Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Wednesday 9 November 2022

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Written evidence from witnesses:

- Charlotte Rainer, Coalition Lead, Children and Young People's Mental Health Coalition [MHB0056]
- Carolyne Willow, Director, Article 39 [MHB0071]

Watch the meeting

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

Questions 108-128

Witnesses

Panel 1: **Dr Margaret Flynn**, Chair, National Mental Capacity Forum; **Dr Quinton Deeley**, Consultant Neuropsychiatrist, National Autism Unit and Neuropsychiatry Brain Injury Clinic, South London and Maudsley NHS Trust; **Professor Mahesh Odiyoor**, Finance Officer, Faculty of Intellectual Disabilities, Royal College of Psychiatrists.

Panel 2: **Carolyne Willow**, Director, Article 39; **Charlotte Rainer**, Coalition Lead, Children and Young People's Mental Health Coalition; **Dr Susan Walker**, Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital.

Panel 1

Witnesses: **Dr Margaret Flynn**, Chair, National Mental Capacity Forum; **Dr Quinton Deeley**, Consultant Neuropsychiatrist, National Autism Unit and Neuropsychiatry Brain Injury Clinic, South London and Maudsley NHS Trust; **Professor Mahesh Odiyoor**, Finance Officer, Faculty of Intellectual Disabilities, Royal College of Psychiatrists.

Q108 **The Chair:** Good afternoon, everybody, and welcome. This is the eighth session of the Joint Committee scrutinising the draft Mental Health Bill. The first panel, which was rescheduled from 18 October 2022, will focus on learning disability and autism. The second panel for this afternoon will focus on children and young people under the Mental Health Act. Could I begin by welcoming the witnesses to the first panel? Thank you very much for coming here today. I would like to call upon each of you simply to say who you are, whom you represent and your key role.

Dr Quinton Deeley: Hello. I am a consultant psychiatrist at the National Autism Unit at the South London and Maudsley NHS Trust. I also work in the neuropsychiatry and brain injury clinic at the trust. I am a senior lecturer in social behaviour and neurodevelopment at the Institute of Psychiatry, Psychology and Neuroscience.

Professor Mahesh Odiyoor: Hello. I am a consultant psychiatrist working at Cheshire and Wirral Partnership NHS Foundation Trust. I am here representing the royal college as the finance officer of the faculty of intellectual disabilities. I also chair the national assessment treatment network of the royal college intellectual disability faculty.

Dr Margaret Flynn: Good afternoon. I am currently the chair of the National Mental Capacity Forum. I have a long-standing interest in the lives and circumstances of people with learning disabilities and autism. I undertake reviews when things have gone really badly wrong in their lives. I also have a brother with a learning disability.

The Chair: Thank you to those of you who submitted written evidence in advance, which is extraordinarily helpful. I will ask the first question. In brief, as we will go into more detail with further questions, what are your views on the draft Bill's proposal to remove learning disabilities and autism as a condition for which people can be detained under Part 2 Section 3 of the Mental Health Act? Before we ask you to respond, if you do not agree that it is right to remove people with learning disabilities or autism from the MHA, what could be done instead to prevent these patients from being placed in inappropriate long-term detention? I have a further question, which I will come to in a minute, about New Zealand.

Dr Quinton Deeley: My view is that autism and learning disabilities should not be removed. There is not always a co-existing mental disorder present that can fully account for acutely disturbed behaviour that brings the patient to the attention of healthcare services. It may be the underlying autistic disorder or learning disability itself that is associated with behaviour that is associated with significant distress or poses a risk to self or others. It is for that reason that, in a small number of people, retention of the ability to detain people under Section 3 is justified and, indeed, in their best interests.

The Chair: We are looking for solutions now. Would you have a solution to how we avoid long-term detention where inappropriate if they were to remain in the MHA?

Dr Quinton Deeley: Long-term detention is a consequence not of the existing Mental Health Act framework, but of shortcomings in the existing provision of care. Those shortcomings stem from two main sources. One is chronic underresourcing of the system, and I can expand on that a bit. The other is variation in what I might call models of care and therapeutic aspiration.

At present, there is considerable variation across the UK in the models of care and aspiration that mental health teams and commissioning services have for people with autism and learning disability. In some cases, services are not merely underresourced; there is also a lack of aspiration, confidence and proactivity in ensuring good outcomes for people with learning disability and autism. That can contribute to the so-called warehousing effect, whereby people are put into long-term, relatively low-cost hospital settings without a corresponding effort to discharge them at the earliest opportunity into suitable, appropriately supported community settings.

By contrast, there are other services where teams are much better trained and better engaged and, from the very point of admission to hospital, proactively seeking to discharge the patient into the appropriate setting and to reduce the likelihood of readmission in future. That is very much a consequence of good mental health care and good social care support. This is the current situation in the UK under the same body of Mental Health Act legislation in England, with corresponding differences in Wales, Scotland and Northern Ireland.

The Chair: Do you know about the situation in New Zealand, where perhaps lessons could be learned?

Dr Quinton Deeley: I heard the evidence given on that at my previous committee hearing, but I do not know the evidence in detail over and above what was fed back to the committee in that hearing.

Q109 **Sir Charles Walker:** Just so we can add some context to this report when it is written and it is not wholly dry, what does being discharged into a suitable setting look like in your world?

Dr Quinton Deeley: The outcomes are quite variable. The needs of people with autism and learning disability who are currently detained in hospital vary considerably. Some people may be discharged into a community setting, which at one extreme might be a council flat with ongoing contact with the community mental health team, or, in some cases, depending on the presence or absence of learning disability, the community mental health and learning disability team.

You can think of gradations of need and gradations of level of support, up to and including very well-resourced 24-hour care, either on an individual basis, with a bespoke package, or often, these days, a person going into small group home with a specialist service provider. There is also still a place, in some cases, for what would be thought of as residential care, which is somewhat different from the highly supported bespoke package, and has, say, four to six service users—a larger number of users.

Sir Charles Walker: You would say significantly more therapeutic, happier environments, which better serve the interests of—I do not want to call them patients— the individual.

Dr Quinton Deeley: Yes, that is right. This is person-centred care, with a therapeutic and rehabilitative emphasis and/or a very strong emphasis on quality of life and social inclusion. That is what good care looks like.

Q110 **Dr Dan Poulter:** For this question and for the duration of this session of the witnesses, I draw the committee's attention to my declaration of interests as a practising psychiatrist in a London NHS hospital trust, although I do not think Dr Deeley and I have ever had any direct interactions before.

Dr Deeley, we will come on to the criminal justice system point in a moment; I think Lord Bradley will ask questions on that. On New Zealand, did these changes, or similar ones, actually not push a number of people with autism and learning disability into the criminal justice system?

Dr Quinton Deeley: Yes, that is my understanding of the evidence given. That is an interesting observation. In the context of deliberations about the proposed changes at SLAM, one of the concerns expressed by a number of consultants and other healthcare professionals would be precisely that this would happen in the UK, should the ability to detain people under Section 3 be removed.

As an ancillary point, if the premise is that, within a 28-day detention under Section 2, it is expected that somebody's needs can be adequately assessed and discharged into an appropriately supportive package, the difficulty stems from the complexity of some patients and the very ingrained nature of the difficulties with which they present. That requires a longer time to assess those difficulties, set up appropriate interventions, risk assess them, with the passage of time, and do an appropriate needs assessment and discharge plan on that basis. In the absence of that, there will be a cohort of patients who are discharged either prematurely from hospital or into inappropriate community settings. By virtue of their behavioural problems, they will offend. By virtue of that, they will then come before the courts and get diverted into the criminal justice system.

Dr Margaret Flynn: I have a great deal of sympathy with the aspiration of families to remove their relatives with learning disabilities and autism from the purview of the mental health legislation. However, I share the concern, which I have no doubt you have heard before, that they will be detained in any event and in another form. These populations have been poorly served by the Mental Health Act, as other populations have, and I suspect that, in terms of solutions, we have to reduce the likelihood of such discrimination in the Act. The Act is there for all of us, but it has not served this population well. It could and should do so.

Most particularly, I understand the importance of giving people time in order to assess. I would also, from my somewhat jaundiced experience, be looking to hospitals and providing services to say, "Let's reverse the burden of proof. What have you done? What are you doing for this person?" Why should the onus be on a regulator, or indeed a family, to challenge what has been accomplished?

I am very encouraged by work undertaken by Ashok Roy in the Midlands, who was very clearly of the view that if treatment has been delivered, there is no case for detaining somebody. We know of the chronic challenges in community provision, but I know of very many people for whom detention equals there being nowhere for them to go. It is as though they have no address. For my money, we need to know where this person will be discharged to at the point of admission, regardless of the awful dynamics surrounding crises.

The Chair: That is very helpful. I see, Professor Odiyoor, you are nodding in agreement with a lot of what Margaret has said.

Professor Mahesh Odiyoor: Answering the questions in the order that you put them, I do not agree with removing reference to learning disability, seriously irresponsible conduct and people with autism from Part 2, Section 3 of the Act, for reasons that are very similar to the ones Dr Quinton Deeley mentioned.

I work in an in-patient setting. I work in an assessment and treatment setting for people with intellectual disabilities, and I have seen a changing group of people coming into the in-patient setting over the last few years. That has been through transforming care. There has been a lot of input to change services out in the community, with resources put in to provide what we call crisis support or intensive support services in different formats across the country, with variable success.

In our area, there has been a reduction in the number of people coming into hospital. However, the people who come into hospital now have significantly complex needs. When I say “complex”, I mean that they present with behaviours that challenge or with seriously irresponsible behaviour as it is defined in the Act. It is very difficult to define in a short time whether it is due to mental illness, because there is quite a mixture of complex physical health needs, mental health needs and a lot of trauma, which might be due to loss, environmental changes, loss of carers and so on. There may be some behavioural elements as well, so it is a complex picture. It takes a bit of time and patience to understand that in more detail.

It is a very multidisciplinary approach. It is not just a psychiatrist making a diagnosis of a mental illness. It involves psychologists, speech and language therapists, occupational therapists and very skilled nurses coming together and understanding the needs. Sometimes we can make those decisions within the 28 days of the Section 2 and sometimes it takes longer.

Taking away the protection of Section 3 of the Act would mean that we would end up not doing a great assessment for these people, because we are pushed for time and we have to give a diagnosis. There is a risk that we might give people labels where they may not be needed, or we might not complete our assessments in a thorough fashion, which might mean that these people are then discharged or sent out of the hospital without appropriate management plans. There is a significant risk of that happening here. That has been my personal clinical practice experience as well.

There is that tension in the legal framework. Does that legal framework lead to people staying in hospital for lengthy periods? I would argue against that. It is not the legal framework that makes people stay in hospital for lengthy periods. Here, I strongly agree with what Dr Deeley said. Most of the time there is a lack of provision in the community to discharge people, which leads to people staying in hospital for significant periods.

Currently, more than 70% of the people in my population group, the people in my in-patient unit, are in hospital as delayed discharges because they do not have a place to be discharged to, not because they need to be in hospital. That seems to be the significant problem. The solution lies in that as well. We need to invest in appropriate services for people in the community. As Dr Deeley said, it is person-centred care.

Quite a lot of people who come into hospital now, at least in my clinical practice, need bespoke services. They like individualised spaces. They do not like to be in groups of four, five or six people, or in the big warehouses, as it has been put—in big units. They require low-stimulus, quiet environments and quite a lot of structured activities. That means that there is a need for staffing to engage in those activities. They have specific communication needs, which mean that the staff who support and look after them need to have additional skills to communicate appropriately. By doing all that, you reduce the unhelpful or challenging behaviours. It is a combination of all those things.

Just changing the legal framework without investing in training, education and resources will not lead to a solution. It will end up causing more problems, rather than fewer. The solution is in investment in community resources, educating and training staff in those resources, and looking at ongoing support for people from hospital out into the community.

The Chair: That is very helpful.

Q111 **Baroness McIntosh of Hudnall:** Professor Odiyoor, you are a clinician, but you also clearly have a particular interest in service provision, and presumably, since you are called a finance officer, in how those services are funded. I wondered if you could give us a thumbnail assessment on the basis of your experience over time of the relative cost of providing the kinds of services that you are indicating would be necessary in order to bring down the rate of detention under the Mental Health Act, or detention in hospital, compared to the cost of those detentions. Ultimately, we keep coming back to this question of resource. What effect do you imagine investing in community services in the way that you describe would have over time?

Professor Mahesh Odiyoor: That is a very helpful and interesting question. I have two management hats. I am a strategic clinical director for learning disability, neurodevelopmental disorders and acquired brain injury services here in CWP, and I have the responsibility for managing the finances in my organisation. Being a finance officer of the college is more to do with the finances of the college than finances that involve the wider provision of care.

There are multiple levels to cost. There is the financial cost, but there is also cost to the person, which is the quality of life for the person but also for their near and dear ones. You need to weigh up both of those, rather than just pounds and pennies.

A hospital bed is not cheap; it is quite expensive. It is not just the bed; it is also the additional cost. A majority of the people I care for at the moment have one-to-one support at a minimum; at a maximum, it can be up to three-to-one support—trained nursing staff or support staff. This is not to cause harm to them. It is to improve quality of life and to support them to engage in activities out in the community in a safe manner, and so on. All that costs money.

If you need to replicate this out in the community, when somebody has been in hospital for lengthy periods, initially when you step them out of a hospital it might be quite an expensive package. However, as time goes by and the person has a happy and healthy life out in the community, those costs can be brought down. It is not just a reduction in support; it is because the person is not constantly bouncing in and out of hospital. They are not requiring quite a significant amount of physical healthcare.

It is not just mental health resources. People with complex needs might end up taking quite a lot of primary care resources. They might be attending A&E. They might end up taking medical support. The wider system cost needs to be taken into account as well.

I have some case examples. I do not want to spend too much time on this, but for a particular person we are caring for at the moment the initial cost of discharging seemed to be eye-wateringly high. We feel that, within the few months that we have had her in our setting, we have already changed her needs quite significantly to the point where the cost of the package could be brought down on discharge. That is an ongoing discussion that we are having.

In terms of evidence, we are looking at some of those things in the north-west region. We are looking in a bit more detail at the number of admissions over the last eight years to see whether we can give evidence-based answers to these questions, rather than just one that says, "In my experience, I've done this. In my experience, I've done that". I hope that, in next few months, we will be able to answer some of these questions in even more detail.

Q112 **Baroness Berridge:** This question is linked to the first question. We have heard various concerns that if we take learning disabilities and autism out of the Mental Health Act, we will just see them detained under the Mental Capacity Act. Does that happen at the moment? Could you outline for us some of the circumstances where that might happen? How do you think it would change if these reforms were brought in for people with learning disabilities in the system? Would it be better or worse than the status quo?

Dr Quinton Deeley: From the standpoint of the National Autism Unit and other in-patient settings I have worked in with people with learning disability and/or autism, the predominant legal framework for justifying detention in hospital has always been the Mental Health Act. The Mental Capacity Act, in my experience and in the settings I have worked in, has not been used as a primary legal mechanism to justify detention. It has a bearing for some individuals at the point of discharge, with the DoLS framework, from care homes or residential homes. The Mental Capacity Act is very relevant to in-patient care, but it is applied to other matters, not the primary fact of detention and treatment in hospital.

If the question is whether use of the Mental Capacity Act would increase should these changes be implemented, doctors and other healthcare professionals have a duty of care, so I suspect that if they were confronted with a patient who had a clear need to continue to receive assessment and treatment in an in-patient setting, and if, in reality, the primary indication for detention is autism or learning disability per se, there would be a tendency for co-existing symptoms or traits of other mental disorder to be elevated to the status of a diagnosis. That would then be used to justify continuing detention.

In certain situations, that could be extremely disadvantageous to the patient, because it might actually redirect the care pathway that they are assigned to. For example, were somebody with traits of a personality disorder to be assigned a diagnosis of personality disorder as an alternative diagnosis, that might increase the likelihood that they would be refused access to certain ASD or LD-relevant services in the future. They are more likely to be diverted into personality disorder services. In certain circumstances, that is appropriate for a small number of people on the autistic spectrum, but for the most part they are not appropriate. Similarly, there would be a tendency for that to happen for other mental illnesses: anxiety disorders, OCD, depression and so on. It is predictable that that will happen.

With respect to the use of the Mental Capacity Act, I think there would be a pressure to use a legal framework in the absence of the Mental Health Act. Therefore, if people were not to use the Mental Health Act by re-characterising the problems of the patients, there would be an increase in the use of the Mental Capacity Act, with all the disadvantages that that brings to the patient.

Baroness Berridge: Do you want to outline any of the disadvantages for us, as you see it, under the MCA?

Dr Quinton Deeley: As has been already discussed, it is the absence of Section 117 aftercare. It is the absence of the protections and safeguards of the Mental Health Act through the tribunal process through Part 4 of the Mental Health Act. It is the absence of the SOAD, through which a second opinion is effectively built into the administration of the Mental Health Act. All these things would be to the disadvantage of the patient.

Dr Margaret Flynn: I would add the concern that there are no nearest relative rights. There is not the same scrutiny of applications that currently prevails. The response to seclusion and restraint is much weaker. The oversight of that is very much weaker. There is no automatic right to complain and challenge. There is no transfer of the statutory care, education and treatment review that currently prevails. It is much weaker, and I believe that people would be disadvantaged.

Professor Mahesh Odiyoor: I agree with everything that has been said by both my fellow witnesses.

Q113 **Dr Ben Spencer:** I will declare an interest, which is that I am a member of the Royal College of Psychiatrists. If we press ahead with excluding learning disability and autistic spectrum disorders from the ability in the Mental Health Act to detain after 28 days, what modifications, if they were possible, do you think would be necessary to the MCA or the liberty protection safeguards in order to give the protections that you need?

I have started pulling a list together from Margaret and Dr Deeley have put down. We have the need for SOAD, nearest relatives, tribunals and automatic rights of appeal for detention, scrutiny of applications—I presume that is the actual application for detention—and added oversights for seclusion and restraints. Is that sufficient? Would you want more things to be added? Would you be happy with a liberty protection safeguard programme that had those extra powers? Is there something particular about using the LPS or the MCA that is unsatisfactory, in your view, as opposed to the Mental Health Act? If so, could you state what it is?

Dr Quinton Deeley: I suppose the way you have just set it out begs the question why you would want to get rid of the Mental Health Act in the first place. Essentially, you are reconstructing it but calling it the Mental Capacity Act. I suppose that would be my reply. It also begs the question what is so inherently unacceptable about the use of the Mental Health Act framework to detain somebody in hospital and treat them, as distinct from the use of the Mental Capacity Act.

It seems to me that the use of the Mental Health Act has acquired stigma, so "sectioning" is a stigmatising term. Were the Mental Capacity Act reconfigured to perform all the functions of the Mental Health Act, with the passage of time, if the provision of mental healthcare in this country remains as it is, the Mental Capacity Act will inevitably become equally stigmatised. That would motivate another attempt to create a new body of legislation that re-characterises it and calls it something else.

Fundamentally, we should be clear that the use of the Mental Health Act is, in many situations, of positive benefit to the people for whom it is used. It secures access to treatment that would otherwise be unavailable to them. Despite all the well-documented and undoubtedly well-founded concerns about the use of the Mental Health Act in the present context of provision of mental healthcare in the UK, it is undoubtedly true that many people have truly benefited from its judicious and appropriate use.

Consequently, it is very important for that point to be made and seriously considered. There is a sort of unspoken premise throughout the White Paper and the subsequent responses to it that there is something inherently problematic about the Mental Health Act. There is not. The Mental Health Act brings enormous benefits to people when it is used appropriately. The difficulty is when it is not used appropriately and when it is applied in a healthcare context that is underresourced and in which models of care lack aspiration.

Dr Margaret Flynn: There are legitimate challenges by families where the Mental Health Act has been used inappropriately. People have been detained even though they have no recognised mental illness. That fact is on record. I do believe that there is discrimination in the Act, and my concern would be to challenge that discrimination and to lower and remove the obstacles to people having fair and competent treatment. That does not currently prevail. So much hinges on the sort of business model that is behind some of the hospital assessment and treatment settings.

Professor Mahesh Odiyoor: I agree with the points that have been made. There are fundamental differences between where you use the Mental Capacity Act and the Mental Health Act. Particularly in the context of seriously irresponsible or challenging behaviours, we need to look at the risk to self versus the risk to others. Sometimes it is mixed. Sometimes the risk to self overrides the risk to other people because of vulnerability and so on.

The Mental Capacity Act cannot replace the Mental Health Act in all situations, because there are areas where the Mental Health Act is paramount and important to safeguarding rights, not just the rights of other people, but the rights of the person themselves. It is important for all the points that Margaret very eloquently made, because there are safeguards built into the Mental Health Act, so it is important that it is not misused. There are times when people might have issues and have experience and so on, but checks and balances are built in to try to reduce and to avoid misuse of the powers given by the Act.

If changing the Act is to reduce potential abuse or people staying in hospital for lengthy periods, I would say that the problem is not with the Act but with the lack of resources in place that are needed in order to support people with intellectual disabilities and autism, whether they are in hospital or in the community.

Q114 **Baroness Berridge:** I have a very quick question about the title of the Act. As far as I understand this, many of the people with learning disabilities and autism who are detained do not have a mental disorder. I am not a consultant psychiatrist, but, looking at the title of that Act, is that also part of the problem here? We want to bring that treatment to bear on someone in a crisis, but it is also getting confused with another section of treatment. Is there a way in which we could step back from the name itself? We did, apparently, rename the mental incapacity Act so that it became the Mental Capacity Act. That may also be part of the problem for people who have learning disabilities and autism. My relative is not ill; my relative has learning disabilities and autism and is in crisis because of that. It is the stigma, as you would say, that has already built up around being detained under the Mental Health Act for them as a population.

Dr Quinton Deeley: You raise a complex topic. There are concurrently different taxonomies or discourses surrounding mental health and developmental difficulties. The legal body of concepts does not necessarily correspond to those of the *Diagnostic and Statistical Manual* or the International Classification of Diseases, for example. In the International Classification of Diseases, the term "mental disorder" is used, but that is an umbrella term that accommodates a very wide variety of what we might think of as mental illnesses: depression, anxiety, schizophrenia; developmental disorders such as autism, ADHD and learning disabilities; and personality disorders. All would be considered under that overarching category.

To make matters more complicated, there is the disability conceptual framework, which is very important in this area and widely used. We also have the concept of neurodiversity, which is another important and valuable concept and innovation. It really emphasises the notion that there is human variation. Human variation includes people on the autistic spectrum, with ADHD and so on. In many instances, that should not be thought of as inherently problematic or disabling.

We have overlapping conceptual jurisdictions, if I can put it like that, and it introduces enormous complexity into these debates, because people are often talking at cross-purposes. If we go back to use of the Mental Health Act, or indeed to any other body of mental health legislation, clearly it is important that the terms are clearly and unambiguously defined.

Q115 **Lord Bradley:** We move on to the criminal justice system and a couple of questions, please. The revised detention criteria will mean that different approaches are taken for patients with learning disabilities and autism on the criminal justice pathway compared to civil cases. Could this lead to more people with learning disabilities and autism being detained under the criminal justice system? What could be done to mitigate this?

Dr Quinton Deeley: We partly anticipated this question in an earlier point. My own view, and actually the view of many colleagues—we have discussed this at SLAM—is that the use of Part 3 forensic sections would increase, for a number of reasons. One is that it is more likely that people who present with behaviour that can bring harm to themselves, or particularly to other people in the case of forensic sections, would present later, with a greater acuity of disturbed behaviour, which would break laws and bring them into contact with the criminal justice system.

The current discretion that exists in court diversion schemes would be restricted, because there would no longer be an option to divert a person or to drop charges at an earlier stage, for example, or to perform a Mental Health Act assessment. If you are detaining somebody in hospital under Section 3, the only mechanism to provide secure care using the Mental Health Act would be through Part 3. That is a clear concern.

The other difficulty is that it is doubly discriminatory. It is discriminatory both to people who present to the criminal justice system and to people who do not present to the justice system and who would otherwise be detained under Section 3. It also introduces an odd circumstance in relation to somebody who has been treated under a so-called forensic section and is being discharged into the community. They might be discharged into the community under the Mental Health Act, and you might want the capacity, should they deteriorate, to use a civil section rather than Part 3 of the Act. Again, it would increase the likelihood of further use of Part 3 of the Act.

My view, and certainly the view of colleagues from the SLAM feedback to the committee, was that this proposed change was ill-advised. The proposed change is to make it no longer possible to detain people with learning disabilities or autism under Section 3. That is the ill-advised change.

Dr Margaret Flynn: I add a further question to your own: do you deprive someone of their liberty to stop them offending? That is the fear and the anxiety about this.

Professor Mahesh Odiyoor: As I said, I work principally with people with intellectual disability, who may or may not have autism, rather than just people with autism without an intellectual disability. I see a risk that a proportion of those people I care for currently under Part 2, Section 3 of the Act may end up needing to be supported under the criminal justice process or not be supported at all in the hospital setting, particularly when they are presenting in that crisis situation, where they are a risk to other people. There is that risk.

I think there was a question earlier about the changes in the Act in New Zealand. A paper was published in August 2019 by Professor McCarthy and Mhairi Duff in *BJPsych International*, which talked about that. In New Zealand, they took the concept of learning disability out of their mental health Act in 1992, I think. That led to people being led through the criminal justice process.

The evidence in the paper does not say how many people, what proportion of people, and those sorts of things, but it says that it led to changes in the Act over there, such as reinstating the concept of learning disability back into the Act. There is some evidence there. I do not know the details of it, but it might need to be explored to understand why those changes took place in a country that in terms of demographics, needs and so on is quite similar and whether this is a wise thing to do.

Lord Bradley: In a sense, for those who are in the criminal justice system, there are the proposals on transfer times and removal of prisons as a place of safety. Are you in favour of those proposals for those who end up in the criminal justice system?

Will it mitigate some of the disadvantages of the criminal justice system for people with learning disabilities and autism?

Dr Quinton Deeley: I agree with the introduction of mechanisms to expedite transfer from prison into hospital settings. It raises the larger question about thinking about the design of prisons and the provision of healthcare in prisons. My colleague Shubulade Smith gave evidence on that. She commented on the enormous variation in the provision of mental healthcare in the prison estate.

Again, we have a situation where, with the same body of mental health law at the moment, in practice there is enormous variation in the provision of quality care. This is to do with service provision, models of care and resources of care. It is not primarily to do with the Mental Health Act. Ideally, at every point at which a person comes into contact with the criminal justice system, you want there to be a facility to identify the presence of learning disability, autism or other mental health condition, for that to be taken into account and for diversion to occur at the earliest possible stage, rather than to have somebody in prison and the diagnosis to be made at a late stage, in the case of crisis. Again, it is a view that emphasises the totality of care provision at a systemic level.

The Chair: Would either Margaret or Professor Odiyoor like to add to that, or simply agree? Okay, that is very helpful.

Q116 **Baroness Hollins:** I will declare an interest first, because I chair the oversight panel reviewing the use of independently chaired care, education and treatment reviews and I will be asking you about CETRs. I want to remind everybody that we are looking for solutions. What will work well? Dr Deeley and, I think, all of you have spoken about the care shortcomings and the fact that the Act will only be as good as the quality of the care that is provided and the therapeutic aspirations that are there. What will making care, education and treatment reviews a statutory requirement for people with learning disabilities and autistic people achieve in practice? Will it lead to higher therapeutic aspirations, for example?

Professor Mahesh Odiyoor: We use the CETR provision quite seriously and significantly in our settings, both at the point of admission—in admission prevention—and when somebody is in hospital, in order to review the care and to support somebody's discharge out into the community. One significant challenge, as has been highlighted in previous answers, is that, quite a lot of times, the barrier to discharge is not the treatment in the hospital, but the lack of provision to discharge the person.

Making it mandatory and making the RC—the responsible clinician—responsible for those actions might mean the RC taking responsibility for things they have no control over. We do not have control over the finances or the provision of a house or community placement out in the community. I do not see how making it mandatory will solve the issue. That is one point.

The second point is how we improve the use of that process. There is also a conversation about developing a clinical contract as part of the admission process, so if somebody is being admitted to hospital, a clinical contract is drawn up between the admitting service, whether or not it is in the community, and the hospital setting, agreeing very clearly what aspects of care need to be met in the hospital setting.

That principle will enhance the process of CETRs, because you have a very clear, agreed process before admission. Then you can review that, through the process of CETRs, to make sure the provisions of care that you agreed to deliver in the hospital setting are met. Once they are met, if there is delay in discharge because of lack of provision in the community, that can be picked up through the CETR process and addressed. The challenges can be put in place for the funding authorities, whether they are health commissioners or local authority commissioners, to say how those obstacles can be removed to support the person to be discharged into the community.

In principle, I am not in support of making it a mandatory or statutory criterion and making the RC responsible for it, because I do not think it will achieve the stated intention.

Dr Quinton Deeley: I would agree with those observations. In practice, the CETR process as it stands can, at times, make a constructive contribution to catalysing planning for and focusing minds on discharge, typically of the referring community mental health team and/or the commissioning body. To reinforce the point, in my experience the delays to discharge do not stem from the in-patient services.

Also, in a sense, where you have a well-engaged community team and commissioners who attend CPA meetings on a three-monthly basis and are actively involved in co-managing the patient and seeking early discharge, the CETR process is essentially redundant.

The CETR process is useful in situations where there is insufficient commitment to the CPA process from the referring team. Then, effectively, the function of the CETR overlaps with what the CPA process should actually achieve, which is a focus on the needs of the patient and timely discharge into an appropriate community setting. In a sense, the need for the CETR process itself is a response to an unacceptable status quo that is due to the failure, where it exists, to properly apply the existing processes. Where they are properly applied, they are effective.

> **Baroness Hollins:** The difficulty is that you are talking to us about best practice, and we know that that best practice is not possible in most places because, you are arguing, resources are limited. I suppose the question is whether there is a place for legislation here at all. The independent reviews that I oversee are for people in long-term segregation. Maybe that does not happen in your hospital, but the point here is that the reviews are finding that the recommendations are not carried out. That may be a resource issue, but what is the solution?

Dr Quinton Deeley: There are two issues. There is a training and model of care issue—an organisational issue—and a resource issue, and they interact in complex ways. I say that, because a service such as the National Autism Unit is a national service. People from all over the UK, including Scotland and Wales, are referred to it, and it gives a snapshot of variation in referring services. There is enormous variation in referring services. Some of them are very proactive, engaged and effective in achieving early discharge, and some are the opposite, in the same body of mental health legislation.

One of the concerns about the proposed revisions to the Mental Health Act is that they are essentially using legal and bureaucratic bolt-on mechanisms to try to make a system that is underfunctioning work more effectively. In reality, the functioning of the system is highly variable, as I have said. There is good practice and less good practice.

For example, let us anticipate that we are entering a phase of limited resources macroeconomically. What could improve services? Well, what could improve services in existing provision would be the dissemination of better models of care, training and good practice. Equally, even with the provision of better models of care and good practice, and even after reducing restrictive practice, embedding quality and improving whistleblowing mechanisms in institutions—all these things that you can embed and build in to improve practice—we will still bump up against the resource issue. That is the difficulty.

> **Baroness Hollins:** I want to bring Dr Flynn in, but I also wanted to add another question, which is about whether the creation of a risk register would be effective in helping to identify and treat at-risk people with learning disabilities before they require in-patient treatment. Margaret, add any comments about the first question, too.

Dr Margaret Flynn: My concern is that families are consistently working against separation and are excluded from reviews. I do not have a problem with reviews, but the families in services where things have gone very badly wrong have, almost without exception, been emphatically excluded from any reviewing process. There are high costs to that exclusion. There is no lifelong perspective; no acknowledgement of the expertise and problem solving of families; and no sense of balance even between somebody's history and likely aspirations for the future. The marginalisation of parents and siblings is hugely problematic.

I am often taken aback by the inattention of staff to the advice and hard-earned experience of families when their address changes to that of an assessment and treatment unit. They are poorly informed, typically, yet it is almost as though families are seen as the problem. I accept that not everybody has a family. I accept that not all people with learning disabilities and autism have been cherished by families, but, where families are there, they are a resource and should be drawn upon. My experience is that they—we—are excluded from reviewing processes. The professional dominance is in ascendancy over family wishes, but also over family integrity.

> **Baroness Hollins:** Thank you very much for those important points. Are there any comments on the risk register from any of our witnesses?

Professor Mahesh Odiyoor: I can come in on the risk register point. In our area, when the dynamic risk register concept was brought in a few years ago, it was suggested that we need to maintain one. When we talked to families and carers, families stated very clearly that they did not like the words "risk" or "register". We changed the term to "dynamic support databases", because it was about supporting people, not putting them on a risk register. Rather than the concept that they are risky to somebody, it was saying that they are at risk of admission to hospital.

In our area, the north-west region, we changed the terminology to call it a dynamic support database. At that time, our commissioners did not have a very clear understanding of how you identify risk. How do you suggest that somebody is at risk of admission to hospital? What are the factors that would make a person at risk of being admitted to hospital? We developed a stratification process. It was a simple, sensible way of looking at 12 key factors that lead to somebody deteriorating out in the community so that they might end up in the hospital setting. It was called the dynamic support database stratification tool and we piloted that in our area. It gives three ratings: red, amber and green.

There is no point in identifying that somebody is at risk of being admitted to hospital unless you do something about that, so at that time we developed an intensive support service. Once you identify that somebody is at risk, you provide support to the person, around the person, to try to prevent that person coming into hospital where it is not necessary. By doing that over the last few years in our area, the north-west region has shown a quite significant reduction in admission to hospital.

The concept of a risk register or support database is valid. You need to have a process of identifying people who are at risk of being admitted to hospital. Then you need to have resources to support those people appropriately in the community. By doing all that, you can support people effectively in the community and reduce the number of people coming into hospital inappropriately.

> **Dr Dan Poulter:** On the care, education and treatment review, which will then come forward with a plan at the end of it, Dr Deeley, you quite understandably highlighted the lack of resource. Another challenge is that there are many agencies involved, with different commissioners, budgets and challenges. If we were looking for a mechanism to mandate joined-up working, so that when there was a plan it would actually happen, are there any recommendations or suggestion that you would make in that area?

Dr Quinton Deeley: One point, which I think is related to the point you were making and has been supported, is the idea of joining budgets of health and social care, because that often leads effectively to a type of delayed discharge due to disputes about funding. A higher level of integration of services, not just at the funding level but in the assessment of need and decision-making about community provision, would improve matters.

I agree that the present situation, where there are many stakeholders involved in decision-making, can be extremely complicated. Quite often, one can find oneself in a room with decision-makers that would have as many people in it as are seated around this table. It is extraordinary, and co-ordinating effective decision-making when there are so many stakeholders and decision-makers is very difficult. Systems that can improve and simplify decision-making are good.

> **Baroness Berridge:** Building on that question, is there any merit, once somebody has been assessed for discharge, in having any kind of time limit running and responsibility passing to them at certain points along that time limit, or in their budget being drawn on regardless of whether they have put that person into the community? What you have described is the result of resource in some areas, but in others it is just not being able to make the process work. Would any such incentive— "Let's have a time limit running"—help this process in some places? You say that, from a national perspective, you are getting referrals from all over the place.

Dr Quinton Deeley: If there is a time limit, who is it for? The question is where the bottlenecks in discharge are. They may not be identical in every case. One difficulty you have is that the provision of good care is, in the short term, expensive. Because resources are limited, there is something of a winner takes all phenomenon, where a lot of resource is allocated to relatively small number of people, whose needs are met. The remainder are therefore managed through a kind of informal rationing. The rationing takes the form of delays in decision-making, delays in assessment or a placement being identified, going to panel, being turned down because it is too expensive and then coming back in another month or two.

In different ways, we bump up against the issue of resource, unfortunately. There is an important question of how to improve practice. Simplification and streamlining will improve practice. At the moment, it is very complicated. That is also worth bearing in mind when considering the proposed revisions to the Mental Health Act.

To my mind, it is an example of what we have also seen, to some extent, with the care and treatment reviews. When you have an underfunctioning, underresourced, chronically stressed system, the solution to that often is to bolt on different regulatory and supervisory layers. You get a regress of layers. More layers are being put on now, but, fundamentally, the underlying system is anaemic. Until practice and resources in the core system of the people doing the primary jobs—the CPNs, the social workers, the commissioners and so on—are improved, it will essentially always create coercive mechanisms at higher and higher levels to force people to do what they should be doing already.

Q117 **Marsha De Cordova:** In your opinions, are there any further provisions needed in the Act to ensure that those with learning disabilities and autism are, first, not misunderstood, but, more importantly, not misdiagnosed with other mental health conditions?

Dr Quinton Deeley: The issue there is of diagnosis and communication. The issue of diagnosis is best addressed through improved training across the health and social care service, and indeed education. In the past 20 or 30 years, there has been increasing recognition of autistic spectrum disorders, for example, I think as a consequence of increased general awareness of the condition, with more children at school being noticed by teachers as potentially being on the autistic spectrum and that leading to assessments.

There will always be a need for specialist diagnostic and in-patient services for people on the autistic spectrum and people with learning disability, because there are complex cases. Fundamentally, the answer to improving assessment and diagnosis is to improve training for all psychiatrists, social workers and clinical psychologists coming through training. When that happens, misdiagnosis will become rare.

Dr Margaret Flynn: I will continue to fly the flag for families. We are credible and rational bystanders, and some of us even have quasi-legal status as attorneys. In diagnosis, the interpretive support and the knowledge that we have of our relatives is essential. It matters that families are part of the picture. That is my contribution.

Professor Mahesh Odiyoor: I agree with Margaret. There was a mention earlier of ongoing care. Whether it is diagnosis or care, there has to be a joined-up approach between professionals, families and carers. That is the best way to avoid possible errors.

As Dr Deeley said, there is a need for that training at all levels. If there is a lack of that, there is a risk of making a misdiagnosis. This is the risk that we are highlighting of changes to the Mental Health Act. If we do it that way, we take away the provision of Section 3 and people have to rush into decision-making because there is a time limit of 28 days, and at certain times there are risks that, with complex needs, clinicians may end up making diagnoses that are not warranted, because there is a time pressure on them. That is one of the risks of making those changes to the legal framework that we are highlighting.

Q118 **Baroness McIntosh of Hudnall:** It might not be possible to give us an answer on this now, but I would be very interested to know. Dr Deeley, you were talking about training and about a wider range of mental health professionals of all kinds, and possibly people outside the hospital and healthcare systems, understanding what they are looking at when they are looking at autism or learning disability. Do you have a sense of what the deficit is—the numbers of people who are likely to be asked to provide that kind of diagnosis and who probably do not have the skills to do it? That is a rather complicated way of saying, “How many people in your profession do you think have enough skill to do this?”

Dr Quinton Deeley: It is hard to give a very precise answer. I gave two lectures recently at the royal college to general adult psychiatrists. One take-home message is that any consultant psychiatrist, or indeed any psychiatrist with membership of the Royal College of Psychiatrists, should be able to diagnose somebody with autism by using, for example, an interview schedule that is free to download on the Royal College of Psychiatrists website. By virtue of their psychiatric training, using structured interview and applying ICD or DSM criteria, they should be able to make a diagnosis. There will always be complex cases that require a more specialist assessment, whether that is due to complex comorbidity, co-existing medical conditions, and so on.

The difficulty is that in practice there are many general adult psychiatrists who would feel that they lack the confidence to do so, so it is very difficult to know the numbers of people who feel that they lack the confidence to do so. The key point is that all psychiatrists, when they come to take the MRCPsych exams, should feel confident about being able to diagnose people with autism in the vast majority of cases.

Q119 **Baroness McIntosh of Hudnall:** That is very helpful. I will now come to the question I was supposed to ask you. We have talked a lot about the deliverability of the proposals in the Bill, in effect. I would like each of you to give us a quick view on whether the plans in this draft Bill are deliverable within the timescale and budgets that have been outlined in the assessments.

To be clear, you have talked a lot about the provision of community care. We have heard concerns from you and many other people that it is not really yet developed enough to provide a viable alternative to detention under the Mental Health Act. What specific investment or reform is needed, over and above what has been indicated, to get us to the point where it is?

Dr Quinton Deeley: To an extent, the question has been anticipated in earlier responses. In terms of the key proposals, the concern about the 28-day timeframe for assessment and identification of suitable community provision has already been raised. That is just too short a timescale in many cases. There is the ancillary concern about the lack of ability under the proposal to detain people under Section 3. Those concerns stand.

We have not yet spoken about the enormous increase in demand on the time of both clinical and non-clinical staff at the hospital with the increased administrative burden of the Mental Health Act proposal. The true increase in time demand with it will be enormous. What the additional resource would be has not been thought about, to my knowledge, or costed.

It raises the question: if resource is limited, where should it be targeted? Do you target resource on creating additional regulatory and supervisory tiers, or on improving core services? That is a question that I would put to the committee.

Baroness McIntosh of Hudnall: I was very struck, Dr Deeley, by what you said in effect about the different funding streams that are coming in to try to provide the care that is being sought and the competition among multiple stakeholders to protect those funding streams, which seems to be implicit in some of what you have described. Does anybody have anything to add about how that might be simplified and made less competitive and more collaborative?

Professor Mahesh Odiyoor: The protection that Part 2, Section 3 provides is the Section 117 aftercare. One of its provisions is that collaborative work between the health and social care parts is needed to maintain the well-being of the person in the community. There is a risk that that 117 aftercare process will not be available to a proportion of people and may make an already complicated process even further complicated.

There is also the principle of funding without prejudice. You do not argue about funding in order to prevent somebody being discharged from hospital. Sometimes in our area, where there is argument about who pays for what, whether it is local authority or the health side of things, we try to articulate that and discuss and debate the cost, and people's share of it, outside, but we need to support the person being discharged early. That should not hold a person in hospital. That reduces to a great extent some of those arguments about proportionality.

There was a suggestion that joint funding would reduce it. There are pros and cons to that, too. I do not think there is an easy answer to that. From the Mental Health Act point of view, taking the provision of 117 aftercare protection away will probably make the process even more complicated.

Dr Margaret Flynn: There are no creative blueprints, unfortunately, but there are some localities investing in try-outs. I would commend the work of Norfolk and its ethical commissioning and effort to bring otherwise warring bodies together to pool budgets around individuals to keep them out of institutions as well as to make provision for them when they are ready to be discharged.

Q120 **Baroness Hollins:** We have had submissions suggesting that some private providers might have financial incentives to keep patients in in-patient facilities for extended periods. Is that a well-founded concern?

Dr Margaret Flynn: Yes, it is. The fees charged by some providers are extraordinary and they are completely unaffected by failure. There are corporate structures that undermine accountability. We would need to revise the rules of corporate governance. I would be very happy to share with the committee a submission I made with some lawyers to the Law Commission about this very matter.

> **Baroness Hollins:** That would be very helpful. Thank you.

Dr Quinton Deeley: I have worked in the NHS and in the private sector, so I have direct experience of both. I have never heard a conversation in which there has been an explicit description of an objective of prolonging hospital stays unnecessarily in order to make more money in a private sector setting.

However, a number of observations are relevant. One is that private provider settings often provide a service where adequate local services do not exist, so people get referred to them. Often, these are people who present with very high levels of need and complexity. Their behaviour can be very difficult to manage and it exceeds the ability of other services to cope with them more locally. It has to be borne in mind that the particular cohort admitted into private settings, not always but often, will include people with among the highest levels of need and the most challenging presentations, which means that their prognosis is more difficult, if I can use that term, than others'.

It is also true that, by virtue of it being a private setting, the onus remains on the referring authority to actively seek to discharge the patient at the earliest opportunity. That responsibility is never devolved. If people have prolonged stays in private settings, that is also a responsibility of the referring team.

At the very least, there might be a kind of institutional, unconscious motivation not necessarily to be as proactive in seeking discharge, as might otherwise be the case, by virtue of the profit motive.

> **Baroness Hollins:** We have talked about the clinical contract. There is also the question of whether the private provider, which may be very expensive, has the competence and skills to provide the range of therapeutic services required for patients. You spoke about training earlier. I do not know whether the Oliver McGowan mandatory training will be sufficient. It seemed to me, when you spoke about all psychiatrists needing to be trained, that it is not just about assessment. It is actually about being able to communicate, understand and apply your knowledge in a clinical settings. Should all psychiatrists have to do placements in learning disability and autism routinely before getting membership of the college? Only then will we have in every provider, NHS or private, people with adequate competence.

Dr Quinton Deeley: That is a good idea, with the qualification that an equal claim could be made for every psychiatric specialism. Having said that, 1% of the population are on the autistic spectrum, and about 2% to 2.5% have a learning disability. It is an enormous number of people in the UK. The mental health burden associated with those conditions is much higher than in the general population. It is inevitable that any general adult psychiatrist will encounter many people with autism and many people with learning disability in the course of their career. On those grounds, you could argue that it should be a mandatory component of training.

Baroness Hollins: They may also have eating disorders, need liaison psychiatry in a general hospital or have other mental health conditions.

Professor Mahesh Odiyoor: I agree that there is a need for training. What form it takes probably needs to be discussed a little more. I agree that it is not just about diagnostic training, but about the wider ability to communicate and to understand the sensory needs and functional skills of the person along with all the other comorbidities.

As Dr Deeley said, the proportion of mental illness in somebody with a neurodevelopmental disorder or learning disability is about 30% to 35%, compared to about 5% without a neurodevelopmental disorder. The proportion of people with a neurodevelopmental disorder—that includes autism, ADHD, learning disability—who have additional mental illness is very high. Sometimes in the complex presentation that they present with, particularly coloured with the behavioural challenges, those mental health symptoms might be lost. It is important that people can pick up those difficulties and address them not just with medication but in a holistic way. All that needs to be part of that training. Whether it is through mandatory placements in learning disability and autism settings or a different way needs to be discussed.

Dr Margaret Flynn: I have come across very many low-paid staff in services in the private sector. They are disengaged and they contribute to the long-term underoccupation, the chronic boredom and the excessive use of restraint and seclusion. That has been my experience, I am afraid.

The Chair: Could I thank all of you for your contributions, which we value enormously? Thank you for your time. Sadly, we have run out of time, so we must move on to our next panel. Thank you very much indeed.

Panel 2

Witnesses: **Carolyne Willow**, Director, Article 39; **Charlotte Rainer**, Coalition Lead, Children and Young People’s Mental Health Coalition; **Dr Susan Walker**, Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital.

The Chair: Thank you everybody. This is the second panel of the eighth session of the Joint Committee scrutinising the draft Mental Health Bill. The panel will focus on children and young people under the Mental Health Act. Can I immediately thank all three witnesses who have come here today: Charlotte Rainer, Dr Susan Walker and Carolyne Willow? I would ask each of you just to say whom you represent, and then we will go straight into questions.

Charlotte Rainer: I am from the Children and Young People’s Mental Health Coalition.

Dr Susan Walker: I am a consultant child and adolescent psychiatrist at Great Ormond Street Hospital. I am also just finishing a PhD looking at the use of the Mental Health Act in children and adolescents that I am doing at UCL, funded by the NIHR. I am a member of the executive committee of the Faculty of Child and Adolescent Psychiatry in the Royal College of Psychiatrists, but I am not representing them today. Finally, I have just finished a Nuffield-funded position at the Parliamentary Office of Science and Technology, where I have been writing a briefing on the potential impact of the reforms on children and adolescents.

Carolyne Willow: I am the founder-director of Article 39 children's rights charity. We promote and protect the rights of children who are living in institutional settings.

Q121 **Baroness McIntosh of Hudnall:** Hello. Good afternoon. I should probably say, given the question I will ask, that a fairly close member of my family is a young person with an autism diagnosis and mental health problems who is currently engaged with CAMHS.

Does the draft Bill need to do more to make the Mental Health Act more relevant for children and young people, and, if so, what would be the most impactful areas of change, in your views? Are there points in the interaction between children and young people and the legislation, as it currently stands, where they are at a significant disadvantage, relative to adult users of those services? Do you have any specific concerns about wider mental health services that might impact on the success of these reforms?

Charlotte Rainer: The Bill needs to do more to strengthen safeguards for children and young people, particularly those aged under 16. The draft legislation is all about enhancing voice and choice in safeguards, and we will be doing a real disservice to children and young people if we do not make it work for them. There is lots of evidence out there to suggest that children and young people do not feel currently heard in their treatment. They do not have a lot of control. Mind submitted some evidence to the committee from young people who are in in-patient settings, who said they want to be more in control of their treatment; they want to have their voices heard. We need to do this for children and young people.

There are areas of the Bill where children and young people are disadvantaged, particularly in decision-making tests for under-16s and access to advance decisions. I know these are topics we will be covering later in the session, so I do not want to go too much into that at the moment, but those areas need to be considered in the context of the Bill. Under-16s are not protected in mental health legislation in the same way that those aged 16 and over are.

The Government have said that they would give due consideration to the UNCRC when making new policy and legislation but, as far as I am aware, a child rights impact assessment has not been done for this legislation. We would be really keen to understand whether the Government will undergo that process.

Finally, the changes in the draft Bill cannot be seen in isolation from the wider mental health system. The success of these reforms is really going to rely on sustainable investment, a strong workforce and effective service provision. We already know that the children and young people's mental health system is struggling to cope with rising demand. It is not as effective as it should be. We have long waiting times and high thresholds for support. If we do not have support in the community and do not have early intervention support, that is really going to put these reforms at risk and, again, we will be doing a disservice to children and young people.

Before I finish, I want to give a nod to learning disabilities and autism in this context as well, because the lack of community provision available for these groups is really relevant in this area. If we do not have this high-quality community provision in place, tier 4 in-patient settings will be the least worst option for young people with learning disabilities and autism.

Dr Susan Walker: I completely agree with what Charlotte said there. Putting the reforms in context, we are going through an unprecedented crisis in child and adolescent mental health care at the moment. We know that the numbers of young people with a mental disorder have gone up from one in nine in 2017 to one in six in 2021. There is much more demand. The mental health services are struggling to meet that demand, which is resulting in long waiting lists, and by the time young people present to services or get seen, they are more unwell. They are presenting more often in crisis. That is what we are dealing with at the moment.

When we have children and young people presenting in crisis, often, as it was talked about in the earlier panel, there is a mixture of mental health problems and social problems. Maybe it is helpful to give an example of a young girl I saw on call, who was brought in by police from her care home after smashing all the windows and trying to self-harm with pieces of glass, having learned that her birth mother had gone out of the country with her new partner and new baby. There is a mental health issue and social care issues there, and one of the problems we are facing is that, as was mentioned earlier with this joint funding, it can be sometimes very difficult to find the right care for these people that is jointly funded and is therapeutic.

We know that the numbers of young people being placed in inappropriate placements are growing. The number of young people being deprived of their liberty has increased by 400% in the last three or four years. We are really struggling to place these young children. In that context, as one potentially really impactful area of change, we could be legislating to try to help prevent these disorders arising in the first place, and certainly prevent them getting more severe, by legislating for access to primary care, like the Mental Health (Wales) Measure. We could be legislating for counselling and therapy in all schools, which might help prevent the mental illnesses developing in the first place.

Another area we mentioned was the law. The law is very complex and the Mental Health Act does not really address that. It would be really helpful if the new Bill could clarify the role of parental consent, and when we can use it and when we cannot. Thinking of parents and families, it would be really helpful to include a duty to support families because, often, the input of families is marginalised, as Margaret said. If there was a duty in the Act to support families, maybe with needs assessments prior to admission, during and after, that might really help. It might reduce admissions, which often happen because families just cannot cope.

Finally, another really important area of change would be legislating for better data. We know so little about the young people who are detained. We do not know who they are, where they are or how many of them there are. We do not even know whether the racial disparities that exist in adults exist also with children. It would be really important that we know more about these young people.

Carolyne Willow: In answering your question about whether the Bill is fit for children, I have been thinking about what the Bill would have looked like, had it had "children and young people" in the title and had we started with children and young people. I believe it would have had the United Nations Convention on the Rights of the Child in the Bill—if not all the provisions, at least a duty to act compatibly with the general principles of the convention. It is international law. We ratified it over 30 years ago. It was a Conservative Government who ratified it. The two main opposition parties have committed to incorporate the full treaty into law. This is a timely opportunity to get that convention into mental health provision.

The general principles are, in Article 2, the right to enjoy your rights with no discrimination; in Article 3, the child's best interests in individual decision-making as well as general, collective decision-making and decisions about resources; and, in Article 6, children's right to survival and maximum development. For that, I refer to the recommendations of three investigation reports that came out last week into the appalling deaths of two girls, and one girl who had just turned 18. I would send the committee to the independent inquiry into child sexual abuse, because its recommendations are also relevant to this Bill. Then, in Article 12, there is the right of every child to express their views freely and have their views given due weight. If this was a Bill for children and we were trying to fit adults into it, we would have had the Convention on the Rights of the Child.

In terms of availability of mental health services for children in their own communities, their own neighbourhoods, where they live, as well as in hospital, I would recommend the committee look to Section 1 of the National Health Service Act 2006. A duty on the Secretary of State simply to promote comprehensive services is clearly not sufficient. You can promote a service that barely exists or you can promote a well-resourced service that is fit for children, and that would be a real development for children.

If Government and parliamentarians are concerned about putting into primary legislation a duty to make sure that provision is available, there is a special and overwhelming case—I would say this, wouldn't I?—to at least start with children. That could be an area. Another strategic measure would be for all hospitals and integrated care boards to have a senior person whose role it is to promote, protect and champion the rights of children, in accordance with the Convention on the Rights of the Child.

There are a number of other provisions that we have looked at in the Bill as it stands that could be improved and extended to meet the desperate and compelling needs of children right now. They relate to independent advocacy, to complaints, and to children being detained and informally admitted to adult wards or being sent hundreds of miles away from home for hospital care. Poorly children are sent hundreds and hundreds of miles away by an NHS that is there to help them get better. That process makes them feel utterly powerless, lonely, abandoned and disconnected from the very people—their friends, family and communities—who are integral and critical to them building themselves back up with help, getting strong again and being well again.

I would have much preferred to have had a child mental health Bill and to have started with children, but there are places in the Bill as it stands where you could recommend serious amendments and improvements that would be fit for children.

Q122 **Sir Charles Walker:** Dr Walker, you mentioned that one in six children had some form of mental health diagnosis or potential diagnosis, but there is obviously a huge spectrum. For most of them, luckily, it is transitory. You also mentioned a 400% increase in the number of children in detained environments. What was the starting point of that number and where it is now? How many children was it when it was 400% previous to where it is now?

Dr Susan Walker: That is data published by the Nuffield Family Justice Observatory. It was, I think, around a hundred and something. This is young people not detained under the Mental Health Act, but deprived of their liberty, which is slightly different.

Carolyne Willow: It is the use of the inherent jurisdiction, but it is related to the absence of good-quality mental health support for children in their communities, including children who are in the care of the state. As you know, 65% of children who are looked after by local authorities are there because of abuse or neglect.

> **Sir Charles Walker:** Very briefly, how many children are we talking about? It has gone up 400%, you said, in the last decade.

Dr Susan Walker: No, in the last three years. In 2017, it was 100. The latest data is more like 580.

> **Sir Charles Walker:** What would be their diagnosis and their condition? What would cause them to be deprived of their liberty?

Dr Susan Walker: These are young people very much like the girl I talked about earlier. Perhaps they are thought not to have a mental health diagnosis, but their behaviour is too challenging to go into a social care placement. They are the young people we talk about falling through the gap of healthcare and social care, and it is a real problem at the moment because we lack appropriate, therapeutic, secure placements for these young people. It is a massive issue. We just do not have enough places for them.

> **Sir Charles Walker:** Have you provided written evidence to the committee about this?

Dr Susan Walker: I have not, personally.

Carolyne Willow: We can.

> **Sir Charles Walker:** It is really important that we look at this and get it covered in the report. We do not have time to go into it in detail, but this is a very important area to look at.
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> **The Chair:** I agree. If you could do that, that would be enormously helpful. Thank you very much.
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> **Baroness Barker:** We might ask local authorities if they can back up that data.
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> **Baroness Berridge:** Are you going to the inherent jurisdiction of the court because you do not have the Mental Capacity Act, which is only for over-18s? Is that why the wardship jurisdiction is being used?

Carolyne Willow: For children in care, it is often because there are not enough secure children's homes. They have been reduced. There are 14 secure children's homes now; 20 years ago there were 29. That is for children in care. The Mental Capacity Act can be used for children aged 16 and 17. Inherent jurisdiction is what has increased exponentially.

Baroness Berridge: We need to clarify which legal buckets we are using for each of these groups of kids.

Q123 **Baroness Barker:** I have a series of questions about an issue you have already raised with us: the determination of capacity and competence for under-16s. Do you agree with the Government that this a matter that should be left to the code of practice? If, as I suspect, you do not, how do you think that the Bill should deal with that?

Carolyne Willow: No, we do not agree. It is dodging the difficult question of how to draft legislation that properly reflects the law, which is in all different places, plus case law. The codes of practice, for both the Mental Capacity Act and the Mental Health Act, attend to it, so it can be done. We would argue strongly that it needs to be in the Bill in order to have clarity and to ensure that children aged 16 and under are not disadvantaged when it comes to the Bill's emphasis on the integrity of patients. The emphasis on patients being heard, understood and respected is integral to people recovering and getting better. That is part and parcel of a mental health service.

Baroness Berridge: What would be the benefits and drawbacks of introducing a statutory test for competence for under-16s? What are the implications of that for wider children's services?

Carolyne Willow: We would prefer not to call it a competency test, at Article 39, because that suggests a deficit and that children are having to prove that they are competent. That is not broadly in line with the Convention on the Rights of the Child, with evolving capacities or even with the notion of Gillick competence.

The advantage for children under 16 is that it would be there in the Bill and there would be clarity for all those who work with children and young people, for children and young people themselves, and for their parents and families, about the straightforward duties.

Baroness Berridge: Take me back through the argument about why this is different from Gillick competence. What is the distinction?

Carolyne Willow: If it was to be put in the Bill, the drafting would have to take in and reflect Gillick competence. That is what is in the codes currently, for under-16s.

Dr Susan Walker: Gillick competence is case law that says that if a young person is competent to understand the procedure or the treatment, they are competent to consent to that treatment. It is kind of broad. It does not tell you how to assess that. It is quite ambiguous, although we use it and it works as it is. However, if there was clear guidance as to how to assess the competency in the Act, it would obviously be in legislation, and how that is assessed would be a lot clearer.

The code suggests that we use the current Mental Capacity Act to assess whether someone under 16 has the competence to make a decision. It would give clarity, as you said, to clinicians and to young people. It would enable under-16s to access all the benefits of the reforms, such as being able to name a nominated person. As a clinician, I imagine, if a 15 year-old chose not to nominate their parents and the parents were not happy with that, you could go back to them and say, "We did this, this and this test, and that's how we came to this conclusion. We really feel like this 15 year-old has the competence to make this decision, and we have assessed it using these methods". It would give more clarity and enable you to explain and be clear about how you have come to your decisions.

On the other hand, I can see disadvantages and advantages of putting it in the Act, because we know this is an evolving area of law. If it remains in the code, it may be easier to change in future, should things change with views on children.

Q124 **Dr Ben Spencer:** Apologies, first, for missing the starting answers of this really important section. Secondly, I was a general adult psychiatrist and did not work with CAMHS, so if I say things that are stupid, I am sorry. I am trying to understand how you would codify a capacity test—and I call it that just for ease—for under-16s and what that would look like.

With the Mental Capacity Act, we have a two-stage test. Out of the four criteria that you must be shown to lack ability on and therefore lack decision-making capacity, it needs to be due to disorder of mind or brain. There is a link to pathology in the MCA when you are dealing with over-18s. Presumably, under 16, there is no pathology. It is normal development of the mind and maturity, for most of the cases we are thinking about, if we are talking about general medical decision-making et cetera.

I wonder how you would go about teasing it out, in terms of codifying it. Would you, for the purposes of the Mental Health Act, limit it to mental disorder, which is leading to the inability to—using the MCA test, for example—understand, retain, use or weigh, and communicate? How would you approach it? Would you create a general new capacity test for under-16s, based on the MCA, or would you do something purely for the MHA?

Dr Susan Walker: The code of practice, the judgment in RS in 2017—which is referenced in the independent review—and the independent review suggest that we use the same capacity test. I think it excludes the first part and then goes on to use the four parts. The difference would be that in under-16s you would not assume competence. Competency would have to be proven, as it is now, unlike in over-16s where you assume capacity. Under 16, you would have the same test, but you would have to prove that you have the competence rather than that you do not, which is what we have to do in over-16s.

Dr Ben Spencer: I am thinking about how these capacity tests play out. You are presenting the information. You are talking it through with the child: "These are the options", et cetera. I used to ask, "Could you help me understand how you've come to this decision?" to tease out the "use or weigh" part. Presumably, that is not linked to anything; it is just saying, "Explain it back to me", essentially. I am just curious as to how you tease out the "use or weigh" component in that context.

Dr Susan Walker: It would be decision-specific every time you are using this test. You would be asking them to explain the decision back to you and then how that works.

Dr Ben Spencer: It is more an epistemological issue. The most difficult capacity tests are when the patient is agreeing with the treatment, but you nevertheless have concerns that there may be an issue of capacity. The person can come back and go, "Of course I agree with you, doctor, because that sounds like a great idea. You're saying I should do this because of X, Y, Z. Rock and roll—there we go". Actually,

when you tease below the surface, there may be reasons why they lack decision-making capacity in that context. For most decisions, that probably does not really matter, because if the patient and doctor agree it is not such a big issue, but for big, long-term consequential decisions it could be more of an issue.
Sir Charles Walker: They might not have the experience to interrogate in a way that an older patient might.

Dr Ben Spencer: It is not so much the experience, but more trying to understand how that plays out. There is concern where someone is refusing but lacks capacity, but equally there is a concern when someone is agreeing but lacks capacity. Exactly as you were saying, Sir Charles, it is about how that is being interrogated, when you have also flipped the evidence barrier in that context.

Carolyne Willow: This happens all the time, in any case, because Gillick competence is there for children under the age of 16 and has been in our law for coming up to 40 years. It is about how a clause could be drafted to take in Gillick, as a starting point, together with the evolving capacities principle and requirement of the UN Convention on the Rights of the Child, together with the neat drafting that is in the Mental Capacity Act.

NGOs in this area are working on and looking at this ourselves. It is not straightforward to draft, but that does not mean that everything you have just described is not happening all the time, out there in hospitals up and down the country, and in all other kinds of decision-making with children who are under the age of 16. It is. It is happening in social care, education and healthcare, including mental health care.

Dr Dan Poulter: The key aspect of this, as Dr Walker said, is that capacity is subject specific as well. That is a key point. Could there be some unintended consequences in this area of codifying and putting things in the statute? At the moment, we have a well-developed case law system, which seems to be well understood in practice. It seems to generally work quite well. I just wondered whether that could be a consequence of the suggestion that you have made.

Charlotte Rainer: On both of your questions, I would like to consult the legal experts we have been working with on this, because they have been advising us a lot on the issue of competence. We can write back to you on both points.

The coalition is strongly of the view—and we have put it in both our White Paper response and our response to the committee—that there should be a statutory test for under-16s and it should not be in the code of practice. There are three key reasons for this. Putting it in the Bill would put under-16s on an equal statutory footing to others. As has been said, the code currently suggests a way for assessing competency, but the independent review highlighted that there are still massive inconsistencies in how that is applied and used in practice. If it is left in case law, these inconsistences will persist. Putting it in legislation will make it more clear cut for practitioners to follow.

It is really important to emphasise that the code cannot make law. It can only reflect it and suggest a way, so we believe that there should be a statutory test. The Mental Health Bill in its current form, in its draft version, refers to competency but does not define it. It talks about capacity for under-16s that will be competence, but there is no definition of what competence is or how that should be assessed for under-16s. As both Carolyne and Susan have said, it would really provide clarity both to professionals, and to children and their families.

On those further points, I will consult with our legal experts and get back to you.

Dr Dan Poulter: That would be very helpful. To refine my question slightly, even when something is set in aspic, as it were, in legislation, the courts will still have to interpret that legislation. We have to be cognisant of that. These areas are very complex. Sometimes, having the flexibility of looking at cases on their individual merits and using the court system to test those merit can have its benefits in a common-law system. It would be quite useful to understand the issues around that. Some of these questions are even more complex in children's issues than with adults.

The Chair: Are we reducing flexibility if we codify, because every case is different?

Carolyne Willow: We worry about entrenching the idea that children have to prove something and that there is a deficit in children, where the broader children's rights thinking, including Gillick competence, is far more respectful. Having said all that, and given everything you have said, we are still optimistic that it can be done.

Dr Ben Spencer: Would you have a basement age from which this applies or would it go all the way down the age ranks? As a slightly more rhetorical question, I totally get the argument for a statutory test. What concerns me is that you are all saying you think it is going to be really complicated putting it together. We are at the pre-legislative scrutiny phase, thinking about what goes in the Bill. How much more work is going to be needed to get something such as that together? Should we be doing this as a separate piece of work or can it be done in time to get in the Bill?

Carolyne Willow: Can we come back to you in writing reasonably quickly?

Q125 **The Chair:** Yes, please. That would be very helpful, thank you. Moving on, what might the consequences for children and young people be of the Government's decision to use provisions in the Mental Capacity Act for advance patient decisions? Is there a reasonable way to provide more advance choices to children and young people under the Mental Health Act, given the complex legal framework in this area?

Carolyne Willow: It follows on from what we have just been discussing, of course. We would like to see the general principles of the United Nations Convention on the Rights of the Child in the Bill. That would include Article 12 on the child's right to be heard and right for their views to be given due weight. We would like an explicit reference in the Bill to the dignity and worth of patients, both children and adults. Again, that would help with the culture change.

We are a small charity that spends most of our time around challenging coercive practice and the abusive treatment of children in a whole range of institutional settings. For us, it is about what will bring about the cultural change and what will be the headline communication when this Bill becomes an Act. It is dignity, integrity and the child's right to be heard at every point of diagnosis, treatment and admission; that comes to informal admissions, too.

Dr Susan Walker: The difference between the White Paper and the suggestion that there would be advance choice documents is that, by using provisions within the Mental Capacity Act, they are not available to anyone under the age of 16 because they are not covered by the Mental Capacity Act. That excludes the young people we were talking about earlier. It also means that anyone aged 16 to 17 cannot make an advance refusal of treatment because, again, the Mental Capacity Act does not allow you to do that before the age of 18. It does change the advance choice document suggestion.

However, a lot of clinicians feel that some kind of advance planning for young people about their care and including young people's voices is really, really important. Young people themselves are very positive about this. In practice, we can see difficulties in implementing these advance choices. In particular, who is going to help young people do this? When does it get done? Is it during admission or after admission, and who has time to do that?

The involvement of parents is really important. What role should parents have in making these advance choice documents, and what happens if a young person wants something in there that their parents do not agree with? Should we be doing this with parents and people with parental responsibility? How would that work in practice? That does not mean we should not do it, but we need to think really carefully about how it is done and what safeguards we put in place for young people and their families.

Charlotte Rainer: I agree with what the other witnesses have said. This is an area of the Bill that disadvantages under-18s. How the Bill is currently formatted, using the provisions from the Mental Capacity Act, means that children and young people cannot make advance decisions about their care and cannot access enhanced safeguards around that. We are not sure why the decision was made to move from advance choice documents, as set out in the White Paper, to the Mental Capacity Act provisions, but we strongly agree that under-18s should be able to access advance decisions. As Susan just said, the wider implications will need further exploration around that. Again, that is something we can get back to you on.

Q126 **Sir Charles Walker:** Turning to advocacy, I could be wrong on this but I think I am right that most children are treated as informal patients, as opposed to formal patients like adults. The Government seem not to want to extend proactive advocacy to this group. Are you concerned about that, given that the restrictions that can be placed on informal patients are as restrictive as those that can be placed on formal patients? Do you think that children will be disadvantaged by this decision?

Carolyne Willow: Absolutely, yes. Around two-thirds of children who are in a mental health hospital are there informally. When we looked at this through advocacy services, we found that children's experiences within mental health hospitals were largely the same, whether they were there as a detained child or an informal child. If we started by asking, "What does the child need?", that right to proactive advocacy would be for all children. The right to an advocate is absolutely vital because that is somebody from the outside who is there to ensure that the child's wishes, feelings and views are known and understood, and that the child knows that in this bewildering, frightening environment, often hundreds of miles away from home. Even if they are not hundreds of miles away from home, their mums and dads, brothers and sisters and grandparents are not there with them. It is an abnormal experience for children to be in an environment where people can have huge powers to segregate them, to take all their clothes off and so on.

> **Sir Charles Walker:** I am with you on this. As Dr Spencer said, of course all doctors and clinicians are acting in the best interests of the child, but you are 14 or 15, and the doctor is an adult. Even if you agree to something, you may not fully understand what you are agreeing to. An advocate could ask, "Do you understand what the doctor's saying? Would you like me to help explain what your choices are here?" That would be the type of advocacy: a friend in the room almost to translate for the child and just make sure that things are being understood, and it is not just nodding in agreement because the child is in a state of distress.

Carolyne Willow: The advocate helps the doctor, too, not just the child. The advocate helps the doctor know that child, what that child is thinking and feeling, what that child understands around why they are in hospital and why they are suffering as they are, and what makes them more or less frightened, distressed and agitated. This is all part of them recovering from their mental ill-health, so it is vital.

The advocates are also there to inform children of their rights in relation to the use of force, segregation and all other aspects of their protections. It does not make sense to say, "We're going to give that protection only to this minority of children", when they are in the same environment. If you accept the principle that children are inherently powerless and are dependent upon adults, that service should be for all.

> **Sir Charles Walker:** I take it that our two other witnesses are in agreement with that point of view.

Charlotte Rainer: Yes, completely. I want to come back quickly on the data point that you mentioned at the start. Carolyne said that about two-thirds are informal patients. NHS England does not actually publish any data on the number of informal patients under 18, so we do not have a clear picture of how many young people are admitted informally.

On top of that, there is also a lack of data collected on children and young people's experiences in in-patient settings, particularly informal patients. This was raised by the Health and Social Care Committee in its inquiry on children's mental health. We do not have a clear picture at all of whether children's rights are being upheld in in-patient settings at the moment because the data is just so patchy.

We 100% agree that informal patients should be included in the new opt-out system. We are not too sure why the Government have made that decision, to be honest. For children and young people, this will mean they will still have to ask for support from an advocate. Again, referencing back to the Mind evidence that I mentioned at the start, young people said that they were not aware that they can access an advocate. It would be really useful, when they are new in hospital, but having to ask for it is just another barrier that they have to cross and get over.

It has been a long-standing concern of the sector. If children are not included in this new opt-out system, they are going to continue to be disadvantaged, and we will not know if their rights are being upheld. I also noted what you said about safeguards and informal patients being subject to those. Thank you for raising that as part of the committee. I noticed there was a question on that, which is something we are also concerned about. We could provide more detail on that as well.

Q127 **Baroness Hollins:** My question was about the concerns that young people have fewer safeguards despite a similar level of restriction between both informal and formal patients. How much of a problem is it? We have been hearing about advocacy and advance decisions. Is there any way the draft Bill could address this issue, do you think?

Dr Susan Walker: In answer to your question, "How much of a problem is it?", like Charlotte said, we genuinely do not know. The number of people who are in hospital informally and formally varies, depending on where you look at the data, from about 88% of people being sectioned to 30% of people being sectioned. We just do not know how many young people are being detained and how many are not. We do not know how much of a problem it really is.

There are several problems here. The Mental Health Act is so stigmatised that people will try to do anything not to be under the Mental Health Act, and that includes people agreeing to come in or wanting to use parental consent. As we spoke about earlier, we do not have enough evidence on what young people's experiences are of being in hospital, either under the Mental Health Act or under parental consent. We do not really know what the outcomes are. We do not really know how much of a problem it is.

In terms of further safeguards, yes, advocacy is one. It is really key to ensure that the advocates are properly trained in child and adolescent mental health care and mental health law, because it is different from adults. We hear from young people that sometimes the advocates they see are brilliant and lovely but do not have the necessary experience or knowledge because they have not had access to that training.

Carolyne Willow: We obtained the data that I referred to through the Freedom of Information Act, which we have to do to get the information.

There is another potential vital role for independent advocates, which is to conduct outgoing interviews with children as they leave services to find out what their experiences were in that particular setting. That could also be extended to their parents or those with parental responsibility if the child is in care, and/or the nominated person. The reason that is vital is because, too often, we end up hearing about the dreadful, chronic failures when a child dies or has been seriously harmed, and it is in a coroner's report, a serious case report or, for example, the three investigation reports that came out last week.

If it was routine, when a child moved from one in-patient service, hospital or unit to another, or when they were discharged, for the independent advocacy service to have—"exit interview" might not be the right terminology—structured time with the child and those who love and care for them, to hear about their experiences within that setting, that could be really vital for the safeguarding of that individual child but also other children in the environment.

The other aspect is looking at the Care Quality Commission. Is it required in law to attend to and monitor human rights breaches? We would like to see the Care Quality Commission explicitly making reference in its inspection reports to that to give some assurance, or not, to the public and to families that it has assessed the extent to which the human rights of children in that setting are being upheld and respected. That would be accountability because, again, too often scandals erupt and people ask, "Where were the inspectors? Why were families not listened to?" Investigations are carried out and families say, "We have been trying for years to get somebody to listen to us".

> **Chair:** That bring us on quite neatly to the question on nominated persons.
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> **Baroness Berridge:** We have two groups here. Those above the age of 16 can choose a nominated person if they have capacity. Should there be any additional procedures in place to ensure that that choice does not disadvantage them? If the child does not choose their parents, as somebody has alluded to already, how would the rights of the nominated person then interact with the rights of the parent, the guardian or, as you might say, the local authority, which might have parental responsibility? That is, first off, for those who are over 16.
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> Then, we have had concerns about potential safeguarding issues in allowing a child under the age of 16 to choose a nominated person, even if they have competence, and what could be done to mitigate those risks. I am particularly interested in this interplay with parents' rights or the local authority, if it has parental responsibility.

Charlotte Rainer: On the previous question, something was not mentioned around statutory care and treatment plans. The White Paper said that they would be put on a statutory footing for under-18s who are informal patients. We are not clear what that statutory footing is. At the moment, it has not been clarified by the Government, just to raise that point with the committee. Further clarification is needed as to where those care and treatment plans will sit.

To your question on nominated persons, for over-16s and over-17s, that is something we have concerns about but have not looked at particularly in the same way as we have for under-16s. We will get back to you on that. As far as I am aware, the nominated person should not impact on parental responsibility or the person with parental responsibility, as they are two separate roles, but there are concerns about how they work together and interact with one another. I am sure the other panellists would be able to respond to that.

> **Baroness Barker:** Is that how it works in practice, though? If somebody has somebody with parental control, would people automatically assume that they also need a nominated person?

Dr Susan Walker: Normally, the nearest relative would be the person with parental responsibility, so it would be automatic.

> **Baroness Berridge:** This is quite a big change, then, is it not? If you have an independent advocate—I am just imagining the child in the in-patient setting—that is potentially three adults, or more, if there is more than one parent.
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> **Baroness Barker:** Is it not the reality for most people that, if there is somebody with parental responsibility, they are not going to have a nominated person as well?

Dr Susan Walker: They would have a nearest relative, under the Mental Health Act.

Carolyne Willow: Yes, now it is the nearest relative. It is changing, as you know, to a nominated person. I could not find anything in the Bill that explains the general function of the nominated person. I went back to see whether I could find the statutory function of the nearest relative. That is one thing that could be done: a general, overarching function to promote the rights and interests of the patient. That is one safeguard, which would be there for adults as well as children. There could be a presumption in the Bill that, for a child, it is a person who holds parental responsibility.

> **Baroness Barker:** I am not advocating that it should be one or the other. I am trying to seek clarity. The situation in law for adults, at the time the nominated person came into the Mental Capacity Act, was that there was a recognition that quite often there was conflict and, therefore, people had the right to choose. We got away from automatic assumption of next of kin. I am trying to understand what this is going to mean in practice here, but also what the practice is now for children.

Dr Susan Walker: Now, it would just be the nearest relative. What young people are saying is that they really like the idea of being able to choose someone. Lots of them have said that they would probably choose their parents anyway, but certainly one person said that they would like to choose a teacher because their parents do not really understand mental illness.

There will be some situations where people are scared of their parents and there is abuse. At the moment, we can displace the nearest relative if that is the case, but this would allow the child or young person to say who they want to be their nominated person. It is a very positive change, really, and it should be available to people of all ages if they have the competence or capacity to make that decision, but it is complicated.

> **Baroness Berridge:** That is how we hope it is going to work, but we know about high-profile cases—I am struggling for clinicians, in this situation—where you have a nominated person and a parent. As far as I understand this Act, nothing is changing in regard to parental responsibility. It may be that we just need to ask some lawyers to help us here. What is going to be the situation if there is a conflict with a nominated person, or the child is competent to consent and the parents are objecting? Physical health wards have this issue, up and down the country, of conflict between what the parents want and what the clinicians want. Obviously, the high-profile ones end up in the situation we have seen.

Dr Susan Walker: That is my concern, too. In practice, how does it work and when does this decision get made? Is it at the point of the Mental Health Act assessment? At that point, I imagine the young person might be too unwell to have the competence or capacity to make that decision, so then the AMHP will have to nominate somebody themselves. What list do they use? How do they make that decision? When does that change and when do you have the discussion with the young person about who they want to be their nominated person? Has somebody already been allocated? Who does that and how is that done?

One option, as you suggested, would be that, by default, it is somebody with parental responsibility. It could then be talked about with the young person afterwards, with some support from an advocate. It would probably have to be a very honest conversation about, even if you choose somebody else, how much information can still be shared with your parents as they still have parental responsibility.

> **Dr Ben Spencer:** I am just thinking through where this might go really wrong. You gave the example of where a child might choose one of their teachers. There is

nothing wrong with teachers—they are fantastic—but just imagine the scenario where a child chooses a teacher and the teacher is in complete conflict with the parents. The teacher, as the nominated person, decides to exert their rights to discharge the child, as under Section 3. Where is the kid going to on discharge?

What are the rights of the parent who has parental responsibility, especially in terms of safeguarding, when their child—who, by definition, the doctors think is unwell, which is why they are under Section 3—goes back into the community? In my head, it goes to an Article 8 rights challenge. From your perspective, do you think it has been thought through in terms of how this might play out in reality? What do you think could happen?

Dr Susan Walker: No, it feels like it needs a lot more thought to how it is going to work in practice. It is true that there is potential for some very complicated situations. Going back to the idea of introducing a duty on improving family relationships, that could perhaps mitigate some of these difficulties. It might help parents support their children. It might help young people feel that their parents should be their nominated person. However, it needs a lot more thought as to how it would work in practice, particularly in terms of that conflict potentially between those with parental responsibility and a nominated person.

Baroness McIntosh of Hudnall: In view of what you have just said, Dr Walker, do you think that this provision should be in the draft?

Dr Susan Walker: It is a very positive thing. Young people have said that they really want it.

Baroness McIntosh of Hudnall: I understand that, in principle, you think that it has potential to be very positive. Is it your view that, as things stand at the moment, with most of those issues that we have just had outlined to us unresolved, it is wise to leave that provision in the draft Bill? I am not trying to catch you out.

Dr Susan Walker: I might have to go away and think about that.

The Chair: I think you are saying, if I may, that it is a good idea in principle but it has not been sufficiently thought through. There are possible unintended consequences. If anyone could produce a solution, while we are continuing with our deliberations, we would be enormously grateful if you could write to us.

Baroness Barker: My question was about what happens in practice. How many of the young people you know about actually go into informal arrangements with people who are not their parents? It could be grandparents, aunts or whatever. It would be interesting to know what is really happening—whether this is happening informally and, by having it in the Bill, we are formalising it and better able to monitor it.

Dr Susan Walker: It would be great to know that. We just do not have that data. There is a little bit of published data on nearest relatives for adults, but it is a very complicated role for parents and it is very difficult.

The Chair: Time and again, through our deliberations, we have heard of the lack of data across the piece. It is something that I am sure we will be referencing in our recommendations. It is unsatisfactory, but thank you so much because it is important that we raise these questions and try to seek solutions.

Q128 **Lord Bradley:** Carolyne, you mentioned earlier children on adult wards and out-of-area placements. On the first issue, your organisation recommends a new clause rather than the code of practice. Would you like to elaborate on that, even say precisely what you think the new clause should say? Secondly, the independent review recommends reducing the time for reporting out-of-area placements from 48 to 24 hours. Do you think that will help the situation or should there be further steps on that matter?

Carolyne Willow: I remember the fanfare when the provision was put into the Mental Health Act in 2007 following lots of work by the first Children's Commissioner for England, Sir Al Aynsley-Green. It was put into primary legislation that hospital managers must ensure that children are in suitable environments for their age. The data we have supplied to your committee shows that that has not achieved its goal.

There is no other setting—be it prisons, children's homes, residential special schools or boarding schools—where children and adults are in close residential proximity. It is in breach of Article 37(c) of the United Nations Convention on the Rights of the Child, which prohibits the detention of children with adults. It was that provision in the convention that got children out of adult prisons back in the day.

For us, we are 15 years on. It was the scandal of all scandals in 2007, which is why it was put in the legislation then. That has not worked, so why not go for a straightforward prohibition with a caveat, which you would always want, of "unless it is demonstratively in the child's best interests"? Unless it is a clear prohibition in the Bill, it will just continue. Unless Ministers, budget holders and senior decision-makers know by law that they cannot do this, it will continue.

In terms of reducing the timeframe for the CQC to be notified, I see that as an administrative data collection task. It is really important—we have already talked about all the gaps in data collection—but it is not a safeguard. For children in care, it is in their primary legislation. Section 22C(8)(a) of the Children Act 1989 has a legal presumption that children are placed near to their home. Why can we not have that presumption in mental health legislation? I can tell you that, in children's social care, it is breached regularly because there is always space for manoeuvre in legislation, as you know, but the presumption is there. It is a really important presumption.

I did not say this earlier, when we were talking about advocates, but my charity runs a network of more than 400 advocates, in all different settings, who work directly with children and young people. Part of our work with advocates is to give them legal information when they are working directly with children. They come to us and say, "I have this child who this is happening to. Can you give us legal information? What's in law and in statutory guidance that will help this child?" If that was in the Bill, both a presumption that those children would be near to home and a prohibition on them being in adult mental health settings, that would really help.

Sir Charles Walker: Chair, it is really important that that is reflected in our report and becomes a point of debate in both Chambers. Out-of-area placements of children and the placing of children on adult wards have certainly been raised in our Chamber—I cannot speak for yours—on numerous occasions, by Alan Johnson before he left the House, by me and by many other colleagues. When we come to debating this Bill as it progresses through both our Houses, we really want to make sure that this point is reflected.

Dr Susan Walker: That fits into what we were saying earlier about these children who are deprived of their liberty. For all these children placed in inappropriate settings, whether it is an adult ward, an out-of-area placement or a paediatric ward, we are really struggling to get this data. It is really bad for the children and their outcomes. It is not appropriate.

Carolyne Willow: Mental health wards, as you know, are really frightening places. People are shouting; people are screaming; people are out of control. If that person who is shouting and screaming, "I'm going to kill you, I'm going to do this to myself, I'm going to do that to somebody else", is aged 40, 50 or 60 and you are 14 years old, that is terrifying.

Chair: Charlotte, you are nodding. I assume you thoroughly agree.

Charlotte Rainer: Yes, I wholeheartedly agree with this. It is government policy that under-16s should not be placed in adult wards. It is part of the current code of practice, but the recent CQC report on the state of health and care shows that there has been a 30% rise in admissions to adult wards for under-16s. It is a real issue and it comes back to what we were talking about earlier: the code versus legislation. Protecting these children in legislation is really crucial.

Dr Ben Spencer: In drafting terms—because this was going to be in the Bill—of course, when children hit the age of 18, they get transferred to adult wards. I am just wondering how, in the law, you would manage that transition. I know what used to happen: "Happy birthday, you're now 18. Off you go to the adult ward". That is not a great transfer of care. It is not a great experience for the child, or adult, going through that. How could you make sure that there is sufficient flexibility to take into account good patient care, while at the same time giving the protections that you want?

Carolyne Willow: We could suggest a clause, which would be a brand new clause from this committee, I hope, on the prohibition around adult wards, but then you could improve current legislation in terms of the correct environment for their age. You probably know this but, in child prisons, there is provision now for children to stay, if they are serving longer sentences, to the age of 18 because of the very issues you have just raised.

Dr Ben Spencer: That is the other thing. If you have somebody who has one week left before you can discharge them, that is not very helpful.

Carolyne Willow: Coming back to the three investigations I referred to, the girl who died two weeks into being 18 had just been moved to an adult mental health setting, having spent several years in child mental health settings.

Dr Susan Walker: There is a movement that CAMHS should be nought to 25 anyway. Perhaps over time we will be able to have wards that are just for adolescents or young people, which would help avoid those cliff-drop transition points.

Lord Bradley: Age is not always the best indicator of maturity.

The Chair: Thank you very much indeed. Sadly, we have run out of time on this incredibly important subject. I am extremely grateful to all of you for your contributions today, which will play an important role in our deliberations. Thank you for your time.