Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Wednesday 2 November 2022

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Written evidence from witnesses:

- Dr Ailbhe O'Loughlin (Senior Lecturer at York Law School, University of York) (MHB0006)
- South London and Maudsley NHS Foundation Trust (MHB0062)
- Howard League for Penal Reform (MHB0063)
- Independent Advisory Panel on Deaths in Custody (MHB0083)

Watch the meeting

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

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Witnesses

Panel 1: Dr Arun Chopra, Medical Director, Mental Welfare Commission for Scotland; Dr Mark Buchanan, Chair of Mental Health Commission, Royal College of Emergency Medicine; Dr Chloe Beale, Consultant Liaison Psychiatrist, Homerton University Hospital; Dr Kevin Stone, Associate Professor in Social Work, University of Plymouth.

Panel 2: Andrew Neilson, Director of Campaigns, Howard League for Penal Reform; Juliet Lyon CBE, Chair, Independent Advisory Panel on Deaths in Custody; Dr Ailbhe O'Loughlin, Senior Lecturer, University of York; Dr Shubulade Smith CBE, Clinical Director for Forensic Services, South London and Maudsley NHS Foundation Trust.

Panel 1

Witnesses: **Dr Arun Chopra**, Medical Director, Mental Welfare Commission for Scotland; **Dr Mark Buchanan**, Chair of Mental Health Commission, Royal College of Emergency Medicine; **Dr Chloe Beale**, Consultant Liaison Psychiatrist, Homerton University Hospital; **Dr Kevin Stone**, Associate Professor in Social Work, University of Plymouth.

Q77 **The Chair:** Welcome to the sixth session of the Joint Committee scrutinising the draft Mental Health Bill. For the first panel of this sixth session, we will explore further what the changes in the detention criteria will mean in practice, particularly for clinical staff in emergency departments.

May I begin by thanking very much the panel of witnesses for joining us today? We really appreciate it and the time that you have taken. For those of you who have submitted written evidence in advance, it is all extremely helpful. We have two members of our committee online today. I will first ask you to introduce yourselves and say who you represent. Then, we will get on with the questions.

Dr Chloe Beale: I am a consultant liaison psychiatrist in east London. I am a member of the executive committee of the liaison psychiatry faculty and the eating disorder faculty of the Royal College of Psychiatrists, although I am not here formally representing the college at the moment; I am representing myself.

Dr Arun Chopra: I am the medical director of the Mental Welfare Commission for Scotland. I was a member of the subgroup of the independent review that looked at the criteria on detention.

Dr Kevin Stone: I am an associate professor of social work at the University of Plymouth. I am also a practising approved mental health professional and have lived experience of being a carer for someone with a significant mental disorder. I am representing, I hope, the profession of AMHPs for this committee.

Dr Mark Buchanan: I am an A&E consultant on the Wirral. I represent the Royal College of Emergency Medicine. I also sit on the Psychiatric Liaison Accreditation Network Advisory Committee. I have been involved pre-Covid in the national crisis care concordat. I am also an honorary senior lecturer.

Q78 **The Chair:** What are your views on the changes to the civil detention criteria in the draft Bill, and how could they be improved?

Dr Arun Chopra: The brief we were given in the subgroup was to look at how to reduce compulsion rates, but also to have a particular regard for groups that have seen a dramatic rise in detentions. I am talking about minoritised ethnic communities. That is one reason why we tightened the criteria.

My sense is that the tightened-up criteria reflect what is happening in practice, to some extent. I accept what many of my colleagues say: that you must have a particular degree of risk to get a bed in hospital at the moment. Having said that, one thing that is helpful about setting the criteria, as we have suggested—I see that has come through the White Paper into the Bill—is that it provides more transparency, more accountability and more clarity about the threshold that needs to be met before you consider compulsion. I hope it will encourage a

move towards lesser restriction, or that the principle of least restrictive practice would follow through from that.

I acknowledge what many colleagues say: this is what is happening in practice. In fairness, this also opens up the opportunity for people to challenge better because they will be able to ask, "What is the serious risk and what is the likelihood?", which is the second arm.

Finally, for those who are at the greatest risk of detention, because of perceptions about their risk, having that greater clarity makes it better for them to challenge. It helps everyone, but it disproportionately helps people from a BME background. It is not just anecdote that people from a BME background are considered to be riskier. In Scotland, my organisation published data last year showing that people who come from black or mixed race groups in Scotland are more likely to be seen as posing a greater risk to other people than other ethnic groups. So strengthening the criteria adds transparency for people to be able to challenge the rates. I will stop there on the detention criteria.

Dr Chloe Beale: One of the things that has already been raised is that, in many ways, it may not change very much. Certainly, I am aware that there is a lot of geographical variation. I am coming at this from an inner-London perspective. On our assessments for detention, the bar is already so incredibly high to get admitted to a psychiatric hospital— people are so sick—that the risks associated with tightening that criteria worry me slightly.

One of the concerns that I have about the tightened criteria—perhaps I am leaping ahead to other questions—is unintended consequences and the possibility that people will have to deteriorate quite a long way before meeting detention criteria, particularly people who might be overlooked already because of certain stigmas; people who might be seen as a bit of a waste of time; people who already are not wanted in hospitals. I am sure that will come up a few times.

It is problematic already. because we know that we are not very good at assessing risk, particularly, suicide risk. In some ways, this is predicated on something that we know we do not do very well: predicting when somebody is going to be risky and when they are not. The idea that you might have to deteriorate and we may not be able to intervene early is of some concern.

Another group that might not have been thought about so much is people with eating disorders who already have to become incredibly sick to qualify for any treatment. The idea of there being a more immediate risk feels very dicey.

The Chair: We might come back to that in a little more detail. Thank you.

Dr Kevin Stone: From an AMHP perspective, broadly speaking, the new admission criteria reflect what occurs in practice at the moment.

The issue with the previous language is the conceptualisation of likelihood of harm—how soon it will occur and how much of a challenge and difficulty that will create for practitioners. There will need to be some strengthening of guidance, particularly Section 139 of the Mental Health Act, which is about liability for those acts that are taken under the Act.

I am also interested in the fact that "nature" is still featuring. If the idea of increasing the threshold is to reduce the number of admissions, detaining someone because they have a diagnosis seems to be a bit of an oversight in making sure that that bar is high, rather than relying on degree. That flies in the face of preventive work.

The other part that I would like to raise, which I am sure is an unintended consequence, is that the criteria seem to suggest that you can detain a person based on the health of another person, a carer. How elastic is that definition going to be? For those who work in mental health services, we all know the incredible role that carers play, but how elastic that is in enabling somebody to be detained because of the health of another person needs a little more scrutiny.

I was pleased to see that the language echoes or is compatible with the deprivation of liberty safeguards legislation, because I am a strong advocate of fusion legislation between the Mental Health Act and the mental capacity law, as we have seen in other jurisdictions.

The last observation that I want to raise is that "psychiatric disorder" seems to have crept into the new language of the Act. As a social worker and as an AMHP, I am charged with ensuring that a social perspective is maintained. Is that at all necessary? At the moment, it suggests that a psychiatric disorder is a mental disorder, whereas the previous definition of a mental disorder as a mental disorder seems to work far better. I wonder whether that needs a little more thought.

Those are my observations about the criteria at the moment.

Dr Mark Buchanan: From an emergency medicine point of view, we are not the people who will do the Mental Health Act assessment. What we will do is ask for it. As long as we can still make that referral at the same scale as we do now, from a safety point of view, that will not change anything for us. If the bar is raised so high that it is refused when we or the liaison team ask for a Mental Health Act assessment, that could cause problems from the point of view of how we keep that patient—who we believe is a risk at that point in front of us—safe from the point of view of intent currently. That is the one worry that I have.

> **Sir Charles Walker:** Dr Beale, you said that the threshold for admission is so high that you have to be very sick. For illustrative purposes, where was it 10 years ago, and where is it now? Will you give a couple of examples of what would have crossed the threshold 10 years ago and where we would be now?

Dr Chloe Beale: Ten years ago, we would have seen more informal admissions, more of a mix and more willingness to admit people on the basis of their own perception that they needed, in a crisis, to come into hospital—perhaps more of a mix of different mental disorders. Now, we are predominantly seeing people with psychosis: people who have lost touch with reality and are completely unable to manage in the community.

Going back to the eating disorders example, 10 years ago there might have been a bit more flexibility to admit people who were, perhaps, not at a life-threatening level of weight loss. Now I see someone with a body mass index in the 14s and 15s and I know that eating disorder services will be doing everything to try to manage that in the community. It is really only the patients who are at a life-threatening stage, who are needing to be force-fed under restraint, who are getting the beds. It is that mix of people who are so unwell and so disturbed

on psychiatric wards. It is difficult to think of examples, but I think that we are not able to intervene as early as we could have done.

> **Sir Charles Walker:** Perhaps an example is if they pose immediate risk of harm to themselves or immediate risk of harm to others, as opposed to someone with a severe eating disorder asking for admission for the opportunity to get better in a supervised way and you having to say, "I'm terribly sorry, but we just don't have the capacity".

Dr Chloe Beale: Yes. We might have been able to intervene and use the Mental Health Act for someone who was not, perhaps, at that horrific stage yet for any condition. But we know the trajectory; we know this person; we know how it is going to end up. We can intervene a bit early and get them detained quickly. It will mean a shorter admission and less of a catastrophic deterioration. We are now in a position where we are able to admit only the people who have already catastrophically deteriorated.

> **Sir Charles Walker:** One of the things that concerned me for many years, and still does, is the shortage of beds. I believe that caring for people in the community is fabulous, but there are people who are so ill that they need to be hospitalised and yet we have closed a lot of beds. I just throw that into the mix.

Dr Mark Buchanan: One of my concerns from what I see and hear from patients who have come into the emergency department in crisis is the quote, "I'm just going to be sent home. They're not going to do anything". They will come back and often have actually harmed themselves more than they did when they arrived in the first place. If the bar is raised and patients who know that that crisis is going to deteriorate and get worse are turned away from what they feel is needed, that will be dangerous.

The last time bed numbers were looked at there were some 37 beds per 100,000 people in the UK, compared with the average in the EU of 72 per 100,000. That is just the average; that is not the top and it is not the bottom. We have the lowest number of beds per capita. Obviously, that causes a big problem.

Where it really makes a big difference is that patients are in the emergency department for hours and days. I am sure I will bring this in later on, rather than bringing it in now.

> **Sir Charles Walker:** Dr Beale, the bed situation is at 37 per 100,000 average. Is that situation now stable or is there still further pressure?

Dr Chloe Beale: It is horrific. It is the worst I have ever seen in my career.

> **Sir Charles Walker:** Is this downward pressure to reduce the number of beds, or is there now a realisation that we need more beds?

Dr Chloe Beale: We need more beds and we need better social care to get people out of those beds.

Q79 **Dr Dan Poulter:** Dr Beale, my colleague was talking about beds, and there is one issue here: doing the right thing by patients in our clinical judgment, particularly patients with psychotic illnesses.

Another issue is how we have to work within the confine of the beds. Do you feel, while we have a clinical reality of the bed environment that we have to work in, that it is important that we do not frame legislation around that clinical reality but around the right thing to do for patients?

Dr Chloe Beale: Yes and no. Broadly speaking, that is right, but even before things were as they are at the moment, the legislation did not work for the clinical reality. I am sure we will talk in more detail about the issue of holding powers: how you hold patients while they are awaiting detention under the Mental Health Act or before they have had a Mental Health Act assessment, or when they have reached the end of their 136 term and there is no bed—all these things.

We already had a gap that had not been sufficiently plugged. We certainly cannot throw up our hands and say, "Well, it's all resources, so the legislation has no role here".

There are two separate issues, but there is no point in legislation that is impossible to enact with the resources that we have. There is space to bring those two things together more and make them marry.

Dr Arun Chopra: One of the difficulties is that this Act is based very much in the current paradigm. The Mental Health Act assessment is based on detaining someone in hospital or the use of compulsory powers. That is one way of looking at it.

There is another way to think about how we might use legislation more upstream—to think about how legislation could be used as enabling rather than something done to protect civil and political rights: what a psychiatrist can and cannot do to a patient. There might be a different way of looking at this, which is more CRPD concordant—looking at what can be done upstream to prevent those situations from occurring so that the legislation actually works better for patients, to take the point that Dr Poulter was making. That is another way of looking at it.

The direction of travel up north is to consider legislation. The Scottish mental health law review is looking at what it calls "human rights enablement". When you are making an assessment of someone's mental health difficulties, you are not simply looking at whether they need to be detained. You are looking at the sum total of all their different human rights and what things you might be able to balance and what things you might be able to intervene in earlier.

This is very much an amendment of a Mental Health Act, rather than "Let's start again", and thinking about how we could shift the dial and about more enabling legislation.

The Chair: We have had a lot of evidence in connection with whether we should amend or start again. Our issue with starting again is time.

Q80 **Dr Dan Poulter:** Clause 3 of the draft Bill amends Sections 2, 3, 5 and 20 of the Mental Health Act, replacing the broad test of whether detention is in a patient's interests or with a view to the protection of others, or is appropriate given the mental disorder in question, with a more specific set of criteria that include a requirement for there to be an assessment that serious harm may be caused to the patient or others.

There is no definition of "serious harm" in the Bill or in the Mental Health Act itself. Accordingly, a court is likely to conclude that it should bear its ordinary meaning. Its

best ordinary meaning probably comes from the criminal law, which would mean that serious harm is something akin to GBH or attempted murder. What are your thoughts on there not being a definition of serious harm in the Bill, when it is proposed that the grounds for detention be changed?

Secondly, what do you think about the criminal threshold of GBH or attempted murder being the possible default position?

Dr Kevin Stone: There needs to be a definition of these new concepts. Professionals are left to interpret these things. The previous criterion of "in the interests of" was equally ambiguous to work out. What is "in the interests of" is a very low threshold; it depends how it is interpreted.

The likeliness of harm and how soon it should occur will cause us some challenges. In the absence of alternatives, they will be the default criteria for whether we detain somebody. We have to think of it in a whole picture. The definitions are definitely important. I would hate for them to be categorised in the same way as a colleague has just described, in terms of the criminal law. That would be completely wrong. We need some guidance, whether that is in the code of practice or in the Act itself—something that really guides us as professionals.

The Chair: Dr Chloe Beale, you are nodding in agreement.

Dr Chloe Beale: Yes.

Q81 **Baroness Berridge:** We have written evidence from quite a number of people about personality disorders and the detention criteria being amended to say that appropriate medical treatment is available for the patient. Many of those conditions are treated by non-drug-based therapies. The evidence is that there is now a potential risk that you would lack the lawful grounds to detain somebody if, in the particular locality, those therapies were not available. Are you concerned about those with personality disorders and the new threshold?

Dr Chloe Beale: I am, but not in that way. The state of affairs on our psychiatric wards is tragic, but I would not say that it is yet at the point where the only thing that we have to offer is drugs. A lot of people come into psychiatric hospitals and receive treatment that is not just medication-based. People with personality disorder diagnosis, if we want to frame it like that, often have comorbid mood disorders and other things. Often, the environment is therapeutic in many ways. There are often forms of psychological therapies in hospital. Quite apart from anything else, often the containing environment and space to be away from the stressors causing a crisis, and to be among trained, qualified professionals, are very therapeutic.

I certainly do have concerns about how people with a personality disorder diagnosis will be treated. That is quite a concrete interpretation.

Baroness Berridge: What is your concern about the threshold and personality disorders?

Dr Chloe Beale: I would not frame it entirely around personality disorders. My concern about people who have a personality disorder diagnosis or who are perceived to behave in a way that health professionals associate with personality disorder—typically, self-harm and suicidality—is related to what I know has been discussed already: the increasing phenomena

of people who particularly fall into that category being told, "You have the capacity for suicide. Therefore, we're not going to help you".

That is something I can certainly speak to more. I know that Simon Wessely talked about it last week. Obviously, we all understand that that is a flagrant misuse and misinterpretation of the concept of capacity; the idea that you help only somebody who lacks capacity is absolutely perverse. With the tightened criteria, you risk people who fall into that category, whom health professionals often see as time-wasting or wasting of resources, being told, "Oh, we couldn't even section you anyway now because of these criteria".

There are always unintended consequences. When you come to a particularly stigmatised group of people—remember that there are many different types of stigma in the Mental Health Act, and let us be intersectional here—that is a group of people for whom the potential for us as a profession to turn them away is greater, citing legalese essentially, which has already happened.

> **Dr Ben Spencer:** On the flip-side, is there a danger, given the status basis of the Mental Health Act, that if somebody already has a diagnosis of schizophrenia—let us say that they hit Section 1 criteria—and by virtue of that, because of their status, because of whatever risk, which may be completely irrelevant, they are more likely to end up down a detention pathway than otherwise if there is a functional assessment such as with the Capacity Act?

Dr Arun Chopra: I did not mention this because it did not make its way into the Bill, but another recommendation we made is that there should be a capacity-based criterion around detention for those very scenarios. We modelled it on what is called significantly impaired decision-making ability. We recommended that, as well as the current criteria in the Bill, there ought to be discussion about whether a person has the ability to make a decision or not. That ought to be one of the factors. That did not make its way into the Bill. I would like to see something like that.

I am also a fusionist, if that is what we are going to call it. Introducing something like that into the Bill would have helped along the path to fusion. The right direction to go in is to take the example from what has happened in Scotland, which has the criteria of stigma in the law. That has allowed the Mental health law reform work in Scotland to start leaning towards fusion. We have already had a capacity-like construct in the Act.

The risk here is that we still have this nature of the disorder, as you mentioned, as one of the criteria. We have not moved on. Again, that comes back to the idea of a paradigm shift; it comes back to the idea of fusion; and it comes back to the idea of a single piece of legislation. This picks up on some of Chloe's points about people and capacity. If we had a fused law, there would be a greater degree of honesty and transparency. It would reduce the stigma associated with mental health conditions.

> **The Chair:** That is very helpful. It segues into our next question.

Q82 **Baroness Hollins:** We have heard concerns that the proposed reforms could mean more people being detained under the Mental Capacity Act. How do you anticipate this changing with the proposed reforms?

Dr Chloe Beale: I would counter that we do not detain under the Mental Capacity Act as such. Do you mean be subject to deprivation of liberty safeguards or LPSs?

Baroness Hollins: And in hospital.

Dr Chloe Beale: If the recommendation from the Mental Health Act review is that the dividing line is objection, very much so, yes. Then we would see the liberty protection safeguards going all the way back to the original purpose of DoLS.

I am sure we will come on to this later, but certainly when it comes to people with LD and autism, that is absolutely a risk, because people with severe behavioural disturbance as a result of those conditions will still end up in hospitals. If they cannot be subject to the Mental Health Act now, they will just be subject to whatever the Mental Capacity Act legislation is and they will end up being held there, arguably with fewer safeguards and less right to appeal. They will not just stop being held in hospital. I work in an acute hospital, not a psychiatric hospital. I work on medical wards, and I am very concerned and disappointed with both the Mental Capacity Act reform and the Mental Health Act reform. It feels like a missed opportunity to address some of those interface issues.

Following some of the case law, in Cheshire West we have a huge influx of patients into general hospitals who would have been subject to DoLS or Mental Capacity Act, or not really anything, who are objecting to being in hospital, and the criteria for treatment of a mental disorder is being stretched paper thin by some DoLS assessors. If somebody has delirium or something and is, perhaps even quite mildly, objecting to their admission in a confused manner, saying, "Let me out", the DoLS assessor will say, "They are objecting to their treatment in hospital for a mental disorder, so you need to detain them under the Mental Health Act". I do not know whether that is necessarily a good or bad thing. Detention under the Mental Health Act gets a bad rap in comparison to the Mental Capacity Act. There are more safeguards and rights enshrined into it to challenge.

There is certainly a possibility that you will just get people held under a different set of paperwork. The problems they present with are not going to change.

Dr Mark Buchanan: Going back to learning difficulties and autism, I also look after children. Obviously, it is very different. There are real examples of the CAMHS team having discussions and arguments with the social care team about who should be looking after a patient who has a significant behaviour disturbance crisis at that point with their learning difficulty or autism. While they are having that argument about who needs to fund a place to keep that patient safe, the child is in an A&E department. I have heard of children who have been in an A&E department for 31 days because of that. That is obviously horrendous. In my hospital we have had 131 hours and discussions and arguments that, "I know they have had a Mental Health Act assessment, but it must be wrong because the patient obviously needs to be sectioned".

My concern about removing that aspect from the Mental Health Act is that that will also happen in the adult population. It will mean that patients who could be somewhere safer and more therapeutic will be on hospital wards or refused admission to hospital wards by trusts, meaning that they will be in an A&E department without a shower, without warm food,

without a bed for days and days, which is happening. That worries me from a patient point of view.

Baroness Hollins: What new tools or resources do emergency medicine services need to avoid that? What about the acute distress centres that some parts of the country are developing? What else do you need to try to prevent unnecessary detention?

Dr Mark Buchanan: That is an interesting question. It is not really about what A&E needs, because the A&E department is an assessment area that deals with the acute management of a patient who comes in with whatever emergency, whether that be medical, mental health-related or learning difficulty-related. It is about what the patient needs to try to see that there is somewhere available.

I certainly know, with children, that one way in which they are moving forward is to try to make sure that there are houses where a child in distress can be housed. There will be the back-up that helps to manage behaviour while it is difficult. That has to be better than a children's ward, where the nurses are not mental health nurses; they are not trained to deal with significant behavioural disturbances and violence. Again, that is not the patient's fault at all.

That needs to be extended into the adult population. That is probably the only thing we can do. We also need to make sure that there is no infighting between social care and mental health over who needs to fund that. This is a funding issue, because it might cost a fortune. It needs to be, "Yes, this person needs help. This person needs somewhere that is humane, that has a shower, that has a bed, where they can be cared for". The argument about who needs to pay for that can be done separately and can be outside that while the patient is in a safe place.

Baroness Hollins: That is a commissioning issue.

Dr Mark Buchanan: Yes.

Baroness Hollins: Being taken out of the environment that is causing such stress is one of the potential solutions.

You made another point about people with learning disability and autism and behaviour. Might the harm criterion be a sufficient way of enabling people with learning disability and autism to be detained under the Mental Health Act, rather than behaviour?

Dr Mark Buchanan: I will pass that question over.

Dr Kevin Stone: We have undertaken assessments under the Mental Health Act of people with autism or with learning difficulties. The harm factor has clearly been relevant. The harms have been significant. We have been searching around, thinking, "What is the best thing that we can do in this person's best interests to decide that?"

My main concern is the misuse of the Mental Capacity Act to deprive people of their liberty when that particular framework is not designed to do that, unless under the deprivation of liberty safeguards.

In AMHP practice and with the medics, we are always weighing up risk, always weighing up harm to find out which is the best framework. There are particular gaps in particular scenarios. Emergency medicine is probably one of those areas. In the current framework, we need an extension of something like Section 5(2), or a similarly named power, which can be used in an ED, and the ability to apply that and then move them to a more appropriate place. Nobody thinks that the mental health setting is appropriate for ED, but we need additional resources and powers like that.

Dr Arun Chopra: The criteria might be helpful to make the case for people with learning disability or autism not being in settings of greater restrictions such as hospitals. It will help to divert them to more appropriate places or back home with a package of care. This is helpful for people with learning disability and autism.

One other point to make in response to your question about what else needs to happen goes back to the idea of trying to intervene earlier and up stream. We know from data that social deprivation is closely associated with assessments and detentions under the Mental Health Act. Social deprivation is a factor. If we can shift resources to ensure that we tackle that, we automatically start reducing the use of compulsion. It is all about acting earlier.

Baroness Hollins: Are there any other risks that we have not touched on?

Dr Kevin Stone: One of the main risks is the environment that someone remains in, particularly if we are looking for a bed and someone waits hours and days for an admission under the Mental Health Act, when we have medical recommendations but do not have the resources. There are real risks of that person being in that environment for a prolonged period.

Dr Mark Buchanan: Picking up on times for beds, in a snap survey we asked 60 A&E departments how long patients were waiting for mental health beds during that week. Some 40% of respondents said that patients were waiting over 75 hours. That was during that week. This is not occasional; this is more than occasional. More importantly, we had a 20-day wait and a 15-day wait. That is certainly equivalent to what I saw in my hospital last week: 100 hours, two patients. In the end, they found beds in Southampton and Brighton. That is over 250 miles away.

Obviously, it is difficult. If you are in an A&E department waiting for a bed, you have more chance of the sedation that is needed and antipsychotics. You have a longer length of stay if you have been in an A&E department for any length of time.

The Chair: Are we talking about patients with learning difficulties and autism or are we talking across the board?

Dr Mark Buchanan: I am talking across the board.

The Chair: I thought it was important to clarify that.

Dr Mark Buchanan: Sorry, thank you.

The Chair: It is fine.

Q83 **Baroness McIntosh of Hudnall:** I think Sir Charles was on this territory a few moments ago. You describe the number of beds available declining to a historic low per 100,000, if I understand you correctly.

Dr Mark Buchanan: Yes.

Baroness McIntosh of Hudnall: That will have an impact. What is the quantum of additional demand that you see daily, if any? We get a lot of anecdotal evidence every day that lots more people are manifesting with mental health difficulties, or whatever it is. In your experience, are more people showing up with mental health disorders?

Dr Mark Buchanan: I am not sure. Certainly looking at the data up to 2019, there was about a 113% increase over 10 years. Since 2019, that has probably stayed the same.

Baroness McIntosh of Hudnall: Does that include young people?

Dr Mark Buchanan: Yes, absolutely, with young children. That is one of my other specialties as an ex-paediatrician. It is certainly within that group as well. The 12-hour waits for a mental health bed have been mentioned, but it is double that for physical illness. That is not just for beds. If you come in with a mental health problem, you are twice as likely to have a 12-hour stay in an A&E department than somebody with a fracture, a heart attack, et cetera.

Q84 **Lord Bradley:** We have touched on some aspects of A&E. How could the draft Bill improve the situation for people attending A&E? Will the impact of removing police cells as a place of safety have a consequence for A&E departments? Are there sufficient alternatives, and how or what should those alternatives be if we want to take pressure off A&E departments?

Dr Mark Buchanan: What do we need? Ultimately, we have many gaps. We had gaps in the Act previously and we have gaps now. I do not think that there has been any improvement in when I can legally keep someone in the emergency department when they are suicidal, when they are so distressed that it is difficult for them to make a sensible decision.

There are gaps to the point that if I think a patient needs a Mental Health Act assessment, the Mental Health Act assessment has been done and the decision to admit made, until that bed has been found the patient is in limbo land because I am not meant to be able to use the capacity Act. That probably did not matter when it was rare to have 12-hour waits. I can remember being in the Royal College of Psychiatrists five years ago and saying, "We're starting to get 12-hour waits". That was up in Lancashire. Now it is the norm. It is different from having a few hours where I am saying, "No, you have to stay", to now, where we are talking days and days waiting for a bed. That is different and we do not have a power to do that.

If it is voluntary, it can take hours and hours and days and days to get a bed. That means that that person is in an A&E department. It might be a cubicle, with no shower, no lights, sleep

deprivation, et cetera. In that case, I am sure I would say, "Right, I'm going home". Who is taking the risk of that patient going home when the likelihood is that they would have been sectioned if they had not agreed to an admission?

The decision-makers are not in the department. The psychiatrist is not in the department. The AMHP is not in the department. A lot of risk is taken on by the emergency department. I have certainly been in front of my amazing coroners—if they are listening—where patients unfortunately lost their life because we had not been able to keep them from leaving. That is devastating for families. It is devastating for staff. The thought of somebody they were looking after going out and ending their life is huge. We have no power to stop that person unless we fudge things, which I am sure we have been doing. I am sure we will continue to do that, because we want to make sure that the patient is safe.

Q85 **Lord Bradley:** We will come on to powers in a moment in a separate question. What about alternatives to A&E? What do you see as good practice in alternatives such as crisis care assessment units?

Dr Mark Buchanan: I see a lot of patients who have taken tablets or hurt themselves or got in touch with Crisis. They told me that for days they knew that this was happening—they knew their mental health was getting worse. They tried to get to see their GP. GPs are working incredibly hard, so I am not at all saying it is their fault. They rang the secretary of the psychiatrist and were told, "You can't just do that", or they went to their mental health hospital and were told, "You're not allowed to just turn up". They felt they were not worthy and that was why they ended up deteriorating. Ultimately, if you could stop that deterioration, that might help. Certainly crisis cafés, crisis lines are more common now. That is certainly helpful. What else would we need? They are the main things, I would say.

Dr Kevin Stone: I completely concur that we have many gaps. One of the key things is not to make EDs look like it is the wrong door into mental health services, because for some people ED is the only access they feel they will be able to get. I would not want a scenario where we thought that ED was never a solution for people who arrive.

I am aware of your point about wanting to move on to the powers, but when they come into ED it is about moving them into a space that is more therapeutic, like a place of safety. I have heard discussions in our areas about emergency departments—or words to that effect—where they go for mental health crises, but we have to think of it as a whole-systems approach and least restrictive alternatives, and those least restrictive alternatives not being considered at the point of a Mental Health Act assessment but being thought out well before.

It is quite interesting that requests for mental health assessments often come from crisis teams, EDs, et cetera, but the fact is that the trusts are not providing the bed, even though they are making the request, and it can place us in limbo.

I have some suggestions about powers, which you might be interested to hear later, but the growth of psychiatric liaison is a really important part of it. They come to the attention of mental health services because somebody in the department is recognised—on the matrix in our area they are red and are a risk and concern—but then the ED staff are left to manage that in a way that they are managing multiple patients.

I could tell you lots about Mental Health Act assessments in ED at some point, if you are interested, but people leave before a Mental Health Act assessment has occurred, because they do not have a legal framework around them.

> **Lord Bradley:** That is why moving them immediately from an ED into an alternative setting, even if it is in the same location, where the environment is conducive to what you are talking about, is a step, but I accept entirely that the upstream work is more important.

Dr Kevin Stone: EDs have clinical decision units or observation wards. They will try to move people into them because it is a ward where they might be able to use Section 5(2), so lots of workarounds are being created.

Dr Chloe Beale: There are a few things here. First, to address the 136 question about whether removal to a police station as a place of safety will have an impact, in all honesty I do not know how much it is still being used as a place of safety. I imagine that there is geographical variation. For my own purposes, where I work it is irrelevant; it does not happen any more.

I have far greater concerns about the policing interface and 136s. Of course, there is the rise of dedicated health-based places of safety in a psychiatric hospital, which is centralised for the area, but all that happens is that they get full instantly and all the overspill comes to ED.

My concern about 136 is that there are lots of workarounds. In very rare circumstances, a police station is the right place if somebody is very violent or aggressive, but now we see people being arrested for something they have done and taken to a police station where it is suspected that they are mentally disordered. They have a Mental Health Act assessment in custody, but no bed is available yet. This has always been the case when you assess somebody in custody and then move them on. Because there are no beds, the police will decide to de-arrest them, put them on a 136 in the police station and deposit them in ED. That concerns me, because that is a potential risk to us and the staff, and it is a workaround based again on inadequate resources.

That is my concern about 136. It is unquestionably the right thing. It should be vanishingly rare that somebody is taken to the police station as a place of safety, but we already have lots of bizarre workarounds, with police using different means of getting people to the emergency department to bypass long waits at the health-based place of safety. I think that everybody who works in an ED in the country will have seen people being brought to ED by police in handcuffs voluntarily—this is something that happens—or under the Mental Capacity Act. It is a workaround. We may come to 136 again later on.

We have the alternative to 136. It is not working very well because we have no beds. They get full and then people come to ED. We can talk more about that if we are going to talk about holding power, because that is another thing.

It is probably not particularly for the Bill—again, it is a resourcing issue—but I am quite opposed to these separate places. It is nice if there is a crisis place that people can choose to come to, but my concern is that what we see here is stigma in disguise. Of course people want to be able to turn up to a different crisis place if they would like, but we already have a problem with stigma; we already have an attitude that people do not want others in a mental health crisis in their department. It is variable in various places, but all of us who have

worked in liaison psychiatry at some point in our career and training—I do not hesitate to add that this is no longer the case in my department; they are great—have heard someone say, "Will you get your patient out of my department?"

This is the attitude towards people with mental health problems. One has to be very cautious that these initiatives are not just about diverting people. If it becomes a pre-hospital decision and something coming through 999 or 111 and it is mental health, the ambulance is diverted to the crisis house or whatever, which is what could happen and happened in the past when we did not have 24/7 liaison psychiatry. As a clinician, I have seen enough people with something very unpleasant in their brain where pre-hospital someone thought it was mental health and would have diverted them to a crisis place where they might be seen by someone not qualified to pick up the neurology. That is dangerous.

An A&E department is not the nicest place to be, whatever is wrong with you, but if I am having a heart attack that is where I want to be. Sometimes I wonder whether we could perhaps concentrate a little more on making emergency departments more conducive to supporting these patients, because they will not go away. What we do not want to do is create a hostile environment.

I suppose the main point is: how can we improve the process for individuals presenting to ED? I think the most obvious way to improve things is to provide explicit guidance on what to do when someone goes to leave before the necessary powers under the Mental Health Act are in place. We have already talked about this. We are going to talk about it more when we talk about holding powers. I should say that I diverge from the official Royal College position on this. I am tired of hearing that it is not the right time to think about that; I am tired of hearing from the Mental Capacity Act side of things that it should be a Mental Health Act issue to sort out, and vice versa.

We know that Section 4B does not cut it, but what I can tell you is that vulnerable people in departments up and down the country are being held unlawfully under no legal framework, or are being allowed to leave with a shrug because they have capacity. As a consultant psychiatrist who might have carried out an assessment, it is absurd that if someone does not have the paperwork completed for a Section 2 and we are still waiting, a police officer has more power to stop them leaving than I do.

The Sessay judgment said that we cannot use 4B of the Mental Capacity Act where the Mental Health Act should apply. It also said that you should do things more quickly—I am paraphrasing—or call the police to do a 136. That has no place in compassionate mental healthcare. I cannot stop my patient leaving officially under the law, but I can call a police officer to do it for me.

The resourcing issue will still be there, but if we codify it and make clear what we do in that situation—if we write the woolly bit of Sessay about each case turning on its own facts—you will probably not be unlawfully depriving someone of their liberty, at least if you do it quickly enough. Can we make it very clear what the hospital should do to cover that period when someone is undergoing a Mental Health Act assessment? Then you can monitor it. There is a time limit and a paper trail potentially, and people have some rights.

At the moment, all of this is going under the radar. A lot of people are being held with no legal framework. I appreciate the position of some, certainly in the college. I am afraid that I

am drifting into holding powers here, but if we introduce a holding power for that situation, detentions will go up, which is not what we want. But I would also ask: do we really want a reduction in restrictive practice or just a reduction in the paperwork that says that it is restrictive practice? Restrictive practice will go on regardless, but people need something auditable that can be monitored.

The Chair: That is incredibly helpful.

Dr Arun Chopra: I agree with the points made. Perhaps I can take the question in two ways: before A&E and then after A&E. If you think about before A&E, there is a range of things that we could be doing to prevent this sort of basket of alternatives for someone presenting in ED. There are schemes where CPNs are embedded with police officers. That helps. There are schemes where people are offering brief psychological support over a period of time. We need to start thinking about those more transformational ideas rather than all of this being about ED.

There is also a point about how many people are repeat presenters at ED with mental health difficulties. One of the strengths in the draft Bill, which I would encourage the committee to think about strengthening further, is advance choice documents. Having autonomy is therapeutic in its own right and it will help people to think about other options.

The draft Bill takes you to the position that we have in Scotland with advance statements. My organisation has shown that only 6.6% of people have these, after 15 years of running the legislation. I would offer that further, so that when someone has had an episode of compulsion, there must be a mandatory offer from the NHS trust or local authority to ensure that they have the opportunity to make an advance decision, if we are going to keep it within the current framework. In and of itself, first, that will be good for that person but, secondly, it will take some of the pressure off ED.

Where someone has got to ED, I agree that the holding power would be useful. People are being held in A&E in all sorts of odd ways. When I worked down south I remember all kinds of fudge being put into operation to allow someone to stay. I think it is far more honest to use the equivalent of a Section 5(2); we call them emergency detention certificates in Scotland. It is much clearer that there is a legal mechanism under the Act to hold someone in A&E. Any medication that is given is monitored and scrutinised by my organisation. We have a record of all that. We can see who is being detained and for how long. That is a much better system than the current fudginess that is going on between the MCA and the Mental Health Act.

Q86 **Dr Rosena Allin-Khan:** I thank everyone for the time and effort that they have put into looking at this.

I want to direct a couple of comments to Dr Mark Buchanan to hear some of his thoughts. As you know better than I do, every A&E department in the country is totally different in how it is set up. I have worked in A&Es where there is no natural daylight. The psychiatric room is in the middle of the department, where it is really noisy in the middle of majors. I have also been in departments where they have had some resources directed towards the psychiatric assessment unit and a better discrete space.

How much, really and truly, of what can bring about the greatest improvement is

down to the physical space within A&E and our acknowledging that a certain amount of resource has to be put into creating a more streamlined process across the country? It will not be the same wherever you go. There will be examples of best practice and examples of horrendous practice. I have seen in my own A&E department—the committee has heard me say this over and over again—some of the worst and most hellish scenarios with people in cubicle 9 for days. I wanted to ask you about that.

I also want to pick up on a point about the place of safety. I have the mental health brief for the Labour Party. I am shadow Minister for Mental Health. Police cells are still being used disproportionately as a place of safety. I do not believe that A&E is much safer. I absolutely abhor the use of police cells. It is not helpful to anyone.

Given how resource-poor the field of psychiatry is at the moment, do you think that, without a concerted effort from government to direct resource into the field of psychiatry and create better community support services, we will ever crack this? We are hearing, for example, "Please can you just get your patient out of my department?" From the perspective of someone working in A&E, a lot of the reason for wanting that is that you know that it is preferable for the patient to be there. I cannot comment on anything that any other clinician has said. I just know that when I go to work and look at the board in the morning I see 47 hours for the patient in cubicle 9 and my heart sinks. That is what we are seeing around the country. Unless you change the structure of the hospital, we will never be able to fix that.

I guess the broader point is: are we just trying to move little pieces around when really what is needed is a far bigger approach and acknowledgement that this is a huge issue that can be fixed only by properly directing resource into the much bigger, wider picture?

Dr Mark Buchanan: One hundred per cent. If we start with the place of safety, I absolutely agree that police cells are inevitably the wrong place. There may be a few situations where that is not true, but it is certainly not the right place for the majority. Someone under Section 136 is not a criminal; they are detained because of how unwell they are. The Royal Colleges of Psychiatrists and Emergency Medicine feel that the emergency department is not generally the right place for a place of safety.

Looking at the figures, there were 133 designated places of safety. Unfortunately, 10 of them are purely in A&E departments. Of those, the majority are in the north-west. I am one of them. I have been trying to get a non-A&E-based place of safety for the past 15 years. We are looking at it now, and I believe that for the first time that will change. That does not mean that I think that the A&E department should not be a place of safety. I believe that in certain situations it is absolutely appropriate. For a group of people, we need to make sure that we rule out a medical problem and that we are not playing with a wolf in sheep's clothing. There is hypoglycaemia, low sugar.

Dr Rosena Allin-Khan: Meningitis.

Dr Mark Buchanan: And sepsis—you name it.

Dr Rosena Allin-Khan: Or a head injury.

Dr Mark Buchanan: Absolutely. It is important to make sure that we are happy that that person does not have that mimicking, because you would not want to be in a mental health hospital with a medical problem—quite the opposite. I would not want to have a mental health emergency in an acute hospital, because there are no mental health nurses. Neither the nurses nor the doctors have mental health training, so that is the wrong place—it is non-therapeutic—but we need to make sure that we have the right environment.

From the college's point of view, our QUIP, which is about to start very soon, states that we need places that are humane and appropriate for patients, and to plan appropriately to make sure it is safe for a person in crisis. I have three. I probably have one of the best in the UK. I have an appropriate nurse, a CSW, there 24/7, but that is about communication, compassion and making sure that you give information, but now we have outstripped that. I have patients in there for 100 hours, virtually every day, which means that I do not have three any more. Those three have completely gone, in which case there is the waiting room or cubicle 9, which is not safe and appropriate.

You then get compassion fatigue. You know you cannot do anything and you do not have the solution to that problem, so it seems that somebody has become uncaring, when what they want is the right thing for the person: to be in a mental health bed that is therapeutic.

It unfortunately comes around and it almost sounds as if they have stigma, which is wrong, because A&E is all about dealing with everybody in an emergency, whether that be gynae, paediatric or mental health. I would certainly be upset if we said that our door was shut to people with mental health emergencies.

> **Dr Rosena Allin-Khan:** Is there anything that we can do in the Bill? When someone comes into a department, everyone looks up whether they have a psychiatric history. There are colleagues up and down the country who, if there is a psych history associated with the patient, will assume that that is why they are there. They will not necessarily think to ask whether there has been a head injury, or to check their blood sugars, do bloods and all of that. Sometimes, if somebody with a known psychiatric history comes into an A&E department, we do not necessarily do the medical tests. What can we do to protect patients better?

Dr Mark Buchanan: In my hospital, in my pathway, I use a SMART assessment, which is an American tool. Effectively, it looks for things that might make you worry about that patient from a medical point of view. Is it the first presentation? We are talking about age. For instance, we are talking about the elderly and the very young, we are talking about whether their observations are normal or abnormal, whether there is something in their history that makes you worry about trauma, or whether an overdose or alcohol is involved. Effectively, that is quite a good triage tool.

In the Royal College of Emergency Medicine and the QUIP that is coming up, that is very much about making sure that patients are triaged, and, as you said, it is important to make sure there is a screen so there is no evidence or likelihood of a medical problem. That does not necessarily mean that we do not need a side-by-side assessment. In certain hospitals, the mental health liaison team may pick up patients early and, if it has any concerns, say, "Can you just … ?", which has to be two ways and is really important. The ideal thing is to have

mental health assessment units within trusts next to A&E departments, jointly run. To me, that is the way forward.

Dr Chloe Beale: I hate to tell you, but that is stigma. We have heard about how it is not stigma; it is compassion and getting people out of the department and into the right place, but diagnostic overshadowing and people not looking at their whole history because they have a mental health history is stigma. The answer to that is not to remove the patient; it is to provide doctors and nurses with better training. We should have more integrated mental healthcare in undergraduate and postgraduate training.

The answer is not to take mental health as a separate entity and remove it. We do not do that for any other condition. I accept the argument that mental health is different. As we have been talking about here, we have an entire legislative framework just for mental health. I guess that we have digressed from that quite a lot, but the answer to stigma is not to remove the people who are being stigmatised; it is to train people better.

Q87 **Marsha De Cordova:** I want to turn to learning disabilities and autism. I know we touched on them earlier in some of your responses. I would be interested in your views on what the draft Bill proposes by removing LD and autism as a condition for which someone can be detained under Part 2 of the Act, but also what, if anything, the practical impact of this change in decision-making by those in clinical settings will be.

Dr Chloe Beale: I have already said it. I would echo what you heard from other people, such as Simon Wessely last week, in that you will not end up with people with LD and autism not being held in psychiatric hospitals; they will be under DoLs or LPSs and, under the liberty protection safeguards, at the mercy of potentially self-authorising hospital management, with even less scrutiny and oversight. We cannot legislate our way out of these massive deficits in social care, which is why people end up in hospitals in the first place. That will not go away; people will still end up there, but with less scrutiny than is available under the Mental Health Act.

I have said before, but will say again, that the question is: do we really want to reduce restrictive practice or the paperwork that makes it look like we have reduced restrictive practice, because that could end up being quite performative? I think we want to do better by patients, not better by the paperwork and the numbers.

Dr Arun Chopra: After working in England, I worked in New Zealand, which removed learning disability and autism from the Act in the 1990s. The difficulties that followed were that people with learning disability were often diverted into the criminal justice rather than the health pathway, and in the 2000s they had to enact new legislation to protect people. I was there in 2015 and I remember colleagues telling me that it was not a good move, and that stayed with me. Even after passing the 2003 legislation in New Zealand to close that gap, there has continued to be an effect on people with learning disability and autism. It may be worth the committee speaking to someone in New Zealand, perhaps by videolink, just to understand some of the difficulties that arose.

Secondly, there is potentially a better way of achieving the aim of removing learning disability and autism from Section 3, which is to enhance scrutiny for anyone with a learning disability or autism who is in hospital under Section 3. You have the fields within the Act to

do that and you could ensure enhanced scrutiny, whether that is more visits from a SOAD, or whether it is visits from someone else from the CQC going in to check whether this is required. That might achieve the same policy objective.

Thirdly, if you are minded to go down that route, it may help to look at what happened up north with the Rome review, which was about removing learning disability and autism from the Scottish mental health Act. My organisation did not feel that that would be the right way forward, for some of the reasons I have suggested, but the data that we had showed that under compulsory treatment orders, which are like a Section 3, only 0.4% of people were detained for learning disability. If they had an anxiety disorder or any other condition, that would be privileged, and that would be what was recorded.

There are other ways to achieve the policy aim, which absolutely needs to happen. We have all seen the documentaries. What is happening is shocking, but there are better ways to do this rather than removing the safeguards under the Act.

> **Baroness Berridge:** Given a choice—we are not in utopia in resources—would you leave them under the Act at the moment, with the additional safeguards under Section 117, or would you go outside, in which case they would tip into MCA or the criminal justice system?

Dr Arun Chopra: Under the Act still for me.

Dr Kevin Stone: Yes, under the Act.

> **Baroness Berridge:** The detention criteria will be different for forensic patients and civil patients. What is your view on that? A psychiatrist may be in a secure mental hospital with a forensic patient in one room and a civil patient in the next room. In your head, how will that work in practice? You apply one test and walk next door and apply another.

Dr Kevin Stone: Looking at it from my perspective and as a sitting magistrate, for me the criteria need to be identical. I can understand why the relevant disorder kicks in—relevant maybe to the offending—but the judicial disposal needs to have options. Consistency needs to be across the Act, because people who go in as forensics might become community patients later as well. I feel that the criteria need to be the same.

Dr Arun Chopra: I am more relaxed about there being potential differences. There are other jurisdictions where there are differences in the criteria. What is really important is that the safeguards are exactly the same and that people can access the same quality of safeguards, regardless of whether there are differences that the courts may wish to impose through a criminal justice pathway or a diversion scheme. Therefore, the safeguards need to be identical; patients, whether forensic or civil, should have the same access to everything that a patient under civil detention gets.

> **Baroness Berridge:** In terms of safeguards, would you have ACDs and the tribunal for forensic as well as civil patients?

Dr Arun Chopra: Yes.

The Chair: Is there general agreement on that?

Dr Kevin Stone: Yes.

The Chair: Thank you all so much. I am sorry that time has gone so quickly because it has been incredibly helpful.

Panel 2

Witnesses: **Andrew Neilson**, Director of Campaigns, Howard League for Penal Reform; **Juliet Lyon CBE**, Chair, Independent Advisory Panel on Deaths in Custody; **Dr Ailbhe O'Loughlin**, Senior Lecturer, University of York; **Dr Shubulade Smith CBE**, Clinical Director for Forensic Services, South London and Maudsley NHS Foundation Trust.

Q88 **The Chair:** We now resume the sixth session of the Joint Committee scrutinising the draft Mental Health Bill. We have before us the second panel. Thank you all so much for coming. The purpose of the second part of the session is to understand the key concerns in light of the draft Bill regarding Part 3 patients—in other words, patients involved in criminal proceedings. Could I ask all the witnesses to introduce themselves briefly and say who they represent, and then we will go straight into questions?

Dr Ailbhe O'Loughlin: I am a senior lecturer in the law school of the University of York. I specialise in mental health law and criminal law, and my research looks particularly at Part 3 of the Mental Health Act. I also specialise in personality disorder.

Juliet Lyon: I chair the Independent Advisory Panel on Deaths in Custody. The ambit of the panel is all forms of state custody and all deaths, whether natural or self-inflicted.

Dr Shubulade Smith: I am the clinical director for forensic services at the South London and Maudsley NHS Foundation Trust. I am also the lead for all acute forensic admissions to South London. I was involved in the Mental Health Act review. I was vice-chair for the African and Caribbean working group as well as co-chair for the criminal justice system group. I have also been involved in tribunal groups.

Andrew Neilson: I am not a doctor, but I am director of campaigns at the Howard League for Penal Reform, which is a criminal justice charity. We also have supported in recent years the All-Party Group on Women in the Penal System, which has taken a particular interest in some of the remand for own protection issues that we will talk about today.

The Chair: Thank you all very much, and thank you to those who have submitted written evidence in advance of today's proceedings.

Q89 **Baroness Barker:** The overall stated aim of the Government in this piece of work is to bring down the number of detentions, including inappropriate detentions. Could you tell us in summary what you think of the changes that have been proposed? Perhaps you might include in that the things that have not been included in the draft Bill.

Dr Ailbhe O'Loughlin: Reforming the discharge criteria and introducing or amending Section 20 as it applies to both Part 2 and Part 3 patients is a positive development. In the White Paper there was an idea about having different criteria for Part 2 and Part 3. It is good that the criteria will be the same and there will be a lower threshold for discharging people who are currently detained.

I have serious concerns about the supervised discharge powers. There is a power to discharge people on a conditional discharge under conditions that deprive them of their liberty. Basically, it is a form of detention that would not be recognised as being detention under the Mental Health Act. I think that is something that needs to be looked at again.

As some of the others on the earlier panel expressed, I am similarly concerned about the exclusion of learning disability and autism from Part 2. That will probably push people into the criminal justice system where their needs are less well catered for. That needs to be looked at as well.

Juliet Lyon: The IAPDC welcomes the draft Bill. There are areas of particular interest to us. One is that prison and police custody will no longer be considered places of safety. That is very welcome and is a longed-for ambition. In our written and oral evidence, I want to draw attention to the fact that there is a need for adequate clinically based places of safety. Some of the ambitions in the Bill, particularly the one banning the use of prison and police custody as places of safety, stand little hope of being realised unless and until alternative arrangements are made. The Bill seems to be an opportunity to press for those.

We also welcome the proposed introduction of the overarching 28-day period for those awaiting transfers from prison to hospital. I frequently encounter this in a prison setting. Healthcare teams say how they accommodate people in segregation or in inappropriate wings in the prison simply because they have to, but they know that they do not have the resources, capacity or training to respond to them appropriately. That might vary between being able to give or offer medication, having suitably qualified staff, or just the sheer ratios of numbers of staff in those settings, particularly the prison setting compared to a health setting.

We also welcome the proposed ban on the use of police custody, as I said, and want to see this as an opportunity for liaison and diversion services to be expanded appropriately, so, as well as the actual rollout, looking at the quality and quantity of the services on offer and whether, for example, they are offered at night or are available only in daylight hours.

Chair, you mentioned things that might not already be in the Bill. There are three areas of particular interest to my panel.

The first is simply to draw attention to the high rate of deaths of those detained under the Mental Health Act and the lack of high-quality data on those deaths. That is hugely important. We did a statistical analysis of deaths between 2016 and 2019 of people detained under the Mental Health Act. They have the highest mortality rate of all those in custody. The data was simply not adequate and did not compare well with other custodial settings. Obviously people are recorded as being detained under the Act, but if there is a death while they are so detained, the data is not disaggregated or not dealt with in a comprehensive way, and it is not published. To give you a stark example, the ethnicity of half of the women who died while they were detained under the Act in 2019 was not recorded. That is really very

troubling. So the first point is the high rate of deaths and the recording of data and whether the Act can somehow be stretched to encourage proper recording of data.

The second is the lack of adequate independent investigation of these deaths. We are concerned that other custodial settings have proper independent investigation, but that is not the case for people detained under the Mental Health Act. The CQC is, after all, a regulator, not an investigatory body.

The third point is whether the safety impact assessments that have been introduced administratively in the Ministry of Justice could be of use for those considering Mental Health Act detention, and whether that would help people to be wise before the event and, if they saw risks, to look at the mitigation of those risks.

Dr Shubulade Smith: I have spoken to psychiatrists up and down the country. For the most part, people welcome the changes, because there is a recognition that having more inputs into an individual's care and the individual having more input into their own care is really important, particularly on treatment decisions. People welcome the idea that there is more collaboration in the approach.

However, there are particular concerns about differences between the detention criteria in Part 2 and Part 3. There is a tension regarding the need to reduce detentions overall for those in the community, but in Part 3, particularly on prison transfers, there is a sense that there needs to be an increase in detentions because people are going from prison into hospital.

I am sure you have heard this already from everyone else, but there is a big concern about workload. We are at capacity at the moment, so there is a big concern about resource and how some of the changes might be resourced. There are significant concerns about the criteria regarding learning disability and autism. You have already heard today that there are concerns that that might result in people with learning disability and autism being criminalised and ending up in the criminal justice system inadvertently.

I certainly agree with what Juliet said about data, but, for the avoidance of doubt, it is well known that people with particularly severe mental illness unfortunately have higher rates of comorbidity of physical health problems, and that results in a shorter life expectancy of 15 to 20 years. I say that just so that the committee does not get the impression that somehow something worrying is being done to the patient. There is, unfortunately, already an increased risk of mortality in this group. If someone dies and they are in hospital under section, there is usually a board-level inquiry. That often means that there is independent scrutiny of that death.

Andrew Neilson: I would echo what Juliet in particular was saying. The Howard League's particular interest is in prisons and to a lesser extent police custody. In principle, we support the criminal justice-related measures in the draft Bill. The keyword there is "principle", because the principle of saying that prisons and police custody are not a place of safety is incredibly important. But where the legislation touches on this in the relevant clauses, perhaps the principle is not being extended as widely as it could be. I will come back to that perhaps when we talk about remand for own protection.

Baroness Barker: All those issues will be covered in our later questions, but we would particularly like to pick up on supervised discharge and community treatment orders and the disproportionate effect of those on some communities.

Q90 **Sir Charles Walker:** Dr Smith, comorbidity, diagnosis of psychosis and schizophrenia and life expectancy reduced by 15 to 20 years is a very depressing statistic. When I first looked at this in 2007, I think, it was exactly the same number. Since then, we have had all this fanfare of parity of esteem. I keep being asked when parity of esteem will be achieved. I think it will be when we reduce the 15 to 20-year figure for shorter life expectancy. Does it depress you that it is still 15 to 20 years? That suggests that absolutely no progress has been made over the past 15 years since we last looked at this piece of legislation.

Dr Shubulade Smith: It is depressing, and it was something I started working on in the late 1990s. At that time, it was something that people were not aware of, but it was historical. We knew in the 1800s that there were higher rates of mortality in people who were in asylums. What has happened repeatedly over the years is that people have remembered it again. The good thing is that now people properly remember that there are shorter life expectancies.

It is probably something about the disorders themselves, but primarily it is to do with lifestyle factors; it is to do with some of the medications that are used; and, more than anything, it is to do with fragmentation of care. People argue about whether it is the responsibility of primary care or secondary care. We know there are huge amounts of stigma involved and that when people go to secondary acute services they do not get the care they require. One statistic is that the number of people who develop severe mental illness can develop breast or lung cancer. It is not as high as you would expect, but when they do they are 50% more likely to die from that cancer than someone who does not have a severe mental illness, which tells us that it is about those people not getting access to the care they need.

Sir Charles Walker: This is a gross oversimplification, but time is short. Having talked to parents over the years, normally about their sons, the general view is that, as long as they are taking medication that controls their mood—not much scientific advancement since the 1980s—and they are not making a nuisance of themselves and not causing a nuisance to other people, it does not really matter if their weight has ballooned to 25 stone and they are smoking 50 cigarettes a day. We are not too worried about that, because they are not making a nuisance of themselves. That is what parents have told me. I know it is an oversimplification, but it is very distressing and it feeds into the statement you have just made.

Dr Shubulade Smith: Now, and certainly in the last few years, psychiatrists are very concerned about that. In fact, you will see that most psychiatrists have a holistic approach to things. Now, if you come into services, you will not simply get medication; there will be an expectation that you will be doing exercise regularly and that people will help you to understand dietary factors.

It is known that if you have a severe mental illness you are likely to develop a comorbid cardiometabolic problem that will shorten your life. So part and parcel of the treatment involves thinking about diet and lifestyle factors. Certainly smoking is something that we have tried to do something about. We have gone tobacco-free. We have had difficulties,

because our patients were excluded from the tobacco and smoking cessation services that everybody else has access to. There are some structural things that need to change to make it easier for us to get that care for our patients.

Juliet Lyon: I was just reflecting on a visit we did a few years ago to a medium secure unit where it was obviously struggling with problems of gross obesity and very little for patients to do, and the psychiatrist we met was helpful in explaining what he hoped to develop. This is a problem replicated in prisons, particularly acutely over the last couple of years, where people have literally been held within a prison within a prison. Lack of exercise and lack of anything to do has been magnified massively, and we do not yet know the full impact of that. It seems to me that we should not accept it, given that the problem has been so well known for so long, as you say.

Dr Shubulade Smith: No, it is unacceptable, absolutely.

Q91 **Dr Ben Spencer:** I want to go back to the points a couple of the panel made about the removal of the definition of prisons as a place of safety. Juliet and Andrew, you both specified that you think that is a good thing, but you have concerns about its implementation. I can see that the entire panel is nodding about the implementation side. Starting with Juliet and Andrew, and then we will open it up, what more do we need to make sure that it actually works in practice?

Andrew Neilson: I emphasise the word "principle", because the correlation is: how does it work in practice, and how do you resource it? There has been lots of written evidence, and everyone was nodding because clearly there is concern as to how it is done, and it needs to be properly resourced. Juliet will want to say more about the work that her panel has done on police custody, so I will not talk about that.

I will focus on one of the mechanisms in the legislation to ensure that people are not in prison, which is Clause 42 on remand for own protection. Our concern is that the definition of mental health regarding remand is in a sense simultaneously narrow and imprecise, so from our perspective it risks limiting the impact of the remand measures and possibly allows the system to renege on the important point of principle, which I think we are agreed on, which is the point about saying in particular that prisons are not a place of safety.

What do I mean by that? I suppose it touches again slightly on the comorbidity point that we have just heard. We are talking about individuals coming before the courts who will often present a complex range of needs across a number of areas. You may have someone who has mental health issues but they are also homeless, or they are being criminally exploited, or perhaps they have all three of those issues in their case before the court. The danger is that the legislation as currently drafted could still see that individual remanded for own protection, but due to their homelessness or their criminal exploitation rather than the mental health point kicking in as envisaged.

That begs the question: if we are saying on principle that prisons are not places of safety, how can that sort of scenario be allowed? At the Howard League we published a briefing on this looking at some of the various other grounds on which someone can be remanded for own protection other than mental health, and there are other mechanisms available.

To give one example, I mentioned criminal exploitation. If the courts are looking at someone who is a potential victim of modern slavery, there is support available via the national referral mechanism brought in with the Modern Slavery Act, and that can include accommodation. We would argue that the simple and principled response is for the legislation to abolish the powers to remand people for their own protection, or children for their own welfare, under the Bail Act entirely.

I recognise that that brings back the issue of resource and beds. None the less, we do not really see why the legislation should be saying only on mental health grounds, "Shall we stop this?" If we say that prisons are not a place of safety, why would we remand people to prison for their own protection because they are homeless or because they are being criminally exploited?

Juliet Lyon: We would certainly like to see whether it is possible to close the loophole on the use of protective bail. On a visit to Styal Prison on 30 September, the governor confirmed that it is still receiving women with warrants of concern raised by the courts who are being remanded into its care. She felt strongly that it was the wrong place for them and that her staff were in no way equipped to respond to their needs.

She also mentioned—I think I should mention it here—the practice of gate sectioning, which apparently still occurs, and it struck us as something that should have been dealt with a very long time ago. This is where somebody is being released from prison custody. They are told that they should prepare for release. They literally get ready, collect whatever possessions they have and walk to the gate, at which point they are sectioned under the Mental Health Act. That is largely because the prison struggled to get anything else for them in any shape or form, and it is the one way of guaranteeing that they will have some sort of continuing protective care. It is a really grim practice.

Dr Ben Spencer: Is it under Section 136?

Juliet Lyon: I should have checked that with her. I assume it is. It is well known.

Dr Ben Spencer: The section process has been completed. All the paperwork has been done, they have been assessed, and they are leaving.

Juliet Lyon: Sometimes, yes.

Dr Ben Spencer: What happens once they get to the gate? Where are they taken to after that?

Dr Shubulade Smith: It happens less and less, but occasionally when someone is at the end of their sentence or remand period and the prison feels that the person has a mental health problem and they need to be assessed, they are sometimes assessed at the gate. That is because people are quite unwell.

One of the issues is that many prisons do not have adequate mental health in-reach services. Some prisons have fantastic mental health in-reach services, but it is very much piecemeal across the country. In some areas, you will have a prison where there is a psychiatrist who will go in once a week to do a clinic. In other areas, they have an in-patient unit with a psychiatrist and a whole team of nurses and psychologists.

Baroness Barker: In that scenario you are talking about, would the person know in advance?

Juliet Lyon: No.

Baroness Barker: They do not know. When they are sectioned, whose care are they discharged into, and does that body know that the person is coming out?

Dr Shubulade Smith: It is rare, but if it happens it is usually because there have been concerns about the person's mental health anyway. They have probably already been referred, and then they go to court at a much earlier time than was expected, so the process of them being assessed is already in train. Sometimes, they have been assessed partly already. A doctor might have done the first recommendation anyway. They might not realise that they are going to be detained at that point. It is usually because there are real concerns about the person's health.

Juliet Lyon: Can I respond to the second part that Andrew mentioned about policing? We are just about to publish a report about good practice in relation to terms of prevention of deaths before police custody, during custody and at the point of release. We have received submissions from police and crime commissioners across 27 of the 43 forces. One thing that many of the forces are proud of is having very strong and good partnerships with local health services. That would mean a range of activities from first responders being health or health-led to partnership response between police and health, and this is where the practice of de-escalation and so forth clearly also takes place in policing.

Also mentioned were the use of liaison and diversion services and street triage, and areas of safety and places of safety. In some parts of the country, there are clearly options for the use of a place of safety that is clinically led and supervised. That seems to be particularly interesting and something that might be developed more widely. Crisis centres are attached to some hospitals where assessments can be made. The point was made almost without exception by forces that they would like to see adequate health resources and the staffing of workforce, as you have referred to already, so that they were not using police time inappropriately and really not able to take on that role.

Dr Shubulade Smith: We have some concerns about this. Of course it is a resource concern. Essentially, psychiatrists do not regard prison as a place of safety at all for the most part. It should not be a place of safety. The expectation at the beginning, when someone might get remanded, usually by a magistrate, is that they will go into mental health services, and it is general adult services that they will go into. For the most part, general adult services already have lots of people waiting for their beds. There are not enough beds and there is not enough resource. The community services are not yet up to scratch to manage the additional demand, so there is a concern about what will happen to those people, and that needs to be taken into account when making a decision about it.

Dr Ailbhe O'Loughlin: I want to add something on the use of prison as a place of safety. There are huge numbers of people in prisons with mental health problems, which I know also touches on the next question about the transfer period. More work needs to be done at the court level at the point of sentencing and at the point where decisions are being made about whether to remand people. There are powers such as interim hospital orders. Judges can use

powers to order an assessment for a person if they are suspected of having a mental health condition. Those powers seem to be underused, and have been for a long time.

There has been a development towards prioritising punishment and public protection in sentencing. Sometimes people are given prison sentences or combined prison and hospital order sentences, which means that later they can end up being transferred back to prison from hospital once their mental health improves, deteriorating in prison and being transferred back to hospital. There are other things going on as well.

We need to look at how many people with mental health conditions we send to prison and think about whether prison is a suitable place for them; and, picking up on what Dr Smith said, whether those prisons have the right resources to take care of them, because it is very variable and the court will not always consider what prison the person is going to. Somebody could be sentenced with the idea that they will get their medication in prison through the prison in-reach team with some of the psychiatrists, but that might not actually happen once they get to prison.

Q92 **Lord Bradley:** That segues nicely into the next question about the 28-day transfer. What are the key barriers to achieving that, and what is your view about making it mandatory and about allowing exceptional circumstances to be included as a provision within that section?

Dr Ailbhe O'Loughlin: The key barrier tends to be resources, at least from what I have read, and finding a bed for the person. Another of the Bill's proposals is to remove the requirement to find a bed for the person before they can be transferred, which is very problematic if we are transferring somebody to a hospital where we do not know if there is a bed available for them. Resources are a big issue for people waiting to progress to a suitable bed.

It is a good idea to make the time limit statutory: to say that this is the time limit that needs to apply and that agencies need to conform with it. The current wording is quite vague and open. It says that they need to seek to ensure rather than that they need to ensure that the transfer takes place. If you have "seek to ensure" and you have "exceptional circumstances", it sets quite a low standard. It would be stronger if it was "to ensure" and they would have to have exceptional circumstances if they had not ensured.

It would also be worth specifying, either in the Act or in the code of practice, what "exceptional circumstances" means—what sorts of things could be taken into account or what sort of threshold that might mean. As the earlier panel pointed out, a lot of the time the words have been left open to interpretation, and it is not entirely clear what an exceptional circumstance is and what sorts of things should be taken into account.

Lord Bradley: That is very helpful.

Juliet Lyon: I want to reinforce that. That was exactly the point we wanted to make. We believe that "exceptional circumstances" and "seek to ensure", rather than "to ensure", could be strengthened most usefully to make it clear that this needed to happen. Whether it is about drafting or providing better guidelines to make it very clear what the new Act intends, it would be very helpful. It is clearly difficult for all concerned, and that obviously includes the receiving hospital.

When you speak to healthcare teams, as I did on a National Audit Office visit to Wormwood Scrubs, you find them in desperation and unable to manage people on the wings. They have to be managed in segregation or in some form of special arrangement, which usually means a reduced circumstances arrangement, until and unless a bed can be found for them. It is not, of course, just the physical bed; it is all that goes with it. It is the clinical team. It is people who understand mental health conditions. It is people who, hopefully, are willing to work with families—to your point earlier—who can relate to that person. They will not get any of that in a prison setting. That is not because staff want to be unkind—far from it; these mental health professionals were very sad about the circumstances they found themselves in professionally, and they felt professionally compromised.

It is a very important part of the Act. It could be strengthened by drafting and guidance, and it would be a great pity if it was not monitored to check how well it was working and that that was not formally part of the way the legislation is drafted.

The Chair: That is very helpful.

Q93 **Baroness Berridge:** I have a very quick practical question. Forgive me if it is very Jack and Jill. People are detained under Part 3 into the same hospitals, if it is a hospital order, as we use for Section 2 and Section 3 patients under the Act. We heard in the previous evidence about the small and declining number of beds, and that logjam is happening in A&E. Do we have a logjam back-up because we do not have the beds to sentence people directly into a hospital, not just the transfer? How does that resource match up when it is needed in the criminal justice system?

Dr Shubulade Smith: The hospital where the patients will go for Part 3 is not always the same place as it is for Part 2. It might be under the same hospital trust, but it is likely to be a very different building, because it will be a low secure or medium secure building, and that is very different from general adult beds. It is important to note that approximately 50% of patients transferred from prison go to general adult beds. The other patients will go to secure forensic beds.

Importantly, there is a sense that prison is just bad for people with mental health problems, but it is not as simple as that. That used to be the case, but over time, because of reforms that were put in place, there are really good mental health services in some prisons now. In addition, you get psychologically informed prison environments. Prison environments are almost like therapeutic communities within the prison. That is important, because certain people do better in those pipes, as they are called, than they would in hospitals. It is the type of mental disorder that matters.

As to the types of mental disorder that Juliet described, which I recognise, they are often people who have severe psychotic illnesses. They may well have comorbid problems—complex problems to do with trauma and personality functioning—but the thing that often makes them extremely unwell and very difficult to manage in prison is their psychotic disorder. Those patients are usually the ones who need a transfer to hospital, but not everyone who has a mental health problem will need transfer or would benefit from transfer to hospital.

Baroness Berridge: We are not hearing judges saying, "I can't sentence them, because there isn't an appropriate place for that person to go".

Dr Ailbhe O'Loughlin: In sentencing?

Baroness Berridge: Yes.

Dr Ailbhe O'Loughlin: In some cases they have not been able to sentence because there is no appropriate bed. To make a hospital order under Section 37 and to make a hospital and limitation direction under Section 45A, a bed needs to be available, and there have been cases where it has not been available.

Baroness Berridge: They remain technically on remand, although they are convicted, but in the criminal justice estate.

Dr Ailbhe O'Loughlin: Yes.

Juliet Lyon: This point dates back a little bit, but it is culturally still important to make it, and it relates to very low staffing levels currently in the prison system and some very severe shortages. Notwithstanding the efforts, which I recognise, to improve healthcare—there are therapeutic units and so forth—they are often the very first to suffer when it comes to major staffing shortages on the officer side. They absolutely cannot be relied on in the same way as clinical settings.

The Prison Service is sometimes forced to move a therapeutic unit miles way to somewhere else altogether, as it once did from Winchester, because it cannot cope with having that provision there any more. It is just not able to pay the same attention. Mental health care in prison needs to be improved, because there are always people with mental health needs who will end up in the prison system, but there are risks in creating special mental health units because it can reassure the courts. In Styal, years back, they closed such a unit for that very reason. The courts identified that it was a unit where they could get medication, they could be placed there and they would be safe, and it led to a huge number of sentencing decisions being made that were not appropriate. That unit closed, which was a good thing.

I absolutely agree that things have improved and need to be good enough, but it is a prison and not a hospital, and the risk is always that the courts could get that wrong if other options are not available to them.

Dr Shubulade Smith: I come back to the transfer limits. Notwithstanding what has been said, there is a question about whether this is realistic and whether the Government have the right balance. I do not think they do, and I say that as someone who runs the services for south London. We were some of the worst, I have to say. Our waiting times were very long. We now have some of the shortest waiting times in the country, and we can still only manage just about 29 days, and that is at full pelt. We have a fantastic referrals co-ordinator, Joyce, sending emails, et cetera, on Sunday evenings, and we have a very senior consultant reviewing and triaging all the referrals.

In order to achieve the 28-day limit in addition to their day job, someone needs to go out and do the assessment. The nurses have to review that patient and let them know how they are going to settle into the unit, and then find a bed. The problem with the proposal is that it only takes into account people getting into hospital; it does not take into account the beds that have to be found and any of the wider system issues—for example, trying to create beds by moving people out into the community, which is extremely difficult because the funding

comes from a different budget pot. Some people get better and do not need to be in hospital any more.

A lot of effort, time and thought has been given to getting people in, but there is nothing about returning people to prison, remitting people, at all, which, frankly, is disappointing. One of our main issues is getting people better. Then they are ready and happy to go back to prison, but we cannot get them back because there are barriers to doing so.

The Chair: There are lots of important points. Thank you so much.

Q94 **Baroness Hollins:** This question is about the difference between Part 2 and Part 3. The proposed changes to the civil detention criteria would create a further widening in provisions for people accessing mental health services through the criminal justice system compared to not doing that. What are your views on that decision? Will this particularly affect people with a learning disability or autism?

People from black communities, particularly men, are more likely to encounter mental health services through the criminal justice system. What are the implications of a division between Part 2 and Part 3 for people from racial and ethnic minorities? There is quite a lot in there.

Dr Shubulade Smith: Our view is that it should be the same criteria. It seems odd that you could be in the community and it is harder for you to get into hospitals should you need it in extremis, but in prison it would be much easier for you to be detained again. That does not seem right. Most of the people I have spoken to feel that, whatever the criteria are, they should be the same, whether they are in Part 2 or Part 3.

People do not realise perhaps that 74% of people who end up becoming forensic patients have been general adult patients for many years beforehand. As someone said earlier, these people will move from being a Part 2 patient to being a Part 3 patient, and then move back to being, essentially, a Part 2 patient again.

It is strange that you would have different criteria depending on which bit of the system they are in. Sometimes it can be arbitrary. Forensic beds are slightly more plentiful. That is probably the wrong way to put it. There are fewer difficulties with forensic beds than there are with general adult beds, so it may well be that someone needs to come in and it is easier to get them in via the forensic route. So many of our patients have challenging behaviour.

Whether that challenging behaviour is counted as being criminal could well depend on whether we could get them in via the courts. Perhaps they end up not being admitted, but unfortunately they deteriorate, the police end up being called, and there is a push towards them going through the criminal justice system. Every psychiatrist I have spoken to has said that they are really concerned that that is what will happen with people with a learning disability and autism. If they are taken out of Part 2, they will get into services via Part 3. Unfortunately, that reflects the fact that we do not have adequate services at all for people with neurodevelopmental disorders.

You cannot legislate for something that just does not exist. The legislation should be around building up not just the units themselves but the expertise and the training. Fewer and fewer

nursing schools provide training for learning disability nurses. Many more used to do it, but now there are four or five in the country that specialise in that.

Dr Ailbhe O'Loughlin: I agree to some extent that the civil and criminal criteria should be the same or similar, but there are differences. In the original Mental Health Act, in the criteria for making a hospital order there was no need to assess risk, because the assumption was that the person had been convicted of a criminal offence or was before the courts, so that risk criterion was met. It is the same with transfers from prison; there is no need to assess risk.

In some ways, we would probably need to think about whether including a risk requirement might present a barrier in some ways. It is also important to note that someone can receive a hospital order for an imprisonable offence that does not include any violence. You can receive an imprisonable offence for fraud. A hospital order can be an alternative to sending somebody to prison if they are convicted of an imprisonable offence, but we would probably need a greater drive towards diverting people into the community and encouraging judges to make community sentences.

If we are going to equalise the criteria, we would need to consider whether it would be a good idea to create possible barriers to people entering through the criminal justice system. Having the same discharge criteria makes sense. For unrestricted patients, in the new Act the discharge criteria will be the same as for Part 2 patients, but I agree that there are definitely difficulties with making a distinction between Part 2 and Part 3 when it comes to learning disability and autism. The assumption is that people in Part 3 are riskier than people in Part 2, whereas, as Dr Smith has highlighted, there is huge crossover. Making that distinction between Part 2 and Part 3 is arbitrary when it comes to the detention of people with learning disability and autism.

> **Baroness Barker:** Are there any international comparators—places where they have made the changes to the criteria? What is the evidence base for that? If you have anything on that, perhaps you might write to us.

Dr Ailbhe O'Loughlin: I do not have anything, but I can have a look.

> **Baroness Hollins:** Can I pick up on the learning disability and autism point? One reason why people have been very worried about learning disability and autism staying in the Act is because of the very long stays, the average stay in Part 3 being six years. What could one do to change that? Will anything improve that situation?

Dr Shubulade Smith: It is about training and appropriate units. People end up staying for a long time because the units that they are in are often staffed by people who do not have very good skills and training in looking after people with neurodevelopmental disorders. Certainly, that is the case with our services. We are now developing a service specifically for people with neurodevelopmental disorders. We have managed to find senior staff who may be able to staff it, but we will have to train up people to staff that unit because we do not have those resources available. That is the problem across the country.

> **Baroness Hollins:** It also goes back to earlier points about a lack of community resources for people to be supported afterwards.

Dr Shubulade Smith: Yes.

Juliet Lyon: I absolutely agree with Dr Smith about the idea of more preventive work, earlier work. It is appalling to read, and to know, that people from black and racial minorities are more likely to enter mental health services through the criminal justice system than any other route—that has been the case for decades—and how many people with autism and other forms of neurodevelopmental disorders end up in custody. Most of this seems to be prior to the work you are doing on the Act. It is about earlier intervention.

There is, I think, relevance to the community sentences with treatment requirements, which are still underused. The one with mental health treatment requirements is underused. If community sentences became more widely used by the courts, it would be worth considering whether a community sentence with a requirement for social care could be developed alongside the mental health treatment order. That might be very valuable.

It is terrible to say this, because it is too definitive and perhaps not that helpful, but the fact is that it is the wrong gateway. People should not end up getting into distress and difficulty and getting into trouble with the police, and the police should not end up in desperation having to restrain them, which can lead to deaths in police custody, or in any other way handle them inadequately. So often when we meet families who have been bereaved by such deaths, they say again and again, "We have sought help for so long, for years, for our son"—or another family member—"and we were always worried it might end up like this".

I appreciate that there are limits to what can be done when you are considering a very important piece of legislation that has a very particular focus, but it has to be seen in this context at least.

Baroness Hollins: Thank you. That is very helpful.

Dr Ailbhe O'Loughlin: I want to add another point about that. I mentioned the differences between Part 2 and Part 3. Under the Bill, there would be shortened initial detention periods and more frequent reviews of the person's detention by a tribunal. That poses problems for equality when it comes to people from black backgrounds in particular, because they are more likely to enter through the criminal justice system.

There is quite a large proportion as well. I looked at the statistics. About 70% of the population of restricted patients were white and 18% were black, so compared to the general population there is a disproportionate representation of black people in the restricted patient population. If we are not going to have as frequent reviews as for civil patients, that is likely to lead to longer detentions for people, and again it might not be justified on the basis of risk, as I mentioned.

Q95 **Baroness Berridge:** You may have covered this point, Dr O'Loughlin. What is the panel's view on the draft Bill not extending tribunals' powers for restricted patients and not extending ACDs into Part 3 of the Act? From what you are saying, Dr O'Loughlin, you think they should be.

Dr Ailbhe O'Loughlin: Yes.

Baroness Berridge: Is that the view of the panel? What about ACDs?

Dr Ailbhe O'Loughlin: I think they should be extended too, yes.

Dr Shubulade Smith: I definitely think that ACDs should be extended. You have patients who are restricted and patients who are unrestricted under Part 3. For patients who are unrestricted under Part 3, essentially that functions in a very similar way to a Section 3. If someone is under a Section 37 or Section 41—usually this is someone with a longer-term admission of 18 months to two years minimum—you could ask for them to have a tribunal at three months, which is probably too early. It is important to make sure that that would not apply to someone who was on a restricted order.

Regarding black patients, as Dr O'Loughlin said, we know that black people are overrepresented in the criminal justice system and that they are more overrepresented in secure services. It is 17% or 18%. The concern about the division between Part 2 and Part 3 is that, because black people are overrepresented in the criminal justice system, it will be easier for them to be further detained inadvertently, so that inadvertently it might well discriminate against them.

Baroness Berridge: From your south London experience, do you happen to have data on the learning disabilities and autism population in south London and whether there is disproportionality in terms of ethnicity within that population?

Dr Shubulade Smith: It is a really good question. We are now gathering all the data, so I cannot give you the answer yet. Ask me in about six months' time.

Q96 **The Chair:** The Government believe that the proposed supervised discharge will allow for a safe management of restricted patients in the community. Do you agree with that, and do you think that any further safeguards should be included?

Juliet Lyon: I wonder if I could respond by asking a question. I want to try to understand what supervised discharge will mean and what the status of the people in that supervised discharge will be. Is it, in fact, a form of state custody? Would it be similar to approved premises in probation where people have to reside where directed? If it is any form of custody, what particular monitoring arrangements and inspection arrangements need to be put in place? I think you raised this earlier, Dr O'Loughlin, when you talked about expanding the custodial net. I am sorry to answer your question with a set of questions.

The Chair: No, it is fine. Did you want to say something, Dr Smith?

Dr Shubulade Smith: Usually what happens is that someone leaves secure services and goes to supported accommodation. It will be a type of residential hostel, and it will be either low, medium or high support. For someone like this, it is likely to be high-support accommodation. This is from the case of MM, who was in such a long stay in hospital that the only way they could leave hospital because of their risk was, essentially, to be escorted when they were in the community, which was kind of agreed to.

The problem with that, of course, is that that is quite restrictive. You leave your accommodation, your home, but you still have to have someone with you keeping an eye on you all the time. There were no safeguards around that. The supervised discharge is literally that. It enables them to leave hospital, which is felt to be more restrictive, but they will be in

the community and have limits on their movements because they will always have someone with them.

Juliet Lyon: Would their status be similar to someone on probation in an approved premise, for example?

Dr Shubulade Smith: It is different, because a clinical team would oversee them, but they would also be under the auspices of the MoJ.

Juliet Lyon: Okay.

Dr Ailbhe O'Loughlin: With this one, it is problematic, as I mentioned, because it would be a form of detention. That is what the court recognised in MM. The person in that case was not free to leave their accommodation. They were, as you said, being monitored all the time, so they were under conditions that deprived them of their liberty. Deprivation of liberty means detention. In some ways, perhaps the Bill is trying to draw a distinction between detention and deprivation of liberty, but, actually, they are the same thing.

Somebody cannot be detained under the Mental Health Act unless the criteria for detention are met, whereas a conditional discharge would mean that someone who is entitled to be discharged from the Act—they no longer meet the criteria for detention under the Act—could be discharged "into the community", where basically they would then be detained in a different setting. It could work for some people if they still meet the detention criteria, but if the tribunal or the Secretary of State decides that they would be better served by a community placement, they could be legally detained in that placement. It would not work for somebody who is entitled to be discharged, and the Bill does not draw that distinction.

This came up in the case of Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust v EG. The patient had been out of hospital and it was against his therapeutic interest for him ever to be recalled to hospital. In that case, he was properly placed within the community, but the gap in the legislation meant that he could not be detained in the community, because the placement in the community did not constitute a hospital. He fell into a gap.

Another way around this would be to make those care homes hospitals, basically, and for them to be subject to inspections by the Care Quality Commission and to have all the usual safeguards that come with that, rather than pretending that people are not detained. If we recognise them as detained patients, they have all the other safeguards that go along with that, which they would not have under this proposal.

> **Baroness Barker:** I sat in meetings like this when community treatment orders were under discussion, and they were sold to us all as being a less restrictive option than detention, that they would be very few, and, of course, that they would not be used in any discriminatory way. We all sat there and said, "Really?" Nowadays, we would sit there and think, "We'll get a T-shirt out that says, 'I told you so'". Do you not look at this proposal and think, "All those potential pitfalls are there. What is the benefit?"
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> We have had evidence from previous witnesses who have said, "There are a small minority of people for whom CTOs are actually a good thing, so we're going to keep them". Equally, we have had evidence from witnesses, particularly within the

community, who said, "This has been disproportionately used against black people. They should go".

You are the professionals in all of this. What do you think? Where should we go with this?

Dr Shubulade Smith: The supervised discharge was a safeguard, as described, for rare individuals who had been in hospital for a very long time. At the moment, we do not have them and we do not use them. This is my personal view: I think we could probably manage without them.

However, interestingly, a particular patient we have has been in hospital for a very long time. He has an intellectual disability and an acquired brain injury. He is very difficult to move out of hospital because of his inability to learn different ways of interacting with people. We have managed to get him out of hospital with escorts when he goes out, and we have used DoLS. That has worked. He is on a restriction order, and we have done DoLS on top.

Baroness Barker: Do you understand my concern that if supervised discharge orders suddenly appear as a new piece of kit for you to use, given the pressure on beds, we will suddenly get loads of people being moved out on supervised discharge?

Dr Shubulade Smith: My view is that they will be used more than expected and they will be used disproportionately against black people, but that is my personal view.

Marsha De Cordova: I am sorry to jump in, Chair, but the evidence also suggests that, does it not?

Dr Ailbhe O'Loughlin: They would be even more restrictive than CTOs if they were enacted in their current form. In the PJ case, the Supreme Court found that somebody could not be deprived of their liberty in the community under a CTO. Originally, there was a proposal to have the same ability under a CTO as under a supervised discharge, but that has been dropped, whereas we still have the proposal to deprive people of their liberty under a supervised discharge. You would have civil, unrestricted patients being given a CTO, whereas restricted patients would be given a supervised discharge, which would be much more restrictive.

Baroness Barker: I was not equating the two; I was just drawing the parallels in the development of the legislation. You are absolutely right in what you say. We are potentially adding layers of confusion.

Baroness Berridge: Where is the pressure coming from to have this? Certain things in the review dropped out of the Bill and some things came into the White Paper. Where is the pressure coming for something that is so edgy in legal terms? Where do we think this is coming from to put something like this on the fringe of the Bill?

Dr Ailbhe O'Loughlin: It is probably from the EG case. It is the repercussions of the MM case. There were people already subject to conditional discharge under these types of conditions, and the Secretary of State put out advice that they should be converted to a

Section 17 leave of absence, so that they should be treated as detained patients who are on leave of absence in the community, but that is just basically a stopgap fudge. Longer term, it probably would not be a good idea to have that continuing.

It is quite difficult already, because under the European Convention on Human Rights, if a person is going to be detained, it needs to be in a hospital or other appropriate setting, so having people on Section 17 leave who are not detained in hospitals is already problematic. That was why in the EG case the court disapplied Article 5. If you have not seen it, it is probably worth having a look. I can send it to you. It disapplied Article 5 to those particular cases to enable people like EG to stay in their placements under Section 17, even though he would never go back to hospital. It is a fictional idea that he is on leave of absence, because he would never be recalled to hospital, as it would not be in his therapeutic interests.

Baroness Berridge: We have had evidence from people saying that we are not good at assessing risk. Is it that we want that person to be out there, but we need a safety net to ensure that the risk is managed?

Dr Shubulade Smith: I do not think it is that. For these cases, it is very likely that when they go out they will interact with someone in an inappropriate way and that person would feel, "Okay, that's certainly overly sexual", for example, in the case of one of our patients. It is for people for whom we know what the risks are and we know that this is likely to happen. It is a way of allowing them to be out of hospital and having a little bit more freedom, although they are restricted.

The Chair: That is extremely helpful, thank you.

Q97 **Baroness McIntosh of Hudnall:** This is the "and finally" question. I would like to ask it in a slightly different way. You were asked at the beginning, "What's good about this? What's in it that you approve of and what isn't in it that you would like to see?" This is sort of the same question.

Having listened to you, broadly speaking you have all expressed support for the reforms that these amendments to the Mental Health Act bring forward. You have also indicated a significant amount of scepticism about some aspects of them or some aspects of how they might work. When you look forward to the possibility that these reforms will be enacted, possibly quite soon, what do you see as the biggest challenges to them having the beneficial and therapeutic effects intended by those who have drafted them?

Andrew Neilson: I will start at the prison end and set the context. Others can speak more eloquently and knowledgeably about how it should then play out. It is worth just putting into context where we are with the prisons. We are talking about a prison population that is projected to grow quite dramatically in the next few years. We have prisons that are already in a staffing crisis of both recruitment and retention, which has been exacerbated by the pandemic.

Given that there is a staffing crisis even where the prison population currently is, if it is going to grow by 20% in five years' time, how on earth will that staffing crisis be resolved? Why is that important? If we are talking about a larger system that is already very troubled and has staffing problems, there is a good chance that the people in that system will get less good care

in the years to come, including people with mental health problems in the system. Yet that section of the prison population should be the easiest to move out of prison.

Baroness McIntosh of Hudnall: Can you remind us, if you have the figures, what proportion of the prison population has a diagnosed mental health problem?

Dr Shubulade Smith: About 70% have a diagnosed mental health problem. For people who are comorbid it is about 70%.

Baroness McIntosh of Hudnall: I know it is not a precise science.

Dr Shubulade Smith: That includes complex personality functioning issues. Almost by definition, if you are in prison, you may well have antisocial traits.

Baroness McIntosh of Hudnall: That is what I thought you said. Going to the points that have just been made, that is massive.

Andrew Neilson: Yes, it is a spectrum. I suppose one of the things I am getting at is that if people's care gets worse and they already have a mental health problem, the danger is that their mental health issues get worse in a prison contest. Getting timely transfers out of prison right and ending the use of things like remand for own protection could really help to ease pressure on the prisons facing this context. All I am really saying is that although it might be a knotty problem and there are real issues with resourcing in the community, now is the time to try to address it before things get a lot worse.

Baroness McIntosh of Hudnall: Who wants to go next, or have you been silenced?

Juliet Lyon: I am glad you thought we were being sceptical rather than cynical.

Baroness McIntosh of Hudnall: I would not dream of accusing you of being cynical—certainly not.

Juliet Lyon: There is some healthy scepticism about the ambitions of the Bill, which are profoundly helpful, in fact. I know that the evidence that you will have heard and the written evidence we have been able to review draws attention to the need for adequate resourcing on the health side; otherwise, prison or police custody is a fallback state. Notwithstanding the fact that prisons themselves cannot cope and are less likely to cope as numbers increase, the impact on individuals and their families has to be the driver for change. It is cruel to put somebody in need of treatment into a place where they cannot really hope to get it and into a culture and an environment where they are almost bound to be made worse. It is clearly really important to strive to change that, and I think the Bill does that.

To steer back to the original question just so that I do not lose the chance to comment on it, there could be more learning from the deaths that occur, and that is important. As I mentioned, it is really important to get proper data collection and publication. That is done in all other custodial services. Disaggregated data helps us to learn and understand what is happening and hopefully prevent future deaths, as would independent inspection.

The CQC is a regulator; it is not an inspector. Thematically, it will choose a number of cases to review, but it is not in a position to respond to and investigate each case in the way the

Prisons and Probation Ombudsman would do in prisons and in immigration detention, and the way the IOPC will do in policing. There is a gap there that needs to be filled. It was interesting that Sir Simon referred to that and felt that a stronger case could be made, although he did not choose to make it in his review.

The third question is whether the ambition of the Department of Health and Social Care in its forthcoming suicide prevention plan—to have some form of assessment of the impact, before it happens, on health and well-being—could in some way apply to the Act. That would mean being clear that adequate resources were in place and that that was part of anticipating impact and seeing what could be done. That would mean in this instance adequate health resources and monitoring those to make sure that they are working in the way you had all hoped.

Dr Ailbhe O'Loughlin: I would also reinforce the point about resources, because that seems to be behind an awful lot of the problems: early intervention and all of that providing enough resources for people to intervene before things become critical, having better resources for mental health care in prisons, and having enough resources for people who need to be moved out of prisons.

It is a pity that the Wessely principles will not be enshrined in the Act. Having something that is similar to the Mental Capacity Act where we interpret the Act in a way that forwards people's therapeutic interest and therapeutic benefit and looks at people as individuals, having less of an emphasis on risk, would make a difference. At the moment, the Bill is tweaking things in the right direction, but it has not taken that more radical step of saying, "We should be trying to use the Act to help people enhance their mental health rather than just intervene when things are really bad and they need to be detained".

Dr Shubulade Smith: I certainly agree with Dr O'Loughlin. It would have been good to have seen the principles in the Act. We have been a bit concerned about how some of the changes have happened. There were recommendations in the review, and they have been slightly watered down or disappeared, or other things have been added.

Take, for example, the advance choice documents. There is very good evidence from across the world that they reduce detention, yet they have been taken out. Essentially, they have been watered down. That is unfortunate, because as psychiatrists we can work with that. Statutory care and treatment plans and advance choice documents work together, and they allow us to work with patients in a much more collaborative way. Many people are doing this already. We need a little bit of training and support for ourselves, but also for patients, so that they know how to get the best out of the relationship with the psychiatrist.

We would have liked to have seen something in the code of practice about training and resource, and how we can manage that. Some of the things that seem to be getting more focus than perhaps they ought are extra tribunals and stuff like that, which are just unworkable. We are absolutely flat out. We actually welcome the idea. We have no problem with people asking us, "Why have you chosen this kind of treatment package?" Why not just do it within the existing tribunal rather than an additional tribunal that will require resource not only from psychiatrists but from judges and so on? Frankly, it is unworkable also because, if a judge orders me to use different medication, it is still me who has to answer to the prescription, and if there is a problem with the prescription, I am responsible for it, so that is not going to work.

Things have come into it that have had huge amounts of focus. I think we understand why, but it seems a distraction from some of the core principles. This is about trying to focus on improving people's treatment in a collaborative way, and that means everyone working together. It sometimes feels as though the idea is that psychiatrists are essentially doctors who are not working with their patients. For the most part, psychiatrists are working very hard and trying to work with their patients and trying to improve collaboration. It is a little unfortunate that somehow what has crept into the Bill is the idea that we are not getting on with doing our jobs properly, when, in fact, we are trying to provide really good care in very straitened circumstances.

> **Baroness McIntosh of Hudnall:** Can I just be clear? Leave the issue of resources to one side for a moment, because everybody knows, no matter where their starting point, that you need the resources to deliver reform on this scale or indeed of any kind. You are saying that the placing of the principles in the Bill, and the inclusion of advance choice documents, would, in your view—you can say I am wrong about this—actually make it easier to implement the rest of the reforms incorporated into the Bill, and those are things that have been left out from earlier recommendations. Is that a fair summary?

Dr Shubulade Smith: I think so, because it would help us to think differently. Since the 2007 amendments, there has been a massive increase in the rates of detention. When we looked at it, 20% of that was to do with risk and people being concerned about risk and becoming more risk-averse, and not thinking about the therapeutic benefit in quite the same way. We would like to see something that focuses more on the therapeutic benefit, because the fact is that if we help people to improve their mental healthcare, that will inevitably reduce their risk if their risk is related to their mental health disorder.

> **The Chair:** Would you agree that the proposal for a nominated person, as opposed to a near relative, makes a real difference? We are looking for all the positives.

Dr Shubulade Smith: I think it is fine. It would make a difference to some people. Unfortunately, a lot of my patients have come into conflict with their relatives, which means that they do not have a blood relative or a near relative in the way that traditionally you might have, so a nominated person is very useful for a large section of that population.

> **The Chair:** Okay. Thank you. We have sadly run out of time. I want to thank you all very much for the contributions you have made today. It is extraordinarily helpful, and we are extremely grateful for you all coming here in person today.