principles that you say that you want. If on the one hand we move to principles and then we keep this in, we are in a mess.

Professor Sir Simon Wessely: We put that in. They should be much harder to get on and much easier to get off. They should be for two years, after which the presumption changes. All that stuff would by definition reduce the numbers. It could not possibly increase them. We do not know by how much, but we think it would halve them.

Baroness Barker: Have you run that past the groups of people whom we have talked about?

Professor Sir Simon Wessely: No, I have not—we made the recommendations—but you obviously have. I am slightly disappointed that some of that has been watered down, which is a bit of a surprise to us.

Marsha De Cordova: The real issue is the disproportionate number of black African and Caribbean people being detained under the Act. There are cultural issues that need to be shifted in the way people are treated in these settings, and that goes to training and all the other things, and there is the legislation. Yes, I know that we have an Equality Act and that there are public sector equality duties set out within those on the way people should respond and behave, but we have this piece of legislation and part of the review was to look at how we reduce some of the racial disparities. We all agree that the principles should be on the face of the Bill. When we look at things like the ACDs and when it comes to the cultural approach to advocacy, would you agree that those should be enshrined in the legislation?

Baroness Neuberger: Absolutely.

Professor Sir Simon Wessely: I thought they were.

Steven Gilbert: Yes, along with the statutory care plan. Principles on the face of the Act, ACDs, changes to detention criteria, significant curtailing, if not abolishing, of CTOs, statutory opt-out on culturally appropriate advocacy in statutory care plans, better access to SOAD tribunals. It is not a picking list. It is all of them.

The bit that I thought you were going to ask was: why do we not write in the legislation that you cannot racially discriminate? You could write that; it just would not have any impact. I am not sure whether that is what was on your mind. We had calls during the review to do that, and the problem is that—

Marsha De Cordova: It is enforcing it.

Steven Gilbert: It is the enforcing, and that is where I have not really spoken about the Patient and Carer Race Equality Framework. I know that when Jacqui Dyer was here she spoke really well to that. I massively believe in it. It was me, Jacqui and Shubulade, who is going to come before you, who developed that along with the rest of the team. We are absolutely behind that.

My big concern is: where are the teeth on that? I am not sure whether that comes through from the CQC or if it is a different area. What is that mechanism? Again, I am not a legislator. I do not claim to be. When these measures are implemented, surely there should be transparency around performance, and underperforming organisations should be fined in the same way as if they abuse other parts of the sector they face a serious reprimand. The

problem I have is that I know that boards and hospital administrators have been looking at the same data for 20 or 30 years and nothing has shifted because there are no repercussions.

All of this is really good, and we are looking to the optimism and what works best, but part of me is still thinking, “With all of this, people will still not do it, so what is that consequence?” Again, I am not a legislator, so I do not know what devices you have to hand; otherwise, people will continue to do it because we live in a society that we know has structural and institutional racism in it.

Baroness Berridge: Maybe what we are talking about here is a communication issue. I am not saying that everybody will read our Act when it gets through—they should do—but if you are from the learning disabilities and autism community or civil society you will look to a section of the Act and think, “Oh, that’s me”. The communication will have to be about ensuring that where this journey began—which was, “Hallelujah, great, at last we’re going to try to deal with this”—is, in simple language, which could never describe the Mental Health Act, in the Act. It is a real communication issue to make sure that communities understand that all of what you have outlined is aimed at them, even though the words are not used on the face of the Bill, unlike LDA.

Steven Gilbert: If you get the Bill right, all the people we have just described will make sure that is communicated. That is not so much an issue. Maybe there is an argument for when those principles go on the face of the Act: “That is what you’re going to do, because we’ve compelled you to do so. We’ve made very good arguments”. You put something in there on reducing discrimination or something about a person’s protected characteristics. There is probably a way of doing that. The community will take care of the communication because we are primed and ready for it, but it has to have the substance. Even though this is a heavy piece of law, we are quite capable of getting to the heart of it.

The Centre for Mental Health does a phenomenal job of breaking down the complex into something that is really digestible for everybody. The organisations are there and primed. We just have to make sure we get this Bill right and it has to be on the face of the Act, and it has to be deep in those details; otherwise, you are selling something on the face of the Act that is not in the Bill or vice versa.

The Chair: May I suggest that it could be achieved with improved data collection and information? There is one form of communication, which Lady Berridge and you, Steven, have alluded to, but it is also about having improved data to show what is happening, and that would improve transparency and so on. Digitisation across the board is what is needed. We cannot legislate for that. You cannot say, “That must happen”. It has to accompany legislation.

Steven Gilbert: Sorry, I am holding the floor here. That is the point from the PCREF. The key thing there is “patient and carer”. Is there a way to incorporate a score or that assessment into those formalised reporting structures so that you are not just marking your own homework?

I have heard for many years, “We’re doing this and we’re doing that”, and it has made no difference. Our view as service users and carers holds no weight, because it does not end up

in anything official. It is just, “Oh, these are murmurings”. Through that function, if you were able to, it becomes part of the dataset. You are seeing at which point the patient experience improves based on which changes you are making and how fast you are going and how fast that can change.

The Chair: There is one other area too, which is training.

Baroness Neuberger: It is the principles on the face of the Bill so that professionals have to take note of them. If you have that, you are bound to have professional training trying to change the way people have been thinking and the institutional discrimination that has taken place. You would use the training that all the professionals involved have to undertake—and they have to undertake it repeatedly—to push the agenda. Is that fair, Steve? I think it is.

Steven Gilbert: Coming into the philosophy of the Patient and Carer Race Equality Framework, it is not just one-off training; it is training for a purpose. As you start to identify where you need to focus, you have that, but it is not just, “Here, go and do your unconscious bias training”, and that is it. It is part of a culture where we are continually working towards improving access, experiences and outcomes.

The bit that I want to say—we always feel the need to say this from a black perspective or any area of discrimination—is that if you get this right for one group you raise everybody’s experiences. This is not, “Why are you prioritising one group?” If you look at what is at the heart of a lot of these reforms and a lot of these issues, we are talking about communication. We are talking about the fact that service users are screaming out for things. Some things cost a lot of money and are quite complex, but a lot of things are really simple.

If you can do in-depth work with one group of people, you can apply that same methodology to how we improve experiences for people who have hearing impairments and what their experience is like in the Mental Health Act system, people who are older, and people who have children and are being separated. The point is that everyone can really benefit.

Lord Bradley: I think it is joint training across all the agencies that are dealing with the same person under the legislation rather than siloing the training in different agencies and then not having a collective response to it that is consistent and co-ordinated.

Baroness Neuberger: With multidisciplinary teams being trained together. Absolutely.

The Chair: That is extremely helpful. I feel we have really covered the issue of advance choice documents. You have all been extremely clear on that issue.

Q74 **Marsha De Cordova:** The Bill introduces new powers for mental health tribunals, but they will not have powers to make decisions about care or treatment either in detention or under a CTO. It would be useful to understand the panel’s views on this—I know it was touched on earlier—and what the impact might be if these tribunals were given such power in relation to the patient/clinician partnership and in terms of resourcing.

Sir Mark Hedley: It is very important to recognise the potential role of the judiciary. The judiciary is not there to tell doctors how to do their job or to allow people to subvert the

purposes of Parliament by refusing all treatment. It has a much more focused role. Clearly, the classic role of the tribunal is determining whether someone should be discharged or not. I appreciate that. In relation to a number of matters where we have suggested, but it has not been taken up, that there should be an opportunity to challenge treatment decisions, it is extremely important to recognise what is being talked about.

First, external challenge is an important factor of human rights compliance and general building up of confidence that people are not trapped within a self-perpetuating system.

Secondly, judges are quite adept at understanding and upholding individual rights. What we have in mind is that people should be able to challenge a treatment decision, and the role of the judiciary is whether the person should be entitled to object. There is no question of judges telling doctors what to do. The question is whether the individual patient has the right to object.

We have suggested that, surrounded with a leave procedure so as to prevent people from making applications who simply do not want to be treated at all or to prevent people from making applications where there is not a good enough alternative treatment available to them. The challenge is where a doctor wants to pursue one particular type of treatment and the patient wants another treatment that is perhaps not as good but is good enough. It is that scenario that we are trying to focus on, because judges are quite good at being able to deal with the question, “Is this person entitled to refuse in these circumstances?”

We need to be quite clear about what the judicial function is here. It is quite limited but quite important because, as I say, it provides some external accountability and it provides patients with the feeling that they are not helplessly trapped within a self-perpetuating system.

Baroness Berridge: Are you saying that the judicial role will be to assess capacity, and once you have assessed that they have capacity to do this, their decision to refuse that treatment is valid and has to be refused?

Sir Mark Hedley: You do not need judges to assess capacity. That is asked of anyone who is treating someone. Capacity may be a relevant issue, because, on the face of it, unless you have capacity to refuse treatment there is no argument about refusing treatment. Capacity is part of the mix.

Baroness Berridge: What is the actual judicial determination? We had a discussion about that yesterday. Was it similar to JR—that you would say you have not done the right process to get to your decision?

Sir Mark Hedley: No, it is further than JR. JR is never used here for reasons that we all understand, because it is completely inaccessible to the ordinary person.

We are thinking of where a doctor proposes a treatment. A person has either made an advance choice that they do not want that treatment, in which case capacity does not terribly much matter, or they are saying, with capacity, “I don’t want it”, and they want to challenge that. We are saying that there may be a proper place for a tribunal judge who does not need a doctor or an assessor or anyone sitting with them for this purpose. It can be done certainly by a judge alone.

Is that patient entitled in those circumstances to refuse that treatment? First, they are not entitled to refuse treatment altogether. We are not entitled to tell doctors what to do. The issue is whether they can refuse this treatment. Am I satisfied that there is an alternative that is at least good enough? If there is, I may pay very close attention to their desire to refuse that treatment because they have a history of the side-effects of the treatment or something like that that is peculiar to them but which is important. It is that kind of role.

Baroness Berridge: This is very different, is it not, to the ability of somebody with capacity to refuse physical treatment? This is where sometimes the struggles come into it. You are allowed to refuse medical treatment even if that means you die, but, in this scenario, in the legislation and in the role of the tribunal we circumscribe your right even when you have capacity to do that.

Sir Mark Hedley: We are assuming in this context that the person is compulsorily detained. If they are a voluntary patient, they are entitled to refuse anyway. The issue does not arise. We are talking about people who are compulsorily detained. To that extent, that takes them out of the norm of refusals of treatment.

You are quite right: there is an absolute right to refuse medical treatment irrespective of the consequences. I have had to deal with several cases where people have refused treatment and died. No doctor ever agrees with the view judges take on it, for reasons I understand. It is a tough world, human rights and freedoms. Here we are talking specifically about people who are compulsorily detained and are therefore compulsorily being treated.

Baroness Berridge: I am sorry to add the last layer to this, but what is the situation where the patient is a child? We do not want to get into any situations that we have had in the public domain about parents' views not matching clinicians' views.

Sir Mark Hedley: We have to split children into two categories: 16s and 17s, who are perfectly entitled to treatment irrespective of what their parents think. Our views were that if they refuse treatment, that is inevitably subject to a best-interest consideration in ordinary children law under the Children Act.

Baroness Berridge: Even if they are detained under the Act.

Sir Mark Hedley: If they are detained under the Act, my view would be that we have to assess whether they have capacity to deal with the matter and deal with the thing from there. If they do not have capacity, the treatment is in their best interest. If they have capacity, you would have to consider the rightness or wrongness, and parental input would be part of that decision mix.

If you are dealing with under-16s, the issue is different. The Act then starts talking about competence without ever defining it, except that it is defined by the great House of Lords case. My mind has gone blank for a second.

Baroness Berridge: Gillick.

Sir Mark Hedley: Gillick, thank you. There is a strong case for saying, to make coherent, that under-16s should be assessed on Section 3 of the Mental Capacity Act on the functional basis

without the presumption that they have capacity. It should be a genuine assessment. The role that parents should play, we felt, was so controversial that there should be further consultation on that because it is a really difficult issue.

Baroness Berridge: Encourage me. I have struggled to understand what happens in circumstances where parents are involved.

Sir Mark Hedley: I can tell you what happens outside the Mental Health Act, and less so within it. For under-16s, you are going to be dealing with anorexics in particular and similar things. You are often dealing with life-saving issues, and with under-16s, frankly, that trumps everything in the real world, however we care to set it out, even if it is only on the judges must sleep at night principle.

I would want to treat 16s and 17s and under-16s separately from adults because the whole law does. It would be helpful if we used the same concepts right across the board rather than introducing a concept that is of judicial origin and has no statutory foundation or, more particularly, statutory definition.

Baroness Berridge: Okay, thank you.

The Chair: That is very helpful. Ben, you wanted to come back in.

Dr Ben Spencer: Thanks. That was very helpful. Can I just get my head around the tribunal appealing decisions? You envisage it being only for people who have decision-making capacity to refuse treatment. Of course, plenty of people are in hospital detained under the Act with a mental illness—we have good prevalence data on that—the majority of whom lack decision-making capacity around their treatment, but who nevertheless are able to explain very sensible and rational decisions about why a treatment option is not for them. It seems to me that you have knocked out where the most need is.

Sir Mark Hedley: There are two things, if I may. One is that capacity is decision and time-specific. If a person has a really clear view about why they should not be treated, they almost certainly have capacity for that particular purpose. There is no such thing as the person who lacks capacity. They do not exist. It is decision and time-specific. Most people who lack capacity will have capacity to do some things and not do others. I do not want to exclude from capacity.

Dr Ben Spencer: On that, if I may, there will be people—I completely appreciate it is decision and time-specific—who will say, “I don’t want to have an antipsychotic. I don’t believe it will benefit me, because I do not have a psychotic illness. However, this antipsychotic, when I’ve had it before, didn’t suit me. If I was to be forced into a situation to have an antipsychotic, I would choose antipsychotic A over antipsychotic B”. One may lack decision-making capacity for treatment, but still have coherent and sensible wishes and feelings that one wants to put across and therefore challenge in a tribunal. That is what I am trying to unpick. Why is the decision-making capacity the gatekeeper here?

Sir Mark Hedley: I wonder if I slightly overstated it by saying it could only be people with capacity. I think we recommended that the nominated person should be able to initiate a challenge on behalf of the person concerned, in which case I think I overstated it. Probably, the challenge could be made by someone who lacked capacity, but their lack of capacity would simply be a factor in the decision whether to allow the refusal to stand or not.

I think that must be the case; otherwise, there would have been no point in giving the nominated person the right to make the application on their behalf.

Dr Ben Spencer: I am not sure why it is not all in, in a sense. Why is any sort of capacity gatekeeping in appealing treatment decisions? There is no capacity gatekeeping in appealing detention.

Sir Mark Hedley: No. The group that we were particularly concerned about were those who had capacity and were refusing because of the need for external vigilance and the need to feel you are not trapped in the system. I probably did slightly overstate it, and I think there may well be a place for someone without capacity who meets the kind of description that you are putting forward, if I may say so.

The Chair: That is very helpful.

Baroness McIntosh of Hudnall: I would like to clarify something that I think you, Sir Mark, said. Forgive me if I have misunderstood. When you described the circumstances in which the tribunal might come to a view, you said quite clearly that it was not the job of the tribunal—the job of the judiciary—to tell a doctor their job.

You described a situation in which a patient does not wish to receive treatment A because he or she believes that treatment B, while perhaps not as good, will still be as effective. The job of the tribunal—forgive me for going over this; I just want to make sure that I have understood—is to say that the patient has the right to challenge that decision.

One of the issues that seems to hang in the air over this question about the tribunal is whether, in fact, giving the tribunal additional powers does, de facto, mean that it can cause a doctor to have to change a decision. If the patient has the right to challenge option A in favour of option B and the tribunal upholds that right, by definition, or at least de facto, what goes back to the doctor is that you now have to choose option B. Is that the case?

There are two things going on here, are there not? There is the potential for the tribunal to override a clinician's preference, decision or recommendation. There is also the possibility that a clinician might override that decision. The question of where the balance of power sits between the tribunal and the clinician seems to me to be quite vexed, and I am not entirely sure I have understood it.

Sir Mark Hedley: There is an important distinction between telling a doctor what not to do and telling a doctor what to do. In the ordinary world of non-mental health, a patient has a right to refuse treatment. If the doctor attempts to treat, the patient has the right to come to court and the court says to the doctor, "You cannot do that". I do not know of any

circumstances in which the court says to the doctor, “You must do that”, because we are not qualified to do that; that is not our business. Our business is dealing with individual human rights and their enforcement, not the techniques of medical treatment. That is not our business.

What I am saying is that we are concerned with the right of the detained patient to object to a particular form of treatment. That is what the focus of the challenge is. It has nothing to do with what the doctors are then going to do.

If the patient is entitled to reject that treatment, the patient is simply being put in the position that they would have been in had they not been detained. They would always have had a right to refuse. We are not doing anything terribly remarkable apart from conferring on a detained patient potentially the right that any other patient has anyway.

Dr Ben Spencer: But they are still detained, and the gatekeeper for them being not detained is receiving treatment in all circumstances.

Sir Mark Hedley: Of course, they are different. I appreciate that fact. All I am saying is that the role of the judge is focusing on the right of the patient as a detained person; it is not focusing principally on deciding what the appropriate treatment for that patient is. If the patient says, “I refuse this treatment and I can offer no other alternative”, the tribunal will not even listen to that, because that is a complete non-starter. You are not entitled to refuse treatment. You may be entitled to challenge a particular form of treatment if that is not the only one that is on the table.

Professor Sir Simon Wessely: It is a limited right in certain circumstances. It is not an absolute right. There would be leave needed. We envisage the number of cases to be quite small. We are absolutely not saying, “You have a right to refuse treatment, because then you will end up, as happens in some jurisdictions, detained and untreated, and absolutely nobody wants that”, so that is not possible. There is a bit of a shift in power saying, “You might accept not exactly the best treatment according to a NICE guideline, but it is one that suits me”. It shifts it a little bit so that the doctor—and it will be the doctor in this case— will have to have cogent reasons why that is still not the right thing to do, but a doctor cannot be made to do something that they will not do. That cannot happen either. A judge cannot tell a doctor to do something. They will say, “You need to think that again”.

The Chair: That is the key, is it not? It is about thinking again. Is that not the solution?

Professor Sir Simon Wessely: We think that doctors will adjust very quickly because they are bright people, whether men or women. They will adjust to a slightly new reality, which has just shifted the dial a bit, whereas at the moment there is nothing to make them pay any attention to patient preference other than courtesy. There are no teeth to it. It is a limited shift. It is absolutely not going to permit people to say, “I won’t take any treatment”, or, “I’ll only take homeopathy”, or something like that. That cannot happen.

Baroness Neuberger: Can I just add that I do not think that is an expensive change to be making?

Professor Sir Simon Wessely: No, it is not.

Baroness McIntosh of Hudnall: I just want to be clear. As Sir Simon said, there is a slight shift in power towards the patient from the clinician.

Dr Dan Poulter: I want to tease this out with Sir Mark for a moment. The WHO would suggest that 70% to 80% of patients with psychosis lack insight into their condition. Sometimes in an in-patient psychiatric ward there can be concern where a patient with very treatment-resistant psychosis heard from other patients about certain drugs—Clozapine in particular, from my clinical experience—and are worried about being put on those medications. For the treatment-resistant patient, that might be the only route forward. Is that the only practical treatment left or route forward?

Sir Mark Hedley: If the doctor satisfies the judge that there is only one practicable treatment, that is the end of it. There cannot be any right to object, because you are objecting to treatment, which you cannot do.

Dr Dan Poulter: In that respect, insight and capacity are different issues. What I want to understand, therefore, is that having a group of patients who we know can be very challenging to treat in hospital would not tie the doctor's hands in having to go to what is not a first treatment of choice but a treatment.

Sir Mark Hedley: In practice, part of the reason for suggesting a leave provision was to filter out exactly that kind of case. It seems to me that a case will not get to a hearing unless the patient is able to demonstrate on a reasonable basis that the treatment they are willing to accept is at least good enough. Otherwise, it will not get there.

Steven Gilbert: The other thing is trying to pinpoint where in the Act and the practice discrimination is happening. We know that it is happening all over the place. It is a really big area not just for black people but for lots of patients who are not being listened to and really describe iatrogenic harm. There are alternatives available that would work.

This is, probably in the first instance, about some clinicians getting their hands slapped. The driver is, “Go back and have a better discussion with your patients”. That is the other thing that we have not really spoken about much today but is really important: there are massive power differentials within the Act. We have to accept that although there are lots of well-meaning psychiatrists and clinicians, there are also clinicians on wards who are not. That is something that we have not written in explicitly, but, with a measure like this, we are saying that you have to have an incredibly good reason for refusing someone who has capacity at that time for that decision. It is one way of chipping away at that power differential that certainly will contribute to the disproportionate outcomes for black people.

Chair: And build trust in the system, we hope.

Steven Gilbert: Absolutely.

Dr Ben Spencer: With the exception of people who are detained who are a risk to others—people know my view—refusal of treatment should be as sacrosanct in the mental health setting as it is in the physical health setting. That would solve a lot of

the problems that we are discussing. We could go back to previous conversations at the start of the session.

I get why the ability to appeal treatment plans would be very helpful to patients in hospital. I have a concern regarding the right of appeal that the RC has to appeal the decision of the tribunal and whether the RC has the ability essentially to say, “I respect the tribunal’s decision but I disagree with it. I think it is unsafe for me to look after this patient with the restrictions the tribunal has put on me”, rather like in other areas of medicine, you could say, “You know what, I’m not willing to do that”, while respecting the decision of the tribunal. What are your thoughts on those concerns? Can you alleviate those concerns in terms of this in practice?

Chair: For those listening in or watching today, “RC” is responsible clinician.

Sir Mark Hedley: I do not speak with experience as a mental health chairman; I speak with general judicial experience. I find it very difficult to envisage a set of circumstances in which I would make a decision that required a doctor to do something that the doctor in good faith has said he could not do.

Dr Ben Spencer: We have just been discussing how most doctors are great but they make mistakes. We are trying to change the law so that we can help them work better. Surely, the same must apply to the judiciary as well. There will be times that they—

Sir Mark Hedley: There is a statutory channel of appeal to the upper tribunal, which is subject to a leave provision. These are all part of a hierarchical system. We are not envisaging anything stepping outside that hierarchical system.

Dr Ben Spencer: Would that be practical, as a responsible clinician? Can the responsible clinician fill in a form and say, “Right, I’m going to appeal this”?

Sir Mark Hedley: Like all these things, it is one thing to give a right of appeal; it is quite another to be able to exercise it. I fully recognise that. I think the court route to the upper tribunal is on a point of law only. My guess is that, if you have a doctor saying, “I actually can’t do this”, I would be astonished if that was not treated as a properly appealable point.

Dr Ben Spencer: Surely that is the other problem, then, because most doctors will say, “Look, I can’t do this unless I do treatment A”.

Sir Mark Hedley: That depends. Remember that these decisions are not made on paper. People have been listened to, questioned, pushed, and pressed. As a general rule, I would reckon in a hearing to be reasonably confident about what a doctor was and was not prepared to do and why.

One has to recognise that there is always a discretion built into these things. I would be surprised if the majority of these challenges succeeded; I suspect they will not. They are there as the fail-safe. They are also there because they are a further acknowledgement of international conventions and human rights provisions and so forth, whereby there is an external route of challenge.



Baroness Berridge: In relation to learning disabilities and autism, there is a bit of a Janet and John situation here. We keep being told, “Take them out of MHA and then they fall into MCA”. Obviously, as you will probably have seen, we have groups telling us to take them out of that as well. With the decision to take them out of MHA, there are less safeguards in MCA. I know that we have gone into lots of good details, but could you help us to understand the dangers of the safeguards under MCA?

Q75 **Baroness Hollins:** That is an important question I want to get to. I wanted to start with a question. This is why this is so contentious and so difficult. We are having to think about what is different about people with learning disabilities and autistic people. One of the differences with respect to the Mental Health Act is that the length of stay is hugely longer—an average of six years if people are detained for treatment.

In the independent review comments, you stated that the decision about whether to recommend that learning disability and autism should remain was a fine balance. You said that the Mental Health Act had sometimes been the only option at a point of crisis. You were, therefore, ultimately persuaded that the risk of completely removing learning disabilities and autism from the Act is too high, although you wanted to keep it under review.

This notion of the only option or the last option is quite problematic because it is often called the last resort. I hear a number of times, “Somebody was admitted as a last resort”, when in fact there has been no first resort because of the shocking lack of skilled community provision, the lack of crisis care and home treatment.

The committee wants to hear from you the evidence that the independent review received to support the concerns about removing learning disability and autism as conditions justifying detention under the Act. Do you have a view on the Government’s proposals in this area and whether they meet those concerns? We have also heard that improved access and a statutory right to community care might address some of the risks. To what extent do you agree with that view?

Professor Sir Simon Wessely: I can certainly say pretty much what you just said. One of the things that we took in—Jane Baird chaired that section, as you know—was the fact that, if that was instituted without adequate community provision, the facts of the case would be that people are only being considered for being detained in a crisis. Obviously something has gone wrong, otherwise we would not be in that situation. If that was the case and we were unable to use the Mental Health Act, as it was, as it is currently there are plenty of other options that could be used. Our view would be that they would be used unless and until there was a better solution. You have just listed them.

You can use the MCA; you can diagnose a mental health disorder quite appropriately because, with severe autism, 80% of people do have comorbid disorders, as we know. You could use that. You could even use guardianship and ultimately someone could also go to prison; they would go through that route, none of which are particularly desirable. The first three would mean that you would not know what was going on; transparency would be lost. The fourth is just a bad idea.

That is the real crux of the matter. Without better provision of alternatives, the social worker, the RC, et cetera, would still be in the same dilemma and would look for alternatives that could solve the dilemma in the short term. We are as aware as anyone else that in the long term all of these are bad ideas and all the recommendations to that group are about preventing long-term admissions. Preventing short-term admissions is going to be much more about having better alternatives available. Unless and until that has happened, people will end up doing other things to get out of the acute crisis. That was the thinking of the working group, and it has some merit.

Baroness Hollins: Some of the recommendations that you have made seem potentially to provide the levers that would improve community and skill provision.

Professor Sir Simon Wessely: Yes.

Baroness Hollins: The truth is that, from what I can see—reviews that I have been doing of individuals detained in long-term segregation, for example—so often there is no specialist treatment, not even specialist assessment. Thus, people are never medically discharged because the specialist help is not there.

Do you think that the measures you are recommending could change that and raise the aspirations and expectations for people? It goes back to other discussions about people with protected characteristics. This is a group of people for whom the same is not offered.

Professor Sir Simon Wessely: True.

Baroness Hollins: Or reasonably adjusted, the same is not offered.

Professor Sir Simon Wessely: All the eight recommendations are about saying that if an admission is no longer therapeutic—if there is no therapeutic purpose to it—the tribunal would then discharge. You are looking quizzical. I need to put my other glasses on, but you are looking quizzical.

Baroness Hollins: If they have been on a Section 3, Part 3, and entitled to Section 117 after-care, then perhaps care in the community would improve for them.

Professor Sir Simon Wessely: Yes.

Baroness Hollins: For me, it is finely balanced. What is the best way to improve the response to people in crisis when they have a learning disability, or for an autistic person? This is the challenge. It seems to be an extremely difficult challenge to address unless there is anything else that can be done. Do any other panel members have a view?

Steven Gilbert: I will come at it from the same argument I come at all of this from. What are we doing to prevent that crisis? There are always people who become unwell to the degree that they need to be treated in hospital. Community responses, especially as you have just described, are woeful. Again, I am not sure how you legislate your way out of that. I am not sure what argument needs to be made that says this is horrific. We have all watched

“Panorama”. I am not in government and I do not hold the purse strings, but I genuinely do not know what the shift is there.

I get what you are saying around raising aspirations. My concern is that we raise not a concern but an unintended consequence. You raise expectations, then they are not met and the review is deemed to have failed in that respect. We do not control those resources.

The recommendations that we made were the best under the circumstances. We rightly deferred to people who have greater expertise. They fed into the White Paper and then into the Bill, and that was the right decision to make. I just do not know what argument needs to be made that means we get something different. I am genuinely not sure.

Professor Sir Simon Wessely: There are eight specific recommendations about increasing knowledge, about changing the code of practice and the decisions of tribunals. All of those are all about that, all of which, I am sure, you do not disagree with.

I can see the merits of saying that you cannot use Section 3 for LD and autism in the future. As things stand, that will not have much impact because, if that is what you want to achieve, the facts on the ground are that people will still be able to find ways around that unless and until there are better alternatives.

Baroness Hollins: I suppose the question is: will there ever be better alternatives? It is very rare, it seems to me, to hear about people who are admitted having a good experience, a therapeutic experience. If that is the case and if people are going to be discharged because there is no therapeutic benefit, will that be any better for them?

Professor Sir Simon Wessely: I do not know. We know that people deteriorate. It is not just about LD and autism; it is the same with schizophrenia and other disorders. People in long-term care are getting no treatment at all. They are just being held there for public protection or whatever, and they do not benefit either, which is why the provisions we have suggested are general rather than very specific. We know there is a much greater likelihood of abuses happening within the system, as we have just seen very recently.

Sir Mark Hedley: I have done a few cases in the Court of Protection where young people have been detained endlessly under Court of Protection powers. For our purposes, we are focusing on the right to detain, and if we cannot provide a therapeutic basis, we do not have a right to detain. It does not solve the problem but it addresses the issue of restricting rights to detain only to where they are effective.

Chair: We might move to the next question, which is the point that Lady Berridge was raising, which Ben was going to ask on the Mental Health Act and Mental Capacity Act. This is really the nub of it, is it not?

Q76 **Dr Ben Spencer:** These are variations on a theme. I will try to keep my question circumscribed. It is regarding the interface between the MHA and MCA, particularly when there is a choice between the two. You knew I was going to come on to this. Your review was around using objections to the gatekeeper. That is not in the draft Bill. What are your thoughts on that?

Professor Sir Simon Wessely: I still think that it is a good idea and that you will return to it. What happened with LPS made that not possible, at the moment. Provision for risk to others clearly means that what we have suggested is not workable, at this moment in time. I do not really know what is. We are still in a dilemma there and that is the answer.

It was a mess before and it still is not clarified, but we still need that clarification. If we do not get that clarification, the result will be a further increase in people detained under the Mental Health Act for various reasons because of greater safeguarding, because of some of Section 117, et cetera, because it is much easier to use and people are more familiar with it; all those things will continue. This is probably the main reason why detentions have been going up in the last decade. The first terms of reference that we had were to make suggestions to reduce the number of detentions. Our term of reference was about that—not to look at it, but to reduce it. That still seems to be one way of reducing the number of detentions under the Mental Health Act.

It is still a problem, Ben. I have not seen anyone come up with a simple, easily understood solution that prevents people from being detained where it really should be informal. All along, we have always had the view that we do not want to go back 100 years where everybody who was inside an asylum, as it was then called, was legally detained. We are moving towards that.

Sir Mark Hedley: May I make a couple of comments? One is to reinforce what Simon was saying just now about the importance of emphasising informality. At the moment, Section 131 is tucked away in the “Miscellaneous and Supplementary” part of the Mental Health Act, which it most certainly should not be. Our suggestion was that, as a matter of driving culture change, it should head Part 2 of the Act. There is no earthly reason why Section 131 cannot appear in Part 2 of the Act; you state the principle of informality and then go on to deal with detention, which is just a cultural thing. It does not change the law in any way at all; it is just a cultural shift. That was one thing.

The other thing, as Lady Berridge pointed out, is that the protections under the Mental Health Act are considerably better than under the Mental Capacity Act. With the Mental Capacity Act, frighteningly, the liberty protection things are all done administratively. There happens to be a Section 21A challenge, which is very rarely used, I gather. It is all done administratively and may not be reviewed more than once a year.

I fully understand why there is an interest in using the Mental Health Act from the patient’s point of view. There is a real risk in mental capacity of people just being lost.

Steven Gilbert: Access to Section 117 aftercare was a huge issue. Again, these were incredibly complex discussions. At some points, we were almost being accused of denying people their aftercare. We pushed back and said, “There are people who should never have been under the Mental Health Act. They should have been always under the MCA”. Then they were saying, “Why doesn’t the MCA have a Section 117 aftercare?” That is not our job. It is really quite tricky at times.

Dr Ben Spencer: This is a problem in a psychiatric hospital, but it is an even bigger problem in a physical health hospital. I have a list of areas where the MHA/MCA interface is problematic. One that is particularly egregious—when I used to practise, I saw disputes about what framework to use—is the context of someone who has

dementia, who is in a physical hospital, who is effectively only in receipt of what I call “hotel services”. They are kept warm; they are fed; they are looked after. Everyone is clear that if they were not in that setting they would perish and deteriorate and, by necessity, they have to be deprived of their liberty, and that is the context.

The question goes: “Well, do you use the MHA or do you use the MCA?” It then gets even more complicated when people may have some medication to help them sleep at night or antipsychotic medication on the form as a regular thing. Do you think what is going forward is going to fix that problem? Would you agree with me that that is something we really need to get fixed and get clarity on?

Sir Mark Hedley: The trouble is that dementia, almost by definition, is liable to draw people under the MCA rather than the Mental Health Act. The problem with the MCA in those circumstances is not only the risk of people getting lost in the system, but somehow that the fundamental needs are never addressed, because there is a conflict within the working of mental capacity between providing for emotional welfare and providing for physical welfare. Professionals will almost always go for physical welfare because it is measurable, whereas emotional welfare is not. You can measure whether people are fed, warm, looked after in hospital and so forth. You cannot measure whether they are miserable or not.

Baroness Neuberger: You need people to tell but you cannot measure it.

Sir Mark Hedley: Exactly—you do have a problem under the MCA, in that people get stuck because their physical needs are being attended to and, therefore, people pass on assuming that the job has been done. Those are MCA problems; they are not Mental Health Act problems.

Professor Sir Simon Wessely: I have to go back to our terms of reference just to look at the interface, not at the MCA side of things, because a huge number of people were doing exactly that. I do not think that we solved that problem.

Baroness Berridge: Can I just ask about the circumstances you mentioned around the cases of learning disabilities and autism that came before the Court of Protection? How is that process done? Obviously, under the MHA tribunal you have time limits that force things. What were the circumstances of the cases that came to you at the Court of Protection?

Sir Mark Hedley: The case that I am particularly thinking of dipped in and out of the Mental Health Acts. Of course, because the two systems are meant to be mutually exclusive, the moment a Mental Health Act detention was made, I had to suspend all Court of Protection proceedings. So, I would come back to it nine months later, after the detention had expired, and try to pick it up again because we were back under another jurisdiction.

That is a classic argument for merging them. One set of proceedings could deal with a thing all the way through. As we said right at the beginning, whatever the merits of that might be, there are things that need to be done now that cannot be done if we put it off to do that. They are two separate bits of work.

Baroness Berridge: We keep being told to take LDA out of MHA, but then you may have an even worse situation fewer less safeguards. I would like your comment on that.

The charities told us to take LDA completely out of MCA as well, vis-à-vis mental health issues, not physical—obviously that was different; that was clarified by my colleagues—which was a bit of a trump moment. We were, “Okay, right”. What is your view on that?

Professor Sir Simon Wessely: We have just said that it would not work because of the high comorbidity, because of the situations that were still arising in law about seriously irresponsible, aggressive behaviour being there. That behaviour would still be there. There is a view that says that would not be there because these things are very socially determined, which is partly true but not entirely. The social model of disabilities is very good but it does not explain everything.

Baroness Berridge: If I interpreted their answers correctly, they thought that this was the kerching moment of enforcing: resources would suddenly be released. If you took it out of MHA and MCA, then you have this.

Professor Sir Simon Wessely: I have heard that argument many times: “Well, the Government would then have to act and do something”. Maybe they would or maybe not.

Dr Dan Poulter: The interface between the Acts is obviously quite a challenging area, which you have already alluded to. To get back to your remit, as it were, we could talk about the inadequacies of the Mental Capacity Act, but that is probably not helpful today. To understand that, Sir Mark gave the example a moment ago of a patient with dementia. Sir Mark took the view—it seemed to me to be the appropriate view—that that person should be better dealt with under mental capacity legislation. We still find that quite a number of patients in hospital—particularly when perhaps in the acute setting, as in the physical health hospital—are initially detained under the Mental Health Act. Do you have any thoughts about how we could direct clinicians and clinical practice towards the more appropriate mental capacity framework? Is there anything that you could recommend to do that?

Steven Gilbert: I am recalling arguments from four years ago. That was partly to do with the difficulties in getting the assessments from the MCA. It was quicker to get a Mental Health Act assessment.

Baroness Neuberger: Yes, it was much quicker. That is why it still happens.

Professor Sir Simon Wessely: Yes, it is much simpler and works 24 hours a day. That is precisely why we tried to come up with what we thought was a quite viable way of differentiating between the two jurisdictions. I still think it is.

Baroness Neuberger: There are two things. One is that you have to sort that out because, if you cannot get somebody to do the assessment, what will a clinician do in those circumstances? They will use the wrong legislation. We need that sorted out.

The other thing is about training, which we talked about earlier. It seems to me that you can train people, but you cannot train people if somebody is not available to do the assessment.

Dr Dan Poulter: I want to tease this out a little more. Absolutely, that is a very real, practical concern, as it is much easier to get a second opinion doctor, an AMHP, to do the Section 2. But then you have 28 days. If you go down the Section 3 route, you could have, which Sir Mark alluded to, somebody parked on a Section 3 for many months and under, perhaps, an inappropriate framework. Is there any way in which we could look at using those 28 days?

Sir Mark Hedley: It illustrates the difference between the way lawyers think and the way medics think quite well. In those circumstances, medics will be concerned with the welfare of the patient and how best we do things, whereas lawyers will be looking at the right of the state to detain is. The state should not have the right to detain the person being housed, because it is not providing them with treatment. Therefore, it is outside the principles, so they should not be detained. In that case, they automatically fall back into the Mental Capacity Act. It is very difficult to apply these things on the ground, is it not? It is a big ask of clinicians. After all, there are no lawyers, thank goodness, prowling the wards. It is a big ask.

Baroness Neuberger: Sometimes they are doing assessments, but yes.

Sir Mark Hedley: It is a big ask of clinicians.

Baroness Neuberger: Can I come back on that? This is partly a training issue. It is also about unlocking. I do not think there is a lot you can do in legislation here, but you could make a recommendation that something is put in the guidance about it. In the communications around the final report of this committee, it is one of the things that you could highlight as a major concern. Mark spoke of the difference in approach of lawyers and clinicians and, under the legislation, it is totally inappropriate.

Dr Dan Poulter: I agree that it would be very hard to justify a Section 3 in those circumstances, under the legal framework. The clinician is going to be thinking, “I’ve got a problem here. I have a patient who I’m very concerned about, who lacks capacity but who I have had on Section 2. I haven’t got time to get what is necessary here”. So there may be imaginative ways of getting a Section 3 in place.

Bizarrely, some of those patients we are talking about—perhaps somebody with alcohol-related brain damage or dementia—may not have the friends and family and advocates around for them, so you almost do need lawyers on the wards. If you had any further thoughts on that, they would be of interest, because it strikes me that that interface is not good at the moment.

Sir Mark Hedley: It is also not helped by having the professional safety-first culture, which is inevitably imposed on us in the society in which we happen to live. I have certainly had people who have wrecked their brains through alcohol. The issue will always be, “Can we keep this person in some kind of institutional care because we at least then know what is going on?” In fact, their own welfare may be better served by being in some entirely informal setting that is under much less control and may not objectively, in our perspective, be as good

for them physically but better for them emotionally. They are just very difficult judgment calls. I fully recognise that.

Chair: We may have to break or close the session fairly shortly because of a vote. I wanted to come to the final question about civil grounds for detention. There are three votes, so on that basis we might have to close the session.

Sir Mark Hedley: How long do you need to break for? Those of us who have travelled long distances may be very happy to stay around. Some people may not. I do not know what people's commitments are.

Chair: I understand that we will need to wind up. Thank you so much; this has been extraordinarily helpful. I wish we had two more hours on this, but we are time constrained. We have to finish our deliberations by the end of the year, so we can go to the next phase. Dan wishes to come in briefly.

Dr Dan Poulter: May we ask the panel, but Sir Simon, in particular, what they believe is the impact of raising to substantial the grounds for detention? Secondly, how might that be interpreted by the courts as well? That legal aspect would be quite helpful. How much importance should we give it?

Professor Sir Simon Wessely: That is a good question. I disagree with Mark, and Mark is going to say something slightly different. However, in reality the decisions to detain people, just as they are made across medicine and everything, are made very quickly on a whole series of heuristics. How bad is the situation? Is there something that I can do? If I do not do something, will I be blamed for it?

The words that you put in the Mental Health Act are important, but they are not as important as what happens on the ground with you, with the relative, with the patient and with the social worker. That is the key thing that will decide whether someone is admitted or not.

It is important to show that this is important. It is a deprivation of liberty that most people do not want. Is it critical? I think less so. Mark will now make slightly the opposite point of view.

Sir Mark Hedley: No, I think I—

Chair: Once Members go to vote, we are not quorate. If you write to us on this point, that will be extremely helpful; that is what I was going to suggest. It is of critical importance and unfortunately we cannot continue as long as my colleagues have to make the vote, which is timed.

Baroness Neuberger: Can we write to you about the advocacy point as well? You were going to ask us about that.

Chair: Please do. We have jumped around to some degree; I appreciate that.

Steven Gilbert: Can I make one final point which is probably nothing to do with quoracy?



Chair: Unfortunately, you cannot make it on the broadcast as part of our official evidence.

Steven Gilbert: I can make it to you.

Chair: As we are broadcast, I would like to say a huge thank you to all of you. It has been tremendously helpful. It will make a serious contribution to our thinking going forward. Please write to us with any further thoughts. If we stay in touch, that would be incredibly helpful as well.