Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Tuesday 8 November 2022

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Written evidence from witnesses:

- Professor George Szmukler (Emeritus Professor of Psychiatry and Society at King's College London) (MHB0020)
- Dr Lucy Series (Lecturer, School for Policy Studies, University of Bristol) (MHB0003)

Watch the meeting

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

Questions 98-107

Witnesses: **Professor Gavin Davidson**, Professor of Social Care, Queen's University Belfast; **Professor George Szmukler**, Emeritus Professor of Psychiatry and Society, King's College London; **Dr Lucy Series**, Lecturer, School for Policy Studies, University of Bristol; **Professor Jill Stavert**, Professor of Mental Health and Capacity Law, Edinburgh Napier University

Q98 **The Chair:** Good afternoon, everyone, and welcome to this, the seventh session of the scrutiny by the Joint Committee on the Draft Mental Health Bill. Our purpose today is to explore the problematic and uncertain operation of the interface between the Mental Health Act and the Mental Capacity Act; the suggestion that a new approach to fusing elements of both Acts may reduce operational problems and create legislation that can be usefully used to assess the capacity of patients to make decisions about treatment for both physical and mental illnesses; and the use of this approach in other nations of the United Kingdom.

Thank you to all of you who have already submitted written evidence, which is incredibly helpful. I am going to ask each of the witnesses now to introduce themselves and just say a few words.

Professor George Szmukler: I am a retired psychiatrist and emeritus professor of psychiatry and society at King's College London. I have had a very long interest in coercive measures in mental health care and ways in which one might reduce those in decision-making capacity, and in reform of mental health law, where I have been one of the proponents of a fusion law.

I have, until recently, also been the chair of the special committee on human rights at the Royal College of Psychiatrists, but I am here in my own right, not representing any of those organisations.

Dr Lucy Series: Thank you for having me this afternoon. I am an academic at Bristol university. My research specialises in mental capacity law. I am particularly interested in how mental capacity law interacts with human rights, and my recent work has focused on its liberty protection safeguards and deprivation of liberty safeguards, and their interfaces with the Mental Health Act.

Professor Gavin Davidson: Thanks very much for the opportunity to join you. I am a professor of social care at Queen's University Belfast. I am part of the Northern Ireland Department of Health's reference group for the development and now implementation of the Mental Capacity Act (Northern Ireland) 2016, the aim of which is to implement the fusion approach.

Professor Jill Stavert: Good afternoon. I am professor of mental health and capacity law at Edinburgh Napier University. My interests, for many years now, have been mental health and capacity law, related human rights and equality, and related reform of the law, practice and policy surrounding this.

In recent years, I have been an expert adviser to the Rome review in Scotland, which was the independent review on learning disability and autism in the Mental Health Act. More recently, I have been a member of the executive team of the Scott review, which was a widespread review of Scotland's mental health capacity and adult support and protection law. That reported at the end of September.

The Chair: Thank you. Let us begin by looking at the interface between the Mental Health Act and the Mental Capacity Act.

Q99 **Baroness Barker:** Good afternoon. Thank you very much for coming to share your expertise with us. I sat on the committee that scrutinised the draft Mental Capacity Act, the first mental capacity Act in England. One of the express intentions of that Act was to close the Bournewood gap. I am not sure quite how many years on it is, but the gap is as wide as ever and I am not sure that the legislation before us is going to make that gap go away. I would like Lucy, in particular, given that this is your area of work, to talk about the way in which the Mental Health Act and the Mental Capacity Act interface, or do not, in practice.

Dr Lucy Series: I think I can safely speak for everyone by saying that the interface between the Mental Health Act and Mental Capacity Act is a real mess. It is probably more appropriate to speak about interfaces rather than a single interface, because this question of which legislation you should use, or, if you are using both, how they operate together, can arise in lots of settings, including community settings and hospitals.

The particular question that the independent review focused on was what happens when you have a choice between the Mental Health Act and the Mental Capacity Act to detain a patient who is in hospital for assessment or treatment for mental disorder. That question can throw up all kinds of difficult conundrums. It can be really difficult for clinicians to understand what to do. It can be difficult for patients to understand what their rights are, or for families to support them. Even judges describe it as like putting their head inside a washing machine or spin drier.

There is real agreement that there is confusion, there is uncertainty, there are arguments and there is a mess, but it is a very tricky mess to clean up. That is because the interface between mental health law and mental capacity law reflects some deeply embedded cultural beliefs about what mental health law is and what mental capacity law is, what they are doing, and, perhaps most importantly, who they are intended for. It is also important because the choice of legislation can have significant implications for how people's rights are protected, and different people will hold quite different views on how to solve this problem.

> **Baroness Barker:** In your written submission to us, for which we thank you very much, you wrote something very helpful. You said, "One way of conceptualising it is to think of each law as different containers for flows of patients entering mental health settings … The MHA was designed to be a smaller container, capturing a particular patient population and filtering out others. The MCA serves as an 'overflow' system, for patients who 'lack capacity' to consent to their care yet whom professionals still think should be confined and treated without using the MHA".
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> That almost seems to indicate that there are different patients who, it is commonly understood by everybody, perhaps including themselves, should come under each piece of legislation. Indeed, some of the evidence from earlier witnesses, particularly people detained under the mental health legislation, said, "The Mental Capacity Act applies only to a group of people and we all know who they are; they are people who lack capacity". Does it work like that in practice, or are practitioners still in quite severe doubt about what to do with them in any given situation?

Dr Lucy Series: Socio-legal scholars talk about the law on the books, and then the law in practice. In a law on the books sense, both detention frameworks, the Mental Capacity Act—whether we are talking about deprivation of liberty safeguards or liberty protection safeguards—and the Mental Health Act, use as their central criterion the same Mental Health Act definition of mental disorder and use risk-related thresholds.

We know from empirical research and from cases that end up in court, including the Bournewood case, that there are real, deeply embedded cultural views that certain populations should not really be subject to the Mental Health Act. We can definitely date those views back to the 1950s; there were people holding them at the end of the 19th century. It turns on these different stereotypes of the Mental Health Act being designed for patients with more classical psychiatric disorders, who are also objecting or resistant in some way, and mental health law is a compulsory power to overcome that resistance.

At the time when that legal framework was created, people with learning disabilities and people with dementia were simultaneously constructed as more tractable. They were literally described in the policy work at that time as childlike and as non-volitional, so people without a real view. If they were manifesting behaviours that we might now read as resistance or objection, it was seen as not purposeful enough to meet those thresholds of objection.

That meant that people who were subject to the Mental Health Act had, over the decades, intensifying rights and safeguards: additional scrutiny of their treatment, as well as the admission; automatic referrals to tribunals; free aftercare; checks on their treatment; and stronger rights for nearest relatives. People who were funnelled out of that system into this overflow had, for a very long time, no real safeguards at all. That is what Bournewood is about.

They now have these quite minimal safeguards under the deprivation of liberty safeguards, which are much weaker. The justification is that they are not really objecting. If you look at what happened to HL, we can ask a lot of questions about whether that was the case for him.

There will be people caught in that basin whose care and treatment might have warranted more scrutiny than it would get under mental capacity law, and stronger levers to pull to get them out or get their treatment reviewed. That is the nature of the problem, really, that we are talking about.

> **Baroness Barker:** The independent review recommended, "The law should be amended so that only the MCA framework … can be used where a person lacks capacity to consent to their admission or treatment for mental disorder and it is clear they are not objecting". I take it from what you just said that that last bit about not objecting is, you think, not valid.

Dr Lucy Series: It is problematic. At the moment, if you are objecting and you could be detained under the Mental Health Act, you cannot go into that overflow; the only container for you is the smaller Mental Health Act container, but if you are seen as potentially suitable for mental health or mental capacity law, and you are viewed as not objecting, clinicians have discretion. That discretion is messy and complicated; it has resulted in litigation. We know from work by the Law Commission and others that it results in arguments and uncertainty on the ground, so there is a problem.

The proposal that we simplify that by just saying, "If they are objecting, Mental Health Act; if they're not objecting, Mental Capacity Act" is problematic in lots of ways. Most explicitly, objections are very hard to identify and to define, and I think we will just see a different frontier for argument: "Is this person just distressed or very unwell, or are they objecting? What do we do about people who are very institutionalised, very scared or perhaps sedated?" The objections are a very difficult boundary line to draw.

In order to divert people out of the Mental Health Act into this Mental Capacity Act basin, you had to change the fundamental structure of the Mental Capacity Act. That is because there were people who would have been detained more because they present a risk to others than to themselves. The Mental Capacity Act was not set up to do that. It was always meant to be about the best interests of the individual. It was seen as being very progressive and aspirational in that regard.

In order to divert people into the Mental Capacity Act, you had to introduce this new criterion of risk to others, which, fortunately, was rejected as the Mental Capacity Act went through Parliament, but if you tried to do it again, and you wanted this risk to others framework within the Mental Capacity Act, you would have all kinds of internal ideological conflicts. "Is this public protection legislation or is this about substitute decision-making for the person? What happens when best interests and public protection collide with each other?"

There is also a real danger of unintended consequences. If you create a very light-touch framework for community and hospital detention on the basis of risk to others, we do not know who else that might be used for. There needed to be a lot more thought put into that as well.

Professor George Szmukler: Culturally, there are deeply embedded beliefs about mental disorder and other kinds of mental disturbances. More importantly, there are prejudicial stereotypes about people with a mental disorder and mental illness. First, they are incapable of making a sound decision—it is just automatically the case if you have this mental disorder, so what is the point of going into capacity assessment and decision-making? There is nothing that this insane person can say that would indicate that they are able to make sound judgment. Secondly, they are intrinsically dangerous. That is why one always has the two elements of risk—to self and to others. The evidence is very strongly against both of those, and they are stereotypes that are prejudicial.

Q100 **Baroness Hollins:** We have heard serious concerns about the proposal in the draft Bill to remove autism and learning difficulties as conditions that can justify long-term detention. Assuming that fusion is not an imminent possibility, what should the draft Bill do to reduce the long-term detention of people with learning disability and people with autism, bearing in mind that they tend to have rather a longer period of detention under the Mental Health Act? Perhaps this is also one for you, Dr Series, but all of our witnesses are welcome to come in.

Dr Lucy Series: I am really grateful to have the opportunity to discuss this question, because there is an enormous problem, as probably few know as well as you, Baroness Hollins, around the long-term detention of people with learning disabilities and autism in inappropriate hospital settings. We know that they stay there for far longer than other cohorts of patients; they are more restricted; they are often inappropriately treated. All of that tells us that the Mental Health Act is not working for them. We know that the Mental Health Act is not working for them, because their detention is not being prevented by its application processes and they are not being discharged, certainly in sufficient numbers, by tribunals.

It is really understandable that people thought, “Well, if we take learning disability and autism out of the Mental Health Act, that will then get them out of hospital”. The problem is that, because we have this overflow container of the Mental Capacity Act, the legal interface rules mean that, if you take people out of scope of the Mental Health Act, they come within scope of the Mental Capacity Act.

That also does away with the objections rule. If you are not within scope of the Mental Health Act, you can be detained under the deprivation of liberty safeguards or the liberty protection safeguards, even if you are objecting, so those patients could still be detained under mental capacity law instead, where the safeguards and the independent scrutiny would be even weaker than under the Mental Health Act. One concern is that we will just shift this problem into a different legislative forum, which may be even worse designed to address it.

One option, then, is just to restrict the use of the Mental Capacity Act as well, in psychiatric settings. You would have to go back and re-amend the Mental Capacity Act, so perhaps you could insert a 28-day limit on its use in psychiatric detention. That is an interesting proposal.

I would come back to the question, though, of somebody in a crisis situation. Perhaps they have only just arrived in hospital, or they have been in hospital for years or decades, and efforts to find them somewhere in the community have not yet been successful. Saying that you cannot detain them under the deprivation of liberty safeguards will not create a route for them out of hospital. You may end up seeing people being detained illegally, and we know that that is happening all over the place, following Cheshire West, or you might see hospitals having to go to court for emergency authorisations, perhaps, under the inherent jurisdiction.

We know, for example, that the courts have been forced to authorise illegal placements for children in care settings, so they may be willing to do that in these scenarios. The core issue has to be this flow of water coming in, in the first place. Why are people ending up in hospital? We need to think carefully about how legislation can strengthen the mechanisms to secure people the care they need in the community—the right support from the right people at the right time—and to get them out again. There has not been enough joined-up thinking between the brilliant work that is been done around getting people out of these settings and how we can give that real legal teeth.

If we look to Scotland, which perhaps Jill could enlighten us more on, there is this idea that what we really need are very strong, legally backed, positive economic and social rights to the right support, and mechanisms to insert layers of accountability, where there is not enough at the moment, around care and treatment reviews and discharge planning. I know that this is anathema to a lot of lawyers, but we could give the courts really strong rights to say, "Well, we know what this person needs to get them out of hospital, and now you have to do it". That might be far more potent than changing the legal coating we dress up their detention in.

Baroness Hollins: You said that the courts should be able to direct. The independent review recommended that tribunals be given specific power to direct, not just to recommend, community provision when people are stuck in hospital.

Dr Lucy Series: Yes, that would be a good start. You would need to look at what happens to people who are at risk of admission as well. You should not have to go into hospital to get the right care put in place in order to stop you going into hospital. You are right; we need those kinds of positive rights. Whether that particular right was well framed in terms of the specific needs of people with learning disabilities and autism might need thinking about. For example, it would depend on whether the composition of the tribunal panel is right for them and how that links up with work being done in care and treatment reviews. That kind of thing would be a step in the right direction.

Baroness Hollins: Professor Stavert, from the Rome review on learning disability and autism, have you been able to solve this problem or come up with the answers?

Professor Jill Stavert: We put forward a proposal. It was more in the Scott review that followed that, which absorbed the Rome review recommendations and then took them further. As a note of warning, we have not had the official Scottish Government response to our recommendations or the report generally, but it has been widely well received so far among stakeholders.

The Rome review, which preceded the Scott review, recommended that there be different legislation for persons living with learning disability and autism, but that they still fall within the Mental Health Act if they had had a diagnosis of mental illness.

The whole idea was one of support and what is missing. As Lucy said, it is more about what is really needed here and how we can make sure that that happens for these people. It does not necessarily mean that they should be detained in hospital, and they certainly should not be if they do not have a diagnosis of mental illness.

In the Scott review, we took that further. Rather than recommending a separate piece of legislation—although we have not completely written that out, and the Scottish Government have said they are intending to introduce one—we widened the definition of who is covered by the Act so that it is very much more in line with the UN Convention on the Rights of Persons with Disabilities, in that we should be seeking to overcome obstacles to the equal enjoyment of rights and, therefore, access to appropriate support and services that people with a diagnosis of mental or intellectual disability are often faced with.

The whole purpose of the law, mental health law in particular, is to move away from just authorising and regulating non-consensual psychiatric treatment, and getting to grips with what somebody wants. This would operate within a wider framework that we have referred to as a human rights enablement framework. Whether this would be located in the Mental Health Act—or our Adults with Incapacity (Scotland) Act, which is the equivalent of the Mental Capacity Act in England and Wales—I do not know. It might be in a wider piece of legislation, but referred to specifically in this other legislation.

It would require anyone who came into contact with a particular need for services to be entitled to an assessment of what they need generally and what rights they have, right across the range, including economic, social and cultural, and a plan to be put in place for that, whether it is a discrete need or a wide range of needs.

As Lucy also said, there would need to be attributive duties and monitoring, and these rights would have to be enforceable through our courts and tribunals, although we are recommending that, ultimately, the jurisdiction for the mental health and capacity law be assumed by the mental health tribunal.

Q101 **Dr Dan Poulter:** I wanted to pick up one point with Dr Series. We know that the Bill is changing the threshold for the grounds for detention in order to ensure that people can be detained only if they pose a risk of serious harm either to themselves or to others. The draft Bill does not define what it means by “serious harm”, which is, in itself, slightly problematic. That could mean that some people who would be detained at the moment under the Mental Health Act—for example, people with chronic psychotic illnesses—find that the only way they can be dealt with in a compassionate manner that addresses their care needs and health needs is under the Mental Capacity Act. Could putting in that quite poorly defined raised threshold push some people who have mental illness to be treated and dealt with under the mental capacity legislation, where there are fewer safeguards of their liberties?

Dr Lucy Series: In a strict “law on the books” sense, that is correct. If a person is not within scope of the Mental Health Act, which means that you could not make a successful application to detain them under that Act, they are potentially detainable under the Mental

Capacity Act's framework, so the DoLS or the LPS, provided they meet those criteria. They would also have to lack capacity and to meet its best interests and risk-related criteria, and they would, indeed, have weaker safeguards. That is why I say it is important to realise that, when we shrink this container of mental health law, we potentially just divert people into mental capacity law instead.

The terms of reference of the independent review were to reduce detentions under the Mental Health Act, which is not quite the same thing as reducing rates of mental health detention. We need to be quite thoughtful about whether we want this Bill to reduce rates of mental health detention across the board or just reduce rates of detention under one specific piece of legislation, because they are quite different things. There is a danger here that some people just end up detained with weaker safeguards under different legislation instead. That will affect lots of different groups in lots of different ways.

> **Dr Dan Poulter:** The practical issue I was trying to address is that of someone with a chronic psychotic illness who becomes unwell, perhaps because they forget to take their medication. Then their life begins to fall apart and disintegrate, perhaps because they cannot pay their bills, or they are unable to work because they are quite thought-disordered, but they may not pose immediate serious harm, if that makes sense.
> Although we do not know what "serious harm" means under this Bill, because it has not been defined, it might push us down the route of using capacity legislation, whereas, in the past, we would have potentially been able to say that it is in the best interests of this patient and their health to bring them briefly into hospital in order to re-establish treatment, which then puts their life back together.
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> It is what I would call the downtown LA scenario, where we see a lot of people wandering around who are very unwell, with untreated mental illness. Is there a risk of our going down that route or, indeed, ending up having to use the Mental Capacity Act if we want to intervene and help those people?

Dr Lucy Series: It is quite hard to predict how a change in the law on the books will play out culturally in terms of how people choose to interpret and apply the Act in clinical decision-making. It is definitely possible that you get a group of clinicians who say, "We have raised this threshold and, therefore, we're no longer detaining people like that", so they would perhaps not be detained at all. You might get other clinicians who are aware that they could, therefore, use the Mental Capacity Act instead and who would be prepared to do that. It would take some close monitoring and probably quite detailed qualitative research to find out how that plays out on the ground, if that change goes through.

Professor Gavin Davidson: Probably the main barrier to reducing long-term detention is the availability of sufficiently well-supported community alternatives. We would have a concern that this proposed change might just add further complexity to the legal framework or frameworks.

We would query whether the safeguards under the mental capacity framework are necessarily not as robust as under a mental health law framework. They can be just as robust and, in fact, a focus on supporting people to make their own decisions in a very inclusive process and determining what might be in their best interest, with special regard for their own wishes, feelings, beliefs and values, may be an even better way to safeguard, promote and protect their rights.

> **Baroness Berridge:** Just following on from Dr Series' comments, you probably saw that we had evidence from civil society organisations around learning disabilities and autism. We can all understand why they have reached the position that they have, in that they wanted that cohort, even outside of MCA. In the light of what you have said about trying to give rights at the end and the beginning of the process, and I know you are looking at it from an academic perspective, if we think about what has happened with EHCPs—education, health and care plans—how do we on the ground ensure that giving those rights changes things?
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> Autism has its own Act of Parliament, but, if you speak to the parents, advocating to get even education and healthcare for their children becomes a full-time job. Have you any insight for us on this cohort? We may put on the statute book, "You have a right to x at the beginning and y at the end", but, without getting enmeshed in needing lawyers and tribunals, can you think of any other way we can make those rights easily realisable with that comparator?

Dr Lucy Series: That is a really interesting comparison to bring up, because, of course, we know that parents of young people with learning disabilities and autism often have to fight tooth and nail to get the legal rights that are written on the statute book. That might well continue to be the case if we introduce positive rights to suitable community support for people. You would at least be giving them a weapon to fight with which is effective for the task.

We sometimes overestimate what you can achieve through law, which is not to say that law is not really important. For a law to work, you need an army of people on the ground who know how to use it to leverage change after change after change in people's everyday lives, and who speak up in meetings, reviews and assessments. You need advocates, families and lawyers, and you need open-minded judges. It is about creating the right legal framework that gives those people on the ground the tools they need.

Professor Davidson is right. Mental capacity law contains some really valuable conceptual tools to raise those questions about what this person wants and what the less restrictive alternative is. What it is very weak on in England—and I am sure he will tell us that things are different in Northern Ireland—is the levers you can pull to get your voice heard. It is about giving people in an already very difficult situation better tools, but it will not magically fix it overnight.

Professor George Szmukler: This is not my area of expertise, although it has been the subject of a lot of discussion in the human rights committee, but I would like to make one point. Most mental health professionals do not recognise the incredible degree of expertise required to support autistic people in the community. A most enlightening book that I have recently come across is *Social Work with Autistic People* by Yo Dunn. She goes into detail about the Mental Capacity Act assessment of capacity and the nature of support for autistic people with degrees of learning disability, and they are really very specialised.

> **The Chair:** Is that also to do with the broad spectrum that you are talking about?

Professor George Szmukler: Yes.

Baroness McIntosh of Hudnall: I am really trying to hang on in here and hear all the nuances of what is being said. I do not know who should answer this. Perhaps it comes back to you again, Dr Series. Forgive me if it does. I am thinking about the possibility that the reforms we are being asked to consider pass into law quite soon. Of course, there will be an implementation plan to go with it, and perhaps we are talking about several years before it gets enacted in full.

None the less, we are hearing from you that the complex range of resource necessary to mitigate the risks inherent in, for example, moving people away from the Mental Health Act and towards the Mental Capacity Act, or whichever of the shifts we are looking at, is very difficult to put in place and is, significantly, not in place at the moment.

Looking at this in real time, what risks are we likely to be putting autistic and learning-disabled people at, if, for example, the recommendation is to take them out of the scope of the Mental Health Act? It is not about whether they would be better off under the Mental Capacity Act, but what risks will they be at if, for example, they cannot be detained under the Mental Health Act and there are no, or not enough, facilities?

Dr Poulter raised the spectre of downtown Los Angeles. You do not really have to go that far. You can look around you in this town and see people who, quite clearly, are in tremendous need of help and support and who probably have serious mental health or other problems. They do not appear to be being helped. In enacting this, would we be exposing many more people to an unregulated risk that they will simply not be treated at all? Have I silenced everybody? I am sorry if I have.

Professor George Szmukler: There is another important risk that has not been mentioned, which is that the person goes down the forensic pathway. The limited number of crises that I have had clinical involvement with have often involved explosive situations and some degree of violence. The discrepancy between mental disorder and psychiatric disorder disappears in the forensic realm. I do not know whether Lucy agrees, but I can see quite a few people going down that forensic route and ending up on long-term hospital orders or even going to prison.

Dr Lucy Series: It is very difficult to predict what happens, because there are many things that could happen. If you take populations who are currently potentially detainable under mental health law and you change criteria or thresholds so that they no longer are, the outcome that I am best equipped to speak to you about is detention under the Mental Capacity Act, but there are other possible outcomes that your other experts have spoken to you about.

One is that they end up down a forensic route. The other is that the Mental Health Act is used, but relying on a co-morbidity of some kind. Another is that they do not get treatment in a moment of crisis. Alexis Quinn spoke with some concern and very movingly about that.

Many people with learning disabilities and autism, and probably some other patients too, are already at risk in hospital. These hospital settings, particularly long-term settings where people with learning disabilities and autism are being held, are inherently dangerous places. There are no easy choices. The focus has to be on how we get them out safely, not just how we play with the legislation to come up with an easy solution to a wicked problem.

> **Baroness Hollins:** Can I just follow up on that point, Dr Series? You have written about how the safeguards under the Mental Capacity Act, but also under the Mental Health Act, are currently not good enough for people with learning disabilities and autism. Medication reviews do not seem to work, the tribunals do not seem to work, and the risk is that there are even fewer safeguards under the Mental Capacity Act. If we do not include this particular recommendation in the Bill, and learning disability and autism remain part of the Mental Health Act, what needs to happen so that people are not at risk in longer-term detention, as they are at the moment?

Dr Lucy Series: That is such an important question, but not one that I feel equipped to answer. If I were given that question as my job, I would want to set up a whole fresh review that had a huge level of input from people with lived experience of learning disability and autism, and people who work closely with them and care about them, to look at why these specific safeguards that are supposed to prevent inappropriate antipsychotic medication, restraint, seclusion or prolonged unnecessary detention, for example, are not working.

Is it that we have the wrong people looking at these problems in individual cases? Do we need to look at the expertise they are drawing from? Are the options available within those settings not appropriate? Is it a more fundamental problem—and I suspect it is—with the landscape of community care and waiting for the market to deliver solutions that the market does not particularly want to deliver, instead of looking at how we can build those solutions ourselves? It is such a difficult problem, which requires the expertise of the right people who know this problem deeply.

Professor Jill Stavert: I go back to the issue of how you change practices, procedures and frameworks without letting people and their families down in the process. We are talking about letting people down at times when they most need support. Just to offer a rather general framework, although the flesh has to be put on the bones, you need a staged but not regressive process.

It has to happen in stages, but the stages have to be clearly defined. It has to be underpinned by core, minimum obligations that are meaningful to people and their families. Nothing can happen that falls below those obligations in terms of what is valuable to the individuals concerned and what is necessary to achieve the highest attainable standard of physical and mental health and to live independently, when that is possible, and safely. I just wanted to offer that as a possible solution in broad terms.

> **Dr Dan Poulter:** Dr Series, you mentioned, quite rightly, making sure that people with learning disability or autism are cared for in the right environment. You said that in-patient wards were sometimes not necessarily the most therapeutic or safest environment to care for people in that respect. One challenge is the lack of capacity and community resource to care in the way that we would like for people with learning disability or autism. Is there a role, in strengthening the legislation, for allowing tribunals to mandate treatment plans?

Dr Lucy Series: Yes. As a minimum starting point, I would like to see the proposal from the independent review, that tribunals have that power. I suspect that it still would not go far enough in preventing crisis admissions and making sure that care remains appropriate in the community. The Rome review has some interesting and much wider-ranging recommendations, but, in terms of this Bill now and a starting point, that would be important.

Q102 **Baroness Berridge:** This is probably a question for those from the other nations. It has two parts. First, do you have any insight, from the work you have done, into the double effect of learning disabilities and autism for those from an ethnic minority background, and their experience? Secondly, when we think about this cohort, we keep talking about those with learning disabilities and autism. Not only is that a huge range of presentations, but we know that some of that cohort will have enormous support networks around them who have to work, as I have said, full time to get these.

Do we have, or do we need, a marker within this cohort for those who are particularly vulnerable? For instance, children who have been in care have x priority and y priority, but the EHCP has not served those in this huge group particularly well. Whether that is due to socioeconomic deprivation or otherwise, they have been even further down. Is there a route here to say, “Well, if you have been detained before you’re 18, you carry a priority for certain things through the system”? Do you have any information from the other nations or any input on whether we could have a system that somehow prioritises within this massive group?

Professor Gavin Davidson: The first issue is about the data available to you, so I wholeheartedly agree that we should have a much better understanding of the complexities that intersect the range of experience and needs that a person may have. There seem to be particular challenges in putting in place the combination of services for people with behaviours that challenge, and that is often one of the main reasons why people are inappropriately detained for long periods.

I have some hesitation about our ability to identify exactly who should be prioritised based on various categories. I am more comfortable with the idea that we try to look at the complexity of people’s needs and prioritise those with the most need.

The Chair: Can we move on now to the issue of fusion? I am a little concerned about time, as we have several questions that we want to cover.

Q103 **Baroness Berridge:** Professor Szmukler, this is probably going back to the beginning. What is the fusion law approach? Are there elements of it that we should incorporate within this Bill?

Professor George Szmukler: The aim of the fusion law is to eliminate the discrimination inherent in mental health law against people with a mental disorder—certain civil rights, liberty and security of the person, but also the gross lack of respect for autonomy for people with a mental disorder, which is just not on an equal basis with all other people who use health and care services. Entirely different rules apply to non-consensual or involuntary treatment.

In the Mental Health Act, it is a combination of a diagnosis of mental disorder, usually not defined in any specific way; risk of severe harm or to the health and safety of the person; and the need to protect others. It is diagnosis and risk.

For everybody else, in order for non-consensual treatment to proceed, it must be that the person does not have the capacity to make a decision for themselves, as in the Mental Capacity Act, and that the intervention is in their best interests. Best interests is very different from clinicians caring for people with mental disorder saying, "Well, in our view, what this person needs is treatment for"—whatever.

Best interests really requires one to look at it from the patient's point of view. One must look at, first, involving the patient as much as is practicable in the consideration of what should be done. This is assuming that the person does not have capacity now. One also needs to look at the person's past and present wishes, feelings, beliefs and values. One must consult with people who know that person and with any other person who might be important here, such as an independent advocate. This is a profoundly different approach, which really centres on the person, as far as possible preserving their autonomy and their fundamental beliefs and values. That plays very little role in mental healthcare.

What can we think of with this legislation? There are forensic aspects that are also discriminatory, but I am not going to go into those. There are three areas that point in the right direction. They are not spelled out perhaps in as much rigour or detail in the Bill as they might be.

First, in Clause 9, "Making treatment decisions", new Section 56A is very important. I was really very pleased to see that. It follows, essentially, the guidelines for the best interests assessment in the Mental Capacity Act—those things I have mentioned about involving a person as far as possible and trying to determine what this person's beliefs, values, wishes and feelings, past and present, are. It says that "the approved clinician in charge of the treatment must" do these things, so it is tremendously important, and we will need to see how that plays out in reality.

The second area is capacity now appearing in relationship to treatment. There is, for the first time, a role for asking what the decision-making capacity and ability is of a person who is detained. One aspect of this that I really am puzzled by is treatment without consent requiring a second opinion and compelling reason. This is somebody who has capacity, and there is provision here in the Bill for a compelling reason to override a capacitous refusal of treatment.

In a regime where everybody else does not have a mental disorder, one respects a person's capacitous refusal of treatment. Here, there is a statement or a provision that one can override. This is hugely important. If there is to be an override, it needs to be spelled out in some way. We have no idea what it is, because it seems to be saying that, if the responsible clinician and the SOAD agree that there is a compelling reason, and the SOAD has consulted two people, that is a compelling reason.

There is no indication here at all of what might be a compelling reason. Is it an immediate and real threat to life? I am puzzled by this, but have discussed it with a very eminent lawyer colleague, whose view is that it is extremely complex; it is going to be extremely difficult to find agreement within society for what is a compelling reason; so we will leave it as it is and then maybe the code of practice might go into it more. Because of this profound level of disagreement, some people will say that a capacitous refusal means a capacitous refusal, and others will say that maybe there are situations where a capacitous refusal could be overridden.

If we are to avoid discrimination here, one might say that perhaps a capacitous refusal for people with a physical disorder ought to be considered. It is in Israel—the only place I know where it is possible to override a capacitous or perhaps near full capacitous refusal of treatment, if there is a risk to life, essentially. It really depends on the values in a particular society. In Israel, perhaps the right to life for religious reasons is seen as more important, in a hierarchy of values, than autonomy and the right to make any particular choice. That is not the case here.

It comes back to that stereotype about people with mental disorder—that, even if they appear to have capacity, there is something fundamentally difficult about their capacity to make sound judgments, and that they are intrinsically dangerous. It is a very difficult problem, but we need to have some clear indication of what might be a compelling reason.

The Chair: There is a possibility that that would be dealt with under the code of practice, because it would be by example, where it would be easier to give clarity than in primary legislation.

Professor George Szmukler: I understand that, but it is odd to have a statute that talks about a compelling reason but makes no attempt whatever to give even a hint of what that might be, other than two people agreeing on it.

Baroness Berridge: Can I just bring you back, though, to your first question? You may have seen in the evidence that we had a discussion with Sir Mark Hedley about the comparison between physical treatment and overriding that. Under the Mental Health Act, as far as I understand it, a belief in preventing people from taking their own life is a very fundamental public good that we have.

If you were to make the comparison that is usually quoted with the Jehovah's Witness who refused a blood transfusion, they will then have died from something that is not the refusal of treatment. It is some physical thing that will then have killed them. If people refuse chemotherapy, the cancer takes its course. In the mental illness situation, that is not necessarily the same progress, from the little that I now understand, of that treatment. It can often be the risk of somebody taking their own life rather than a mental health condition causing their body to die. Is that also what is underpinning the difference that we have here in the ability of a person with capacity to refuse treatment?

Professor George Szmukler: I do not think so. It is that stereotype; it is more fundamental.

The Chair: With regard to the issue of fusion, as you have described it, would it be better if the four principles set out by Professor Wessely's inquiry were in the Bill? You talk about choice and autonomy, least restriction, therapeutic benefit, and people as individuals, which you have described. Would you say that we should include them in the Bill?

Professor George Szmukler: The only problem there is that we are talking about amendments to the 1983 Act. Normally one starts from the principles and then works out the content. This is the reverse. It is important, because there will always be taxing cases where one really reverts to the principles. If they are not there in the Act, that is a problem.

Could I just mention the third area in the Bill? It is reaching out over the divide. I have mentioned new Section 56A, which talks about capacity in making treatment decisions. The other is advance decisions, which is perhaps the major innovation in the Bill. That is moving us towards a stronger recognition of the autonomy of the person.

I am very puzzled about why this is not in the headlines and why it is not an opt-out, for example. It would be very reasonable, given that there is so much evidence on this. The number of compulsory readmissions is reduced by 25% in a pretty large meta-analysis. It has an effect. If we want to reduce detentions, here is something the research is pointing to.

It should be on a statutory basis. Every person detained while on recovery should be offered it. It needs a facilitator or support. There is very good evidence from the United States, where psychiatric advance directives are on the statute books in many states, that without a facilitator the take-up rate of psychiatric advance directives was 3% and with a facilitator it was 60%.

Developing an advance choice document or an advance statement is a complex process. There is a lot that goes into it. It needs somebody to go through it and support the patient in making it. There are many things that could be included, including preferences that are absolutely idiosyncratic for that individual, as well as preferences about treatments, refusals and so on. I am very disappointed that it is not highlighted there.

The Chair: It is not there in lights.

Professor George Szmukler: If one has to look at the implementation assessment, advance choice documents are listed there, including some calculation of the savings that will be made by reducing the number of detentions. I do not know what is going on there. That seems very odd to me.

The Chair: We have heard that there has been a low take-up of advance choice documents in Scotland. I do not know whether that is due to a lack of facilitators.

Professor George Szmukler: You will have to ask Jill that. I suspect it probably is. It has made a huge difference. We did a very large study of joint crisis plans. That would not have worked at all without facilitators. We had facilitators, and we had very big take-up. This was a large randomised controlled trial that involved about 570 patients.

The Chair: That is very helpful.

Professor George Szmukler: There are some other things about taking a fusion approach or a capacity approach. For example, it is little known that there seem to be no differences across ethnic groups in the rate of determinations that somebody lacks decision-making capacity. If we are talking about reducing inequalities, that is a very important point.

Coming back to the best interests assessment, one must inquire about cultural differences. If we are talking about beliefs and values, there are cultural differences. One really has to look at them and try to understand them. That is another important plus for a capacity-based approach.

Looking across the divide, one of the questions was about what we can do to amend the Mental Health Bill to move it in the direction of fusion, which is going to be the direction of travel eventually. There are those three points I have mentioned, which are trying to bridge the gap to some degree. From the other side, there are the liberty protection safeguards. In fact, you can add some of the regulations that you find in civil commitment or the Mental Health Act. Who can order a detention and for how long? Where can the person be detained? What appeal mechanisms are there? What kinds of review mechanisms are there?

If you add that to the liberty protection safeguards, you are almost there. I should explain why we came up with the label “fusion law”. It fuses the best of both systems. The Mental Capacity Act-type system is very strong on autonomy; the civil commitment system is very strong on regulations around detention and the use of force. All that the current Mental Capacity Act has is something about restraint. The DoLS were then introduced, and they are becoming the liberty protection safeguards.

They are moving perhaps in a direction that will facilitate fusion. The more the Mental Health Act and the Mental Capacity Act have common definitions and common conceptualisations, the more that will facilitate the eventual fusion. That is the approach that Jill, I think, would support in Scotland.

The Chair: I know others want to come in, but I am really conscious that we are only half way through our questions. Could we ask Professor Stavert, please, to comment to the lack of take-up of ACDs in Scotland? Then I fear we ought to move on to the next question.

Professor Jill Stavert: Yes, we are very aware of that. There are a number of reasons for it. One is that people do not want to revisit a distressing time in their lives. The other is the feeling that they do not work. Facilitation and support for making them is absolutely vital. The power of them has to be made clear to those who are entitled to make them. That is a problem we are facing and something we have to address in the review report.

The Chair: That is really helpful. Apologies to those who wanted to come in but we really must move on to the next question. Lord Bradley.

Q104 **Lord Bradley:** I want to ask about fusion law in practice in Northern Ireland. Professor Davidson, what lessons should have been learned from the development and implementation of the Mental Capacity Act 2016 in Northern Ireland? What lessons, therefore, are there for us on this draft Bill, as we consider changes or recommendations that we want to make around fusion?

Professor Gavin Davidson: To provide context for the developments here, they come from the conclusion of the Bamford review, the equivalent of this process in Northern Ireland. That concluded that having separate interfacing legal frameworks would be an anomalous, confusing and unjust. It suggested that we follow the recommendations of George and others to have a single comprehensive legislative framework, with people's ability to make decisions as the gateway criterion.

In terms of the process since then, that recommendation was in 2007. The law was passed in 2016, and partial implementation began in 2019. We have not fully implemented the Act. We are still not there yet on the full potential of the Act in terms of having one framework for all, which would, I hope, have the anticipated benefits of addressing stigma and discrimination, promoting access and equity and so on.

In terms of possible lessons, the process of development and implementation has been extremely open and inclusive, as I am sure your process is. The involvement of service users and carers in that process has been central. Our Department of Health and Department of Justice have really emphasised the importance of that.

As George talked about, there was also a focus on the legal framework that we wanted rather than just trying to revise what we had, which was a helpful starting point. We also benefited, I suppose unfortunately, from some of the difficulties created by the development of interfacing legal frameworks in Scotland initially and then in England and Wales. As a result, we really thought it would be much better to have one comprehensive framework that people would find less confusing and fairer. That required some additional safeguards in our Mental Capacity Act, as Lucy was talking about, compared to the 2005 Act in England and Wales, such as the role of trust panels in authorising interventions.

There were a couple of other lessons. We did not take the opportunity to address the difficulties with the language used, especially the phrase "mental capacity" itself, which is not a particularly helpful way to frame or talk about people's ability to make decisions. "Best interests" is a fantastic concept. If it is defined in the way where the person's wishes, feelings, beliefs and values are central, it is a wonderful phrase. The past association with paternalistic practice, clinical best interests and so on is also probably slightly problematic.

As a final lesson, you probably do not need to take quite as long as we have in developing and implementing a fusion approach. There is a certain frustration here. We need to get on with full implementation.

> **Lord Bradley:** We have heard this afternoon about lots of the difficulties and the consequences of the current situation with two pieces of legislation and the problems that arise from that. I know you have been listening intently to that. Has your fusion legislation overcome many of those difficulties? Where it has not, what is the underlying problem associated with fusion legislation?

Professor Gavin Davidson: Even the most brilliant legislative framework available does not address the difficulties with the funding of services and the availability of sufficiently trained staff to meet people's needs.

However, the general response to the approach is extremely positive. While it is not yet fully implemented, it is having a positive impact on practice, services and people's approach generally even beyond the specific focus of the Act itself.

> **Lord Bradley:** Are there resource concerns for alternative community provision, particularly for autistic or learning disability patients?

Professor Gavin Davidson: Yes. We have very similar concerns. There is currently a public inquiry addressing concerns in Northern Ireland about the care that has been provided specifically for people with learning disabilities and autistic people. That is an ongoing concern.

The Mental Capacity Act has the potential to address those issues of wider stigma and discrimination. I hope it will help better prioritise services to meet the needs of those people. But it does not address the wider resourcing issue.

Q105 **Baroness McIntosh of Hudnall:** Professor Stavert, this is inevitably directed to you. The Scottish Mental Health Law Review says, "Fused, or unified, mental health and capacity legislation should be the ultimate long-term goal in Scotland". I put my own emphasis on "long-term"; it is not underlined or bolded, as far as I know, in the document. I am picking it out because I want to get some sense of what you think "long-term" means or implies in the way that has been written. What steps have been or will be necessary in order to get there?

There is a final question that is related but slightly broader. When you look at the work that has been done in Scotland, what lessons would you point us towards not just about fusion but more generally about legislation on mental health or mental capacity? What should we be watching out for, given that we are a little bit behind you in thinking about it?

Professor Jill Stavert: Thanks for that question. There were a number of elements to it. First, what do we mean by "long-term"? How long is a piece of string? I would hope within a decade, but there are lots of steps to get there in the first place.

There are lots of alignment steps. In the review, we recommended that there be incremental alignment of mental health capacity and, where relevant, adult support and protection. The feedback we got from stakeholders was that they were not absolutely convinced that the Adult Support and Protection (Scotland) Act would easily fall within fused or unified legislation.

The reason that we could not do it immediately was that we could see it was going to require huge culture change and massive buy-in from all stakeholders concerned, right the way through. We saw that. That was a lesson we learned from Northern Ireland. We also want to be sure that what is ultimately offered is something better than what we have already, even as enhanced.

We had to consider things such as eligibility. Who is the law there for? We have come up with a general description of who the law should be responsible for going forward, right across the board, and a set of basic shared principles. We identified those, but they need to be fleshed out further in the legislation and the codes of practice. They are principles by which we should all live our lives, such as autonomy, dignity, non-discrimination, equality and inclusion.

These pieces of legislation are not fused yet, but they are working in alignment with each other. They would share these principles and the human rights enablement that I mentioned before of a supported decision-making regime. Where somebody is unable to make and express an autonomous or authentic decision, there is an autonomous decision-making assessment. I do not know whether I have time to talk about that, but that is something we have come up with as an alternative to a pure mental capacity test.

Measures should be put in place, both in practice and under the law, to enable different services to share information much more easily and to facilitate the move from one piece of legislation to the other. Importantly, we would recommend a shared judicial forum in the mental health tribunal, as I mentioned before.

We reckon that the shared definition of who the law applies to, the shared principles, and the human rights and autonomous decision-making framework could probably be achieved incrementally through legislation and operational changes in the next three to five years. We could have a look at it then and see whether it is working very well as it is or whether we take the final step to the preferred position of fused legislation.

> **Baroness Berridge:** Could you clarify the point about "best interests" in the MCA? I keep thinking about the best interest of children from the Children Act. That trumps everything. Is it the same when you fuse the law? What would you do if somebody with capacity cogently argues, "It is in my best interests to end my life, to commit suicide"?

Professor Gavin Davidson: It is an extremely important point. While "best interests" centres on the person's own wishes, feelings, beliefs and values, it is not absolute. A person may well express clearly the desire to end their own life, but their ability to make that decision may well be impaired by, for example, them experiencing severe depression, delusional ideas, and so on.

There is a huge positive potential for promoting autonomy and choice, individualised care and support, and so on, in prioritising people's wishes, feelings, beliefs and values, but those are not absolute. In some circumstances it may be necessary not to respect a person's clearly expressed desire, for example, to end their own life or to harm someone else.

> **Baroness Barker:** It is important to emphasise that the best interests decision is in relation to a specific decision. There is not a blanket assumption of best interests.
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> **Baroness McIntosh of Hudnall:** Can I come back to you, Professor Stavert, on the relationship between the work that has been done in Scotland and the recommendations you were just speaking about, particularly on this issue of autonomous decision-making? Looking at the proposals in the draft Bill we are scrutinising, do you see obvious ways in which some of what has been thought about, developed and recommended in Scotland could usefully be imported into the drafting of these amendments to the Mental Health Act?
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> I do not mean word for word, but do you have a view about whether more could be done, for example, to meet the principle of "least restrictive" that is not currently proposed to be in this Bill but is there in the Wessely review principles? Has Scotland thought about how to meet that principle and come to different and perhaps better conclusions than are exemplified in our Bill?

Professor Jill Stavert: This is an amending piece of legislation. What is important is that you have human rights principles that govern all decisions made under the legislation. In an ideal world, yes, human rights-based principles would be identified in the main legislation and you would look at the whole range of a person's rights. That is not just their civil rights related to authorising and regulating non-consensual psychiatric care and treatment; you would also be looking at the economic, social and cultural rights that underpin the person's wider needs. There would be a requirement to consider all of those rights and what the person's needs are so that you could be considering alternatives to coercion and detention. You would also be looking at a person's values and characteristics, dealing with the intersectionality side of things.

Something that struck me when I was looking through the draft Bill was the need for enforceable rights. You need attributable and enforceable duties to underpin these rights as well. I would therefore go back to this idea of core minimum obligations. That would be a good way forward to ensure the assessments that the legislation is promoting are meaningful.

Accompanying this—it is more something that is accompanying the legislation rather than the legislation itself—is data. What works in different situations? What do you have already? What do you need to get? Why do you need it? What is meaningful for people and families with lived experience of the legislation? How do they want their lives to be? How do they want their condition to be cared for, supported and treated?

Q106 **Dr Dan Poulter:** I just want to pick up on the issue about capacity in the context of being able to make a capacitous decision to harm yourself or end your own life. Increasingly in mental health law, certainly in England, we have moved towards medicalising personality disorder much more than was the case before. Personality is a continuum; what is a disorder is quite subjective. I just wondered how you would see legislation working in respect of the current amendments to the Bill and, if we were to move towards fusion, as in Northern Ireland, how this would work in that particular area.

Professor Gavin Davidson: We do not often focus on this because in societal terms it is a difficult debate. Under the current and traditional approach of mental health law, it is perfectly possible for a person to be clearly intent on ending their life, clearly meeting the risk criterion under mental health law but not the mental disorder criterion under mental health law. This situation already does arise. In practice, it is a very difficult question of professional judgment.

In Northern Ireland, personality disorder is specifically excluded from the grounds for detention. You cannot be detained by virtue only of issues associated with a diagnosis of personality disorder. There are complexities around that. It is relatively rare, arguably, for people to be experiencing personality disorder alone. There are all sorts of controversies around that concept itself.

Dr Dan Poulter: I suppose we do not necessarily know the details of why someone was detained under Section 2 of the Mental Health Act in this country. When the 2007 legislation came in and changes were made there, it pushed the law in England much more towards the detention of people with a personality disorder, even though there is no evidence that detention in hospital mitigates risk or is beneficial for their care.

> I am more getting at how we square that with a desire, if we are fusing the law, to uphold capacity. What you are suggesting is that in Northern Ireland the way of managing that and dealing with it was to say, “Personality disorder needs to be taken out of this”.

Professor Gavin Davidson: That is currently the case under our mental health law. It is not the intention for there to be specific exclusions under the Mental Capacity Act. If a person’s ability to make the relevant decision—to take their own life, for example—was sufficiently impaired and that impairment was associated with issues that had been diagnosed as personality disorder or some other form of mental health problem, they would come under the scope of the Mental Capacity Act and some form of compulsory intervention could be authorised.

Dr Lucy Series: I want to come in on a slightly different topic. It is not about when you can detain someone with a personality disorder. One of the unintended consequences of the rising profile of mental capacity law in England and Wales—I would be interested to know whether this has happened in Scotland and Northern Ireland too—is that mental capacity is sometimes used as a gatekeeper to people accessing services they are actively seeking.

This seems to be affecting particularly people who have been diagnosed with a personality disorder. It can also affect other people whom services might find quite difficult to engage with but who are very distressed. As we continue down the road slowly towards fusion law, it is important to make very clear that, just because capacity might become a criterion for involuntary treatment, it is not a gatekeeper to services that people are actively seeking. It will be really important to press home that point, because that is already happening here and we have not even set down fusion law yet.

Professor George Szmukler: The last point that Lucy raised is very important. I have asked colleagues in Germany and the Netherlands whether they have come across this, and they have not. It seems to be an English phenomenon. It is outrageous. It is an absolute abuse of the notion of capacity. A person with capacity knows what their best interests are. That is the point of it. If somebody says, “I need help; I recognise I do and I have capacity”, one cannot say, “You have capacity; therefore you do not need help”. It just does not make sense.

I have a point about the question of somebody who is refusing treatment and it is endangering their life. A real-life case is Kings College Hospital v C. You might have read this. This is the woman who wanted the life that sparkled. A life that did not sparkle was not, for her, acceptable. It is very instructive. It gets to the essence of it. In the end, the judge says, “Many people will feel that this is immoral or that this is certainly imprudent”.

This is a woman who had taken an overdose and was on kidney dialysis. She refused dialysis because she wanted a life that sparkled. Her whole life had been one of marrying lots of men. She had four marriages. She wanted to look good in a bikini so she refused a mastectomy when she had cancer of the breast. For her, the idea of looking ugly and living in a nursing home—although the prognosis for her renal failure was good with dialysis—was just unacceptable. Her daughters, and I think it might have been her father, agreed that this was her value system. This was who she was, and they accepted, as did the judge, that she could refuse dialysis, which meant certainly that she was going to die. I imagine she did die. That is a really good case to look at in thinking about the issue you are raising, the complexities around it and how it might be approached. There is a movement more and more towards respecting the decisions of people.

On the point about the least restrictive alternative, that is related in some way to best interests. There was a case in New South Wales that I read where the judge made that point. What the least restrictive option is depends on the person. There are some people who would rather have a number of involuntary admissions to hospital and not be on a community treatment order because they want to feel free during the intermissions between admissions. For other people, being on a community treatment order is something they value more than putting up with admissions to hospital.

There is a link between best interests and least restrictive alternative. One needs to look at least restrictive alternative not as being what I, as a clinician, think of as the least restrictive alternative. The person can determine, better than I can, what for them is the least restrictive alternative.

Baroness Berridge: Professor Davidson, what happens to Section 117 aftercare when you fuse the law? Here there is a very clear demarcation as to who is entitled to what.

Professor Gavin Davidson: We do not have a similar entitlement. For us there is equity, though perhaps not in a good way: no one is entitled to it.

Chair: We have touched on the issue of human rights, but let us take it a little further.

Q107 **Dr Rosena Allin-Khan:** Thanks everyone. I have listened with really great interest. What lessons can we learn from the Northern Ireland and Scottish approaches to mental health legislation in ensuring that the draft Bill in front of us respects the human rights of service users? I will open that up to whoever wants to answer that.

Professor Jill Stavert: If you are talking about the current legislation in Scotland, it is down to human rights-based principles that restrict unwarranted interventions and protect autonomy. The problem is that at the moment that is the focus of our legislation, and it does not consider the wider needs or the underpinning economic, social and cultural rights.

Our review in Scotland very much embraced the UN Convention on the Rights of Persons with Disabilities, the International Covenant on Economic, Social and Cultural Rights, and the UN Convention on the Rights of the Child, all of which the Scottish Government have committed to incorporating into devolved legislation and the devolved framework in Scotland going forward. We were tasked with considering, along with giving further effect to developed European convention rights, how these other rights, particularly those in the UN Convention on the Rights of Persons with Disabilities, could be given real and meaningful effect.

Going back to the purpose of the law, what is important is what it is actually seeking to achieve. What rights are we identifying as important rights to protect when we are considering people with a diagnosis of a mental or intellectual disability? How do we go beyond the current restrictive approach to this and make sure we have principles that underpin and support that?

We need to involve people with lived experience in not only the review of the law but the drafting of the legislation. We need to obtain their views and the views of their families as to what is important and what values they want to see reflected in the legislation. I cannot emphasise that enough.

When we monitor the legislation through data gathering, we have to ensure it is properly reflective of that and is meaningful. One of the problems we had in Scotland was that, as you probably know, when our mental health legislation was originally enacted it was regarded as world leading in terms of its human rights-based principles, but later we started to discover that it was not being realised in practice. What does it mean for people who are actually experiencing the law? What does it mean for their families who are supporting them as unpaid carers?

The other thing is bringing about a culture change right across services and with practitioners, and the training and guidance needed to do that. One of the particular challenges we have had and are continuing to have in Scotland is the completely new approach to equality, non-discrimination and the enjoyment of rights by persons with mental and intellectual disabilities.

The comparator there is not people in the same group but everybody else. Decisions have to be made on that basis when you are looking at restricting someone's rights and what they are entitled to in terms of services and support. That is quite a difficult hill to climb, but it is one that absolutely needs to be dealt with.

Those are the main principles in terms of enshrining the rights of persons with mental and intellectual disabilities in our legislation and its related practice.

Professor Gavin Davidson: In the period—I hope it will be relatively short—before you move to the fusion approach, I would just reinforce what Jill has said about the inclusion of principles in the Act. You have identified some of them. The addition of the support principle from the Mental Capacity Act approach, which focuses much more on prevention and the potential around positive rights, reciprocity and so on, would be brilliant to see.

To go back to something George mentioned in terms of the potential for, broadly speaking, advance care planning, an encouragement for that to be part of the process would also be great to see.

The Chair: This has been an incredibly helpful session. Thank you to all witnesses very much indeed for your contribution, which is enormously helpful to our deliberations. We are extremely grateful. Thank you very much.