

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Tuesday 15 November 2022

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Written evidence from witnesses:

- [Law Society \[MHB0037\]](#)
- [Dr Judy Laing \(Professor of Mental Health Law & Policy at University of Bristol Law School\) \[MHB0080\]](#)
- [Justin Leslie \(Mental health lawyer and former parliamentary counsel\) \[MHB0082\]](#)

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

Questions 129-137

Witnesses: **Kirsty Stuart**, Chair of Mental Health and Disability Law Committee, Law Society; **Professor Judy Laing**, Professor of Mental Health Law and Policy, University of Bristol; **Justin Leslie**, mental health lawyer and former parliamentary counsel.

Q129 The Chair: Good afternoon and welcome. This is the ninth oral evidence session of the Joint Committee on the Draft Mental Health Bill. The aim of this session is to hear legal perspectives on the proposed changes to the draft Bill, to support the discussion and consideration of possible recommendations to make. I start by welcoming the panel of witnesses who have come here today. I kindly ask you to say who you are and whom you represent.

Professor Judy Laing: Thank you for inviting me here today. I am a professor of mental health law and policy at the University of Bristol Law School. I have a long-standing interest in mental health law and have carried out quite a lot of extensive research—from an academic perspective, not as a practitioner. I am also on the CQC’s Mental Health Act monitoring committee as an expert adviser, so I have experience in that context as well.

Justin Leslie: Good afternoon. I am a mental health lawyer. I am in private practice now but I previously acted as parliamentary counsel to the Government where I drafted Bills for the Government, including in the areas of mental health law and healthcare law more generally. I am able to comment on the Bill from that perspective, as well as from a practitioner’s perspective.

Kirsty Stuart: Good afternoon. I am a solicitor in private practice but I also chair the mental health and disability committee, on behalf of the Law Society. The Law Society's members play a crucial role in the mental health system in terms of representation at mental health tribunals as well as being tribunal judges. The Law Society also has the mental health accreditation, which is recognised.

The Chair: Thank you very much. What would be the main benefits and challenges of including the independent review principles in the draft Bill? If included, should they be declaratory only or should specific duties be attached to them?

Justin Leslie: We were actually having a discussion about this in the corridor; it was creating some difference of opinion. First, I do not think anyone would argue that a modern mental health law should not embody the principles set out in the review. The question for me is how they are given effect. Whether they are in the Bill is almost not the question because, if the Bill gives effect to them overall, we could look at the legislation and say, "Yes, this is achieving choice and autonomy, least restriction, therapeutic benefit and so on".

The problem is that the Mental Health Act is a 40 year-old piece of legislation. It was drafted a very long time ago in a very different environment and has been chopped and changed somewhat over the years. It would be a chop and change too far, in my view, just to put the principles in the Bill unless we are clear about what they are doing. You could have principles that form the basis of some sort of duty to have regard to them when making decisions under the Act. How that flows through to every single decision that can be made under the Act is a complicated question.

It does not surprise me that the Government took the view that going through that exercise may result in an amended Act that is more difficult to navigate overall. There are a lot of things in the Mental Health Act that are aimed at very different things. There is the key distinction between Part II and Part III patients but there are things in Part VI about the transfer of patients around the UK. People do not really talk about that much but how the principles would interact with that part is not clear to me.

If you think about the principles in declarative terms only, it is quite difficult as well. Putting things in legislation that are not intended to have much effect legally creates risks because, at some point, a court will look at them and say, "Perhaps they do have an effect". From the Government's point of view, having things in legislation where their meaning is unclear and waiting for them to be adjudicated by a court increases the risks of things going wrong in the future.

I was interested when the Government indicated that they were going to put the principles in the Bill initially but then I was not surprised that, when the draft Bill was published, the principles were not in the Bill. It seemed to me to be quite an exercise, and perhaps not for that much gain, to insert principles at the front of the Bill. I am not suggesting that there can be no benefit to inserting the principles. In fact, if you work them through the Act and make all the adjustments needed—all the nips and tucks required to make them effective—you may well be able to justify having a clause of that nature.

My view, on balance, is against including such a provision at this stage. There may well be differences of opinion on this panel.

The Chair: Could we hear a difference of opinion?

Professor Judy Laing: Yes, we were debating it outside. From my perspective, this is a bit like history repeating itself. I was a younger academic when we had reforms the last time round. I know that the Richardson committee recommended putting the principles in the same way in the Act but the Government at the time did not agree. Look where we have ended up: with legislation that does not fully respect the rights of the people who are subject to it.

I get the logistical and practical challenges but we are not going to be looking at mental health law again for a while. Human rights norms and expectations have moved on considerably since we last looked at this. If we really want to focus people's attention on rebalancing the relationship between clinicians and patients, we need to put that front and centre of the legislation. As I am sure you have heard from other witnesses, the reality is that the CQC looks at these as part of its monitoring role. The evidence suggests that patients are not involved in their care in the way they should be and the principles are not well understood and not applied.

I was having a look. The first edition of the code of practice in 1993 had 135 pages. It has now swollen up to 459 pages in the latest edition. That is a lot of heavy lifting that the code has to do, literally and metaphorically, in terms of what the expectations are. Putting the principles in the legislation—particularly that focus on choice and autonomy, which is where we need to rebalance—will send a much more powerful message.

These principles were co-produced with people with lived experience, which is very symbolic and highly significant. They would make the legislation clearer in terms of how it applies, provided that you can deal with the nips and tucks that Justin was talking about, and would bring it into line with international human rights norms more closely. However, I realise that there are challenges.

I have quite a lot to say about this but I know that there is not enough time to talk to you about it in depth. I carried out some collaborative research with approved mental health professionals around their knowledge of the nearest relative provisions. They admitted to us, in our interviews, that they do not really look at the code of practice. There is quite a lot of detail there about unsuitable nearest relatives et cetera but they did not find it very helpful. They tended to look to each other for guidance, rather than the code.

We have to recognise that, even if you put something in the code, it is not necessarily going to influence behaviour in the way we would perhaps like it to. I guess it does not have the same legal force but, if we put it in statute, the CQC might be able to hold providers to account a bit more. We might be able to complain a bit more around the fact that those principles have not been followed if we give them legal force.

If we look at other statutes that the professionals in this area are having to use on a regular basis, the Care Act has principles enshrined, as has the Mental Capacity Act. I know that, initially, the culture change did not happen as quickly as we would like but the law can nudge people. It might not bring about wholesale reform but it has a real expressive and symbolic function. This is a once-in-a-generation opportunity to reform the law. We should grasp what we can to try to push it in that direction.

That is an academic perspective on this but, in reality, it draws on evidence of how practitioners and people who are subject to the Act try to navigate a 459-page document. There is evidence that patients and their families do not really understand or know the code of practice. They might be more inclined to understand and appreciate the role of those principles if they were in the Act.

The Chair: Kirsty, which side are you on?

Kirsty Stuart: The Law Society recognises the difficulties of introducing statutory principles and how that may be challenging, in terms of needing significant changes to the Mental Health Act. Our view is that there are positive arguments for including the guiding principles in the Bill, such as giving more force to them and better enabling patients to have their views and choices respected.

Having them in the Act would also allow for ease for lawyers practising. From a member's perspective, that is definitely something that members would rely on in the same way that they can with the Care Act principles, for example. Having them front and centre, not hidden away in other parts, is potentially an advantage on that, albeit, like I said, we recognise that it may well also be difficult and challenging to do.

Baroness McIntosh of Hudnall: I listened very carefully to what you said. I understand that there are practical difficulties. What you seemed to be saying—forgive me if I have misunderstood—was that it is probably not really worth doing the work that needed to be done to embody them in the amended law that is now being proposed, because it perhaps would not really make that much difference. You know that the Mental Capacity Act and the Care Act have the principles on the face on them. You would no doubt argue that those were there *ab initio* so that is helpful, but would you say that those laws are improved by having the principles in them? Or would it not be a big problem if they were not there?

Justin Leslie: I work with the Mental Capacity Act as well. It would be right to say that the principles in that Act do not necessarily intrude too much on the day-to-day operation of it inasmuch as you know roughly what the Act is about but, when you are dealing with a particular provision of it, you are dealing with that particular provision and trying to figure out exactly what is required by it. Treatment under Section 5 of the Mental Capacity Act is a narrow code for what you can and cannot do under that particular provision. The principles do not really decide one way or the other in many cases; that is the practical experience of working with an Act such as that.

Having said that, the Act itself is well constructed. As a reader reading it, it flows very nicely. You can understand it by going from Section 1 to Section 2 to Section 3. You are guided through it. As a reader, it is a nice Act to read. As a practitioner, however, we do not spend all our time discussing the principles in Section 1. We spend our time discussing what the main operative parts of the Act can allow. My concern about taking an approach such as that into the Mental Health Act is that it may not necessarily make much of a difference.

There is an assumption there about what exactly the principles would be doing in the Mental Health Act. If they were there as principles to which decision-makers had to have regard when making their decisions, it may be that that would have a practical effect because, when

challenged in court, for example, a decision-maker would have to show that they had had regard to the principles.

The Chair: If I could just interrupt you there, we know that clinicians must have regard to the code of practice under Section 118. Trying to shortcut it a bit, do you feel that that would be sufficient in terms of ensuring that there is enough regard for those principles in the code?

Justin Leslie: In terms of the legal effect, yes. In terms of some of the effects that Judy was talking about, I can well understand that a reader of the Mental Health Act might prefer to have these principles up front in the very first provision of it. That may well create a benefit from that point of view but how it would decide individual cases is more up for debate, I would say.

Baroness Berridge: We often have this argument in the House of Lords: in the Act, in statutory instruments or in codes. Professor Laing, is there any research? I was talking to a registrar-level psychiatrist who was saying that they do not read the Act. Do you have any research as to how many clinicians actually read the Act?

Professor Judy Laing: This points to training and how well trained psychiatrists are. I know that there is a debate about the advance choice documents, which we may get on to later. I was reading some research, if I could draw on that, that points to the quality of training—or lack of training—and awareness of advance directives and planning among psychiatrists.

I know that there is approval status for an approved clinician but I do not know how heavily those kinds of areas feature in their training and whether they are foregrounded as much as they should be. Certainly, in terms of continuing professional development, it raises awareness about that. I know that this is another issue that probably arises at this time. There is going to be a whole load of new training. This is a really good time to reset the dial and think about what awareness levels there are. I am not aware of any research specifically about the law but about different aspects of it and how those are applied in practice.

Can I just come back on the point about the Mental Capacity Act, relating to your question? I am aware of research that suggests that the Mental Capacity Act principles inform healthcare decision-making among professionals. Their awareness is perhaps stronger. I guess the argument is that they have grown up with those principles in the Act, so the challenge is around putting them in retrospectively. We are not going to get an opportunity to do this for quite some time so we need to look more broadly at what we want to achieve from this legislation. If we really want to rebalance, I do not think that tinkering around the edges with these bits of provisions will necessarily achieve that result unless we send a strong message about where we feel that balance should be.

Q130 **The Chair:** That is very helpful, thank you. When considering a rights-based approach to mental health care, would legal rights in community care rebalance a right to treatment and care that is currently available only under the Mental Health Act? Would this be possible in future legislation?

Professor Judy Laing: I have an interest in human rights as well as mental health law; that is how I tend to look at the law. We need to look at what a human rights-based approach to mental health looks like. To me, that is anchored in a system of rights and corresponding state

obligations, which I guess is established by international and European law. You would then be looking at the full range of civil, political, cultural, economic and social rights. A human rights-based approach also recognises the importance of capacity development and time to allow these things to happen.

Logically, if we want a truly human rights-based approach, we should be looking to address those deficits. I know you have heard a lot about the need for earlier intervention for prevention. The Mental Health Act is, essentially, a reactive, crisis-driven piece of legislation that comes in right at the end so there is perhaps a limit to what we can achieve, but we could try to redress the balance and put in place duties elsewhere. Of course, at the moment, the Care Act imposes a preventive duty to address the health needs but that is from social services and local authorities, not in a health context. We might want to think about whether we could do that elsewhere. It might not be the right place to do it in the Mental Health Act, given the framework that we have.

You may have heard evidence about the Mental Health (Wales) Measure. That has tried to achieve this by putting pressure on health services to respond to and address needs in the community. At the moment, you have a right to that treatment only once you are detained and then in the aftercare. There is nothing there to impose that positive obligation for intervention earlier in the process, if that helps.

Justin Leslie: I am fully supportive of a human rights-based approach towards mental health law and seeing what can be achieved through that, but it is important not to have a discussion about rights when what we really want is to have a discussion about resources. Having a discussion about whether there should be a right to community mental health services, for example, does not avoid the fact that more funding and more resources are required and would be appreciated by those who work in that area.

There is always a limit to what legal rights, particularly those of a socioeconomic kind, can achieve. It almost comes back to the discussion we were having previously about principles. Although you might see some benefit in having a right to certain forms of mental health services, the point is whether they are actually being delivered; that is a question of resources, really. There is already a complicated system under the NHS Act for how mental health services are commissioned. I do not know whether picking out community mental health rights is consistent with that approach to commissioning. I suggest that it would start to fragment that approach. I note the approach that has been taken in Wales but whether that has had tangible effects and benefits for the people who need community mental health services remains to be seen.

The Chair: I am particularly interested in the point you make about resources because we were discussing this. It is one of the reasons—I am sorry—we kept you waiting. It is about how we make this happen in a way that respects the fact that it is manifestly a resource issue as much as anything else. We are talking about primary legislation here, so how do the two conflate? It is quite difficult.

Justin Leslie: It is a very difficult question. When I worked at the Law Commission, we would undertake projects in areas of law and would often come up against this problem. You can refine an area of law and make it efficient and user-friendly—the Mental Capacity Act is quite a good example of that—but, if it is not funded properly, giving effect to those rights is

always going to be a challenge. It raises the question about the value of the project as a whole.

A real challenge for this particular draft Bill is that giving effect to it will incur costs. That is recognised in the Government's impact assessment, which was drafted in a slightly different world to the one we live in now. The Department of Health and Social Care is going to have its work cut out to get the money it needs to implement this Bill in full; I am sure you will hear more from it about that in due course. We are discussing the Bill but, as you say, an elephant in the room here is the resource question.

Lord Bradley: You were saying that you have considered these issues before in previous legislation. Did you come up with any tentative solution to that linkage between the legislation and resources in terms of a formulation in the Bill and how you would address it?

Justin Leslie: No, because the way that government money is funnelled into departments is not through individual pieces of primary legislation; it is through the supply process. It would not really work, given how government funds itself.

Lord Bradley: So there are no examples of where a lever was placed in primary legislation that had an effect on resource allocation?

Justin Leslie: The simple answer to that is no. In other projects I work on, the focus is not necessarily about increasing the amount of money available; it is about making the legal framework as efficient and user-friendly as possible.

Lord Bradley: That is sort of a lever, is it not?

Justin Leslie: It is, but that is about making the best use of the pie you already have. Part of the conversation we are having is about how the pie is going to be made bigger to achieve some of the things that the Bill contains within it, particularly when it comes to the tribunal. That is a funding question for a department that is not the Department of Health and Social Care.

Kirsty Stuart: I have one point to make, if I may. It is about the resources of lawyers in terms of our members, if we are talking about community services and access to justice. At the moment, when you are talking about supporting aftercare services, they are covered under legal help, legal aid and community care contracts, so by community care lawyers. That would also need to come into consideration if we are thinking about different things in terms of community aspects.

The Chair: That is helpful.

Q131 **Baroness Barker:** Following on from that, the independent review recommended that mental health tribunals should be able to look at appeals on treatment decisions, but that is not in the draft Bill. Do you think that tribunals should have that power? How do you think it will work?

Kirsty Stuart: The Law Society endorses the need for a proper route to challenge treatments, independent of medical professionals, as a matter of access to justice for individuals.

However, we question the effectiveness of the proposal that a mental health tribunal judge sitting alone should be able to order that specific treatment is not given.

If that is the process and there was remit for a decision back to the responsible clinician for reconsideration, the Law Society's view is that it would provide a very limited form of redress, which may prove unsatisfactory for the patient and their confidence in that decision. It could also create negative feelings from the patient towards their representative, due to them not being able to get exactly what they are trying to achieve— ie a different decision— but also towards the tribunal judge. Therefore, it could have an impact on the way patients feel about tribunals in general.

There is also a concern from lawyers who practise in the area around resourcing, not only for lawyers with appropriate mental health law contract and experience but also for tribunal judges themselves. This would have a knock-effect on access to justice in general for those detained. As part of that process and proposal, we would consider it important to look at the resourcing of all the different areas within that.

Baroness Barker: That leads me on to the next question, which is about the draft Bill providing that the county court, rather than the mental health review tribunal, should have jurisdiction to overrule or displace a nominated person. Should the tribunal have that power?

Kirsty Stuart: The Law Society takes the view that the mental health tribunal, or the Mental Health Review Tribunal for Wales, has the expertise to manage those sorts of things. We think that representation in such proceedings should be funded on a non-means-tested legal aid basis, in line with other tribunal proceedings akin to those, to ensure access to justice. That is the point we wanted to make on that.

Professor Judy Laing: We talked about this one outside as well. We did not rehearse and agree to agree; as you can see, we have disagreed about some issues. I do not see any reason why the mental health tribunal should not have this power, apart from the obvious one of increasing the workload. It is a specialist tribunal that has expertise. Often, these hearings take place in hospital so it is more accessible in terms of access to justice, certainly for those patients who are subject to detention. I am not quite sure how it would work for people who are in the community.

I tried to do some research into the Section 29 power and county courts before I came. There is very little out there about how it all works. It is rare. It tends to take a long time, which is particularly problematic if it is an urgent issue. That raises questions about the extent to which Article 5 rights have been breached if somebody is in detention and this is ongoing around that issue. I do not see a problem in theory, subject to those kinds of issues around workforce capacity et cetera.

Kirsty Stuart: To follow on from that, from a practising perspective, these kinds of applications within the county court are really rare, from what we see on the ground and what members tell us they see. As a lawyer practising in this area, it is difficult when you come across these applications to get to the bottom of some of the forms. It is more the practicalities of actually doing it that can make it quite challenging, not only for lawyers but for professionals who have to go through the process of going to the county court. The

tribunal system is perhaps a lot more accessible, not only to lawyers but to professionals, in that way.

Dr Dan Poulter: On that, when we are talking about the issue of potentially displacing the nearest relative, the medical and other healthcare professionals on the ward often need to build therapeutic relationships with not just the patient but the wider support network. Do you feel that, perhaps putting the other side of this, there is also a case that it makes it more difficult to challenge where an inappropriate nearest relative may be being put forward if that sits within the tribunal setting? That could disrupt some of those therapeutic relationships or make it more difficult for those professionals to be straightforward in airing their views or, potentially, concerns.

Kirsty Stuart: It is very difficult to know until we are in that scenario, but I think there is a risk of that. Think about the accessibility of a tribunal versus a county court to an individual, in terms of access to justice, knowing that they can do it and for their family members. Whereas in other proceedings, such as Court of Protection proceedings, you often find litigants in person, to go into the county court as a litigant in person would be rather intimidating and difficult. It might be quite tricky for the person to attend.

Dr Dan Poulter: How would you suggest that that could be in some way disaggregated from the hospital complaints process? For example, following your logic—I take your logic—the healthcare professionals may be more concerned in a tribunal setting, in terms of the way that has been carried out, about being as straightforward and open about things, which may well disrupt therapeutic relationships. There is also the risk that, if they say something that the relatives dislike, or the nearest relative dislikes, a complaint will be put in about their conduct in the tribunal where it is conducted within that hospital setting. I wondered how you might suggest that we mitigate against that concern creeping in.

Kirsty Stuart: It probably happens in any event. Any time that family members are part of a system, across tribunals in general, there will always be that issue. There has to be a complaints procedure and process that families are entitled to and allowed to go through in order to express their views. I am not sure exactly how you would go against mitigating it in the particular circumstances of this. As it stands, I have not heard from a lot of members that there is the issue of an increased level of complaints in tribunals.

Dr Dan Poulter: I suppose that, by having a county court deal with it, there is a separation from the hospital and the ward. Also, in the time it takes to get to that point, the issue can often be resolved because the patient has already left hospital or other things may have taken place to mean the situation has resolved itself. There is a difference because they are often quite emotive issues, particularly when it is about displacing relatives or appointing nearest relatives. I wonder how we can make sure that we allow the independent professional voice to still be heard effectively and allow that separation, which perhaps the county court system allows a bit better.

Kirsty Stuart: I am not sure.

Professor Judy Laing: The research I am aware of around tribunals suggests that the views of the clinician, the medical professional, have a lot of respect in that process. I cannot see why that would be any different in relation to these kinds of decisions as against appeal decisions, in terms of cogency and weight of evidence given. That points to some research I was looking at in relation to patients' experiences of tribunals, where the evidence suggests that they often feel that their voices are not heard as strongly as perhaps the clinicians and other people.

Again, it is about rebalancing the relationship and thinking about where we want to put the emphasis. The problem we have is that this Act tries—I think there is a famous quote by Brenda Hale in her textbook—to serve a shifting mass of conflicting interests, with families, patients, professionals, being clinicians, lawyers and social workers, all coming from a different perspective. Principally, as a human rights lawyer, I would like to see the patient's interests at the heart of this and put at the front. I understand, in the context of a tribunal, that the tribunal would be able to respect the evidence put before it in a similar way.

Dr Dan Poulter: I understand what you are saying. I am sure you did not mean that to sound disingenuous to professionals. We hope that professionals would always have the patient's best interest at heart; I am sure we all agree on that.

These particular issues around the appointment and displacement of nearest relatives can sometimes be very complex and emotive. It is about how we ensure that healthcare professionals can speak without having their professional integrity compromised by fear of damaging therapeutic relationships or potentially being subjected to other parts of the hospital process, such as the complaints process, more readily because of how it is conducted. I wonder whether you can see a way, if we were to go down that route and move to tribunals, of protecting that independent professional voice and making sure that professionals feel emboldened to speak in the best interests of patients, no matter what the consequences may be.

Professor Judy Laing: I did not mean to suggest that you do not do the best for your patients. I am sorry if it came across that way. I was just trying to say that I understand that we have to balance all these competing interests. I am not sure whether I really know how to answer that question. I am an academic lawyer, not a practitioner. I do not work in tribunals. I do not know how that would differ from the appeal process scenario, where nominated persons and nearest relatives are also potentially involved. You have a lot of different people in the room.

I think you are probably speaking from your experience of having to work in that environment and confront those kinds of challenges. I am not sure where this proposal came from, really, in terms of where we go and what the advantages would be, other than those access to justice-type advantages. Perhaps the impact on that therapeutic relationship has not been thought through. For me, it is about access to justice and making sure that patients, as well as families, feel that they are in a place where they have access to that justice. Clearly, at the moment, the low numbers and lack of awareness about the county court suggest that it is not working for whatever reason; maybe we need to try to tweak it. I hope that helps.

Justin Leslie: On this point about the county court, when reading the Mental Health Act, it strikes one that one suddenly comes across a reference to the county court as a forum. It makes one wonder why that is the case. I do not think that, between us, we have discovered a

particular reason why the Mental Health Act referred to the county court when it was originally enacted.

I would venture to suggest that the Act tries to be protective about what the tribunal does. Its role is quite limited. It plays a very important role in terms of discharging patients and so on but that is quite a limited role. The resources it has available to it are limited as well. As we heard, these sorts of disputes about nominated persons and so on can be quite involved. They are not very common, but, when they happen, there is potential for them to take a disproportionate amount of the tribunal's time and resources to resolve. It is a question for the Ministry of Justice as to whether it is prepared to move money from one bit of the Courts Service to one bit of the Tribunals Service to allow that to happen. Between us, we have not really come to a rationale of why the Act is the way it is, apart from the one I just ventured.

This point about appeals was quite interesting to me. A concern of mine when I read it was that an appeal is an adversarial process. One thing that we are conscious to try not to do, particularly as practitioners, is to interfere with the clinical relationship that a clinician has with a patient. It is a really important part of ensuring effective mental health care that that relationship is safeguarded as much as possible.

One thing I was reflecting on when my colleagues were discussing the point was that, in the Court of Protection, things are done in a slightly different way. There is a certain category of treatments: serious medical treatments. Before a hospital, takes a step in what it regards as the best interests of someone who lacks capacity, for example, it will seek a view from the court about whether it is lawful to do so. Those sorts of proceedings are not especially adversarial because everyone understands that the reason why the hospital trust is in court is to get the court's approval for a proposed step.

It may be that that sort of approach could be grafted on to the Mental Health Act. You could have a system whereby, particularly in decisions around treatment to be given without consent, there is a certain category of decisions that need court authorisation before the treatment is given. This would follow the template given in the Court of Protection context. That avoids some of the adversarial nature of an appeal as such and may be an alternative approach.

There will be complexities around the edges, of course. One of the main challenges in the Court of Protection field is identifying exactly what sorts of decisions need court authorisation before the treatment is given. It is a pretty effective procedure that most practitioners are quite familiar with so there is a precedent there.

The Chair: That is extremely helpful. We might be looking for more clarification from the Government on this really important point.

Q132 **Dr Rosena Allin-Khan:** Thanks, everyone, for coming. The changes proposed in the draft Bill would result in a widening difference between Part II and Part III of the Mental Health Act. Is this difference in application justified? How might it be improved? What will be the implications of this widening division between Part II and Part III for people from racial and ethnic minorities? Is there anything that can be done legally to safeguard against higher detentions via the CJS?

Justin Leslie: This is another point that we were discussing outside.

Professor Judy Laing: We were busy talking about resources, which are actually far more important.

Justin Leslie: For my part, it is striking how, if it were amended by the Bill, the Mental Health Act would be quite different in the way it treats Part II and Part III patients. That is quite a departure. When one thinks about Part III patients, it is really important that one keeps coming back to the fact that they are patients. They are not prisoners and they are not receiving their treatment as a punishment at all. The reason why they are treated differently, in particular why the Secretary of State's role is so different in relation to them, is that there is a risk element to their treatment and presentation in many cases.

Can the changes made by the Bill be justified? The Government would say yes. We might feel a little more nervous about saying yes to that. I feel it is fair to say that Part II and Part III losing their lockstep will create challenges.

Particularly on this point about how the Act operates in practice in relation to racial and ethnic minorities, I have to say that that is beyond my areas of expertise. We know that the Act and the criminal justice system operate differently for those categories of people. It is almost inevitable that, unless something else is done to try to achieve an equilibrium somewhere, those differences of experience are going to be only more marked.

I imagine that a lot of the evidence you have heard about these differences of experience will have focused on the fact that there is a limit to what the law can do. We have the Equality Act and protections provided by it are relatively strong, but that does not mean that the experiences of racial and ethnic minorities are not different. They are. It is one of those things that, as a lawyer, I feel a bit awkward talking about because it comes down to training and people on the ground doing their best.

Obviously, there will be an extensive exercise of trying to implement this Bill in practice. As Judy alluded to, there is an opportunity there to reset some of the practices that are evident from the data being presented. As a lawyer, I work with these practitioners. I have never detected anything in the individual decisions taken by the people I work with that deliberately or intentionally makes such a distinction between the different types of patients they have, but we cannot get away from what the information says.

It comes down to training. There is a big question for the code of practice. It is a very large document but it is an important source of information for people. When the code of practice is inevitably amended, I would hope that there will be an increased emphasis on this point so that we can begin to tilt that area of practice further towards trying to achieve equality.

Dr Rosena Allin-Khan: You have a nervousness about the widening division between Part II and Part III. That is basically what you are saying.

Justin Leslie: Yes.

Dr Rosena Allin-Khan: You do not really see it as a justified application.

Justin Leslie: If there were to be a justification, it would be about the fact that Part III patients present a risk that is different from Part II patients. I find it difficult to say whether the Government have satisfactorily made the case for that risk justifying the difference of

treatment. You will hear from them in due course and they will make their own case about that.

Dr Rosena Allin-Khan: This is quite important so can I open it up to the rest of the panel?

Kirsty Stuart: From the Law Society's perspective, as laid out in our written submissions, we recommend that the emergency detention criteria should apply to patients in the criminal justice system so as not to have that gap, akin to what Justin was saying. The Law Society recognises the need to protect the public from offenders but we do not think that there is sufficient evidence to create that distinction between Part II and Part III, nor that it would be useful in that way. For example, although patients detained under Part II may not have been prosecuted for a criminal offence, they may have a long history of violent behaviour so they may have equivalent or higher risk levels than a patient under Part III.

To the other point that you were making before, as the Law Society, we appreciate that you have heard evidence regarding those who are more specialised, in terms of black and minority-ethnic groups. The statistics are really clear around that issue. When we look at the stats from 2021-22, there were four times as many black British people detained in hospital and as many as 11 times as many subjected to community treatment orders. There is absolutely a disproportionate number detained and subjected to community treatment orders.

The Chair: Before you come in, Professor Laing, I am going to ask Baroness Berridge to ask a question that might supplement what you are going to say.

Baroness Berridge: We have had other evidence that has made us aware that the whole principle of this for the Part II criteria is to make it harder to section people who are civilian patients. Therefore, the presumption is that the current test that applies is too low so, in Part III, you will have a lower threshold test that does not fit with some of the descriptions about the risk. Can you answer the question but in the light of the fact that it also seems we are going to have an easier test in the forensic patient?

Professor Judy Laing: Yes, in theory. How that works out in practice is, I think, coming in a question later. I get what you are saying; I have been trying to think it through in my head. If the point is that we want to divert those offenders with mental health problems out of the criminal justice system, we should make that easier, should we not? The problem is not necessarily always the criteria. The problem is finding the sufficiently secure hospital bed and arranging that process, as well as perhaps the awareness of Section 35.

I went to have a look at the data. There were four reported instances of Section 35 in the latest data. I do not think that that is a complete set for last year, but I could not understand why that is not happening if the aim is to be moving people out.

If I could expand a little, I think you said "a slight nervousness". You will not be surprised to hear that I would have more nervousness about this. A long time ago, my PhD was looking at mentally disordered offenders and their diversion from the criminal justice system before Lord Bradley's review. I was quite concerned at the time about the number of people in

prison who should not be there, the lack of co-ordination in court and all those sorts of processes.

Things have got better since liaison and diversion schemes but the reality is that, if they are working well, we should not really be seeing what we are seeing in the prison estate and we should not be dealing with this issue. This could potentially be discriminatory. I am not sure that there is a legitimate aim or a reasonable and proportionate response here. I am not sure that that case has been made out. It could create added complexity for professionals and patients. The whole point of this is that you are no longer a prisoner; you are a patient. You are within a mental health framework and you are transferred out. I do not understand why we would have different thresholds depending on where you come from.

The assumption around risk also assumes that everybody who comes from the criminal justice system is there because they have done something risky. It could be that they committed a low-level offence that maybe put them at more risk. Possibly, it could be that they have committed fraud; there is a whole range. That assumption around risk is wrong. Equally, it ignores the fact that risk is a really important factor in civil detention anyway.

I do not think that that really answers your question but I am not sure that it is the criteria that are the challenge—it might be the way that the processes of getting people out and across work—but that depends on evidence around how those sorts of provisions work in practice and are interpreted. Does that help?

Dr Rosena Allin-Khan: That was really illuminating, thank you. I want to supplement the original questions with a further one. The revised detention criteria have led to concerns that people with learning disabilities or autism will be more likely to be detained under the criminal justice system. Is there anything that can be included in the draft Bill to mitigate this?

Justin Leslie: A key distinction about how the Bill operates is that people with autism and learning disability are kept within the Part III system in the way that they are removed from the Part II system. A relatively straightforward way of dealing with that is to remove them from the Part III system as well. That would be my starting point. The Government have made their own decision about why they are treating people with learning disabilities or autism in the way they are. It is part of the picture that Judy is painting about this increasing divergence between the two systems and the problems that that creates. That is where I would start, certainly, in trying to equalise the position across the Bill first.

Professor Judy Laing: I would endorse that. If we do not change the criteria, the reality is that there is that risk. I do not think that we can ignore that. My feeling would be to get parity across the Act as to how you treat people who are, fundamentally, patients in need of treatment. That is probably all I can add on that.

Baroness McIntosh of Hudnall: Can I be clear? I think you, Mr Leslie, are saying that the fact that it is still going to be possible to detain people who are autistic or have learning disabilities under Part III is not only an inconsistency but possibly a latent injustice. If one group of people who suffer from those problems is to be detained and another group is not, that is inherently unjust. I may be putting words into your mouth but is that what you think?

Justin Leslie: Yes. It is clear from what we have all been saying that that disparity calls for some justification; we are not sure what that justification is.

Baroness McIntosh of Hudnall: What if I said to you, “You could mitigate that injustice by not removing people from Part II”?

Justin Leslie: That would put all the groups on an equal footing. As you will have heard, it is a striking feature of the Bill that those with autism and learning disability are being taken out of Part II, which was not a recommendation of the review. That is quite striking to me. I would be very interested to see how that works in practice because someone with learning disability or autism could be detained under Part II if they have another serious mental disorder. I hesitate to say it but, in practice, there might be a temptation to try to find a mental disorder to justify a Section 2 admission, for example, for a certain period. There is that risk.

One thing I would be very interested in having the Government’s take on is whether they would commit to some sort of review mechanism as to whether, after a year or two of the Bill becoming an Act, they can provide evidence that people in that cohort are not in fact still being detained but, if they are, on what basis. There is a real practical question that we do not know the answer to here. Because this proposal has come somewhat out of the blue, given the review, a lot of us in the area are slightly on the back foot here and wondering what will happen if it is implemented.

I would go so far as to say that a statutory duty to review the operation of the Act in relation to those with learning disability and autism might be quite profitable because it would generate information that could be laid before Parliament. A committee of this kind could then meet again in two or three years hence to discuss it and see what has happened in practice.

The Chair: This is touching on an area that, listening to many different witnesses, we have found to be quite fraught. There is a strong concern that people who have autism and learning disability may get pushed into the criminal justice system or the Mental Capacity Act, which has fewer safeguards et cetera. We are asking, “How do we mitigate that?” Is there something from a legal standpoint that could put a shutter down and say, “That’s not possible”?

Professor Judy Laing: We have all gone a bit silent now, have we not? I was thinking about this before I came.

Kirsty Stuart: It is going to be really difficult to know that until, as you were saying, we do a review and figure out whether the numbers have decreased. The number of people who are autistic or have learning disabilities is carefully monitored; we can follow it through in that way. Having that review and getting that further information is something the Law Society would definitely consider to be a positive suggestion, in order to see how that particular cohort is affected in terms of the impact of the criminal justice system.

Baroness Berridge: We have heard a lot about data. Are we really going to be able to disaggregate, in two years’ time, the increase in numbers who have learning disabilities and autism? If they are undiagnosed and in the prison system, how are

we ever going to track these people? Even in the civilian context, staff are going through the process of being trained to diagnose that. Are they not potentially going to be awash in the criminal justice system?

Professor Judy Laing: That would be my worry, given that there are huge gaps around data collection at the moment.

Baroness Berridge: In theory, a review is good, but it will be only as good as the data that exists in two to three years' time, which I am not sure would be good. Is that fair?

Justin Leslie: It is.

Baroness Hollins: Can I just follow up on that? Kirsty, you were saying that there is good data on learning disability with respect to people being admitted. It is being monitored very carefully, is it not? Are you of the view that that data is incomplete?

Kirsty Stuart: It is difficult to know whether it is incomplete. There are people who are misdiagnosed. Some members of the Law Society whom we represent would suggest that that was the case. Quite often, women in particular can be misdiagnosed with different conditions. That is certainly no criticism of clinicians but it appears to be the case. This would be an inaccuracy in terms of data. However, the data is present and is being monitored on its way through by different organisations. It would be as accurate in a couple of years' time as it is right now. It is very difficult, is it not?

Q133 **The Chair:** That is very helpful, thank you. Can we move on to Clause 42? That would remove remand solely on mental health grounds. Some consider that the "own protection" ground should be removed as a ground of remand entirely. What is your view?

Professor Judy Laing: I am not a criminal lawyer. My research latterly has focused on civil rather than criminal law, although I have some origins in the criminal justice sector around mental health. I understand that this stems from the desire to improve the use of remand to hospital for report. It seems that the data would suggest that that is much needed, if the data I saw is accurate.

It is welcome in principle if it will have that effect. Of course, it relies on the availability of alternative provision in sufficiently secure mental health settings. I do not know what the secure estate looks like at the moment in terms of mental health. I do not know whether the challenges are as acute but I understand from some of your witnesses that they perhaps are.

I do not know what the impact of that "own protection" provision will be. I am afraid that I do not have the relevant expertise to comment on that; perhaps Justin or Kirsty might be able to.

The Chair: Before either of you come in, can I add to that? Is it sufficient to impose a duty on relevant bodies to "seek to ensure" that a transfer takes place within 28 days? We are looking at the legal terms. From a legal standpoint, "seek to ensure"

sounds a little weak. Is that your view? This is in addition to the first point about Clause 42.

Kirsty Stuart: This is not really an area of focus in terms of the Law Society's response but, as a general point and on behalf of practising lawyers, we would definitely recommend that a strengthened explanation as to any wording is carefully considered for the reasons you have just outlined there, so that the duty is sufficient for all involved in relation to it. That is probably all I can reasonably add on that point.

Justin Leslie: The language could certainly be toughened up. However, it is important that there is some sort of safety valve. There will be individual cases where transfer within that period simply may not be possible for whatever reason. There may be an issue about finding an appropriate place or that might break down, and so on. The exceptional circumstances provision that is included does provide a safety valve. In terms of the duty, I agree that "seek to ensure" is not "must". That is the word I would have reached for here.

Professor Judy Laing: I have "must" written down as well. I was looking at the evidence around transfers. The criminal justice subgroup of the independent review heard evidence that it takes 100 days on average to transfer from prison to hospital. This is somebody who has been identified as being in need of mental health treatment. I know things have improved in terms of treatment in prison but it is not comparable. This is important but I agree that we need something that is not quite as permissive and loose as what is currently there. We clearly need to define the exceptional circumstances as well so that it is clear what that safety valve embraces.

Lord Bradley: I was just going to ask that question on exceptional circumstances. It can be used as a safety valve but it can also be used not to do something. It absolutely needs to be more substantially defined. Is there any alternative wording that you would suggest? Would you just put it in the code of practice or some other vehicle to ensure that it is used reasonably?

Justin Leslie: You could have a definition of what "exceptional circumstances" include in the clause. For example, it could include the bed in a particular unit becoming unavailable or not being available in the first place. Whether that is best in the code of practice or in statute is perhaps a bit of a judgment call. Given the importance of the provision working properly, I tend to favour putting it in statute. The code of practice could very well supplement and provide more practical examples of how to navigate such a provision but you could have a useful definition in the Act.

The Chair: Can I ask a quick question—I am sorry if we have covered it; I am just looking ahead a bit here—to do with supervised discharge? Are the safeguards included sufficient to ensure that this is used appropriately? If not, how might it be improved?

Justin Leslie: Can I jump in on that one because I have a bit of practical experience of these cases? This clause is trying to address a complexity in the law following a Supreme Court case about five years ago. There have been subsequent cases where the courts have grappled with the situations in which they can discharge patients into the community subject to deprivations of liberty and so on.

There is at least one notable case where the rationale behind depriving the patient of their liberty in the community was for their own protection more than the protection of the public. The clause as drafted really focuses on the protection of the public. A patient in a position like that of the patient in that particular case would not necessarily benefit from how Clause 30 is drafted at the moment. I encourage the Government to consider how the case I am talking about—they will know it; it is called EG—could be delivered through Clause 30. At the moment, it goes only part of the way.

The Chair: That is helpful. Do you agree?

Kirsty Stuart: The Law Society recognises that patients who are deemed to present a risk requiring a level of supervision and control should receive the necessary support in the least restrictive environment. The proposals in relation to supervised discharge may be suitable but further consideration and thorough debate are required. We support patients subject to a supervised discharge order having an annual tribunal review, albeit that there would then be issues around representation and access to lawyers linked to that, with the correct legal aid contracts. That would need to be considered to ensure access to justice. Those are the points we wanted to make around that issue.

Professor Judy Laing: I understand that this is a response to the case law you have been talking about. I am just concerned about the fact that this is a significant deprivation in the community with severe restrictions on movement. From a human rights point of view, I would be concerned about making sure that there are safeguards built in.

That is not just from an Article 5 “speedy review” position; it is also around the United Nations’ OPCAT. When people are deprived of their liberty, there is an obligation on signatories to the convention against torture to make sure that they are not subject to ill treatment and torture. When they are deprived of their liberty—these people would be out in the community—the CQC, as a member of the UK’s national preventive mechanism, which has a responsibility to monitor the convention at a national level, must have very strong powers around making sure that there is scrutiny of patients in this position. I know that it has a responsibility at the moment in relation to aftercare and CTOs but this will also need to be worked through and captured in some way if this provision goes ahead. Otherwise, these patients will end up with significantly weaker safeguards.

The Chair: We are now going to turn to the changes to the detention and treatment criteria.

Q134 **Dr Dan Poulter:** This is quite a key aspect of the proposals. Do you feel that the detention and treatment criteria in the draft Bill are sufficiently clear? If not, do you have any examples of improvements that could be made?

Justin Leslie: Who would like to go first?

Professor Judy Laing: We were thinking you might come in there as the one with drafting experience.

Justin Leslie: There are two separate questions there: one about detention and one about treatment. On treatment, there are changes, particularly with respect to serious harm and how that harm is to be assessed in the moment. A concern I have about that approach is that it

seems to have in mind a situation where a patient is at a point of crisis before they are admitted. We all know that trying to intervene before a person is at a point of crisis will be better for them overall. That is a real question I have about the usability of the new detention criteria.

First, we have to assume that they are going to be followed to the letter. If they are, the presentation of this cohort of patients could become much more acute and extreme in practice. That is a difficult thing for clinicians to be faced with. It may mean that the treatment such a patient goes on to have could have been avoided if they had been admitted that little bit earlier. That is following the letter of the law as it would be if the Bill were enacted.

Judy has alluded to how the Bill might work in practice and whether in fact a patient would have to be at a point of crisis before an admission for assessment is made or treatment is given. That remains to be seen but there is a potential for a fracturing between the words on the page and the practice. That is where I become quite nervous. The further away the practice moves from the words on the page, the choppiest the waters become from a legal point of view.

Dr Dan Poulter: Your legal view, as in how this would be interpreted by the courts, is that this is a significant change.

Justin Leslie: It increases the threshold needed to justify a detention.

Dr Dan Poulter: On that, “serious harm” is not defined in the Bill. Is it desirable to define it? If we do not define it, how would the courts interpret “serious harm”?

Justin Leslie: My preference would be to define it because it is going to be a key concept in how the Bill will work in practice. Having said that, there is a limit to what a statute can define while still being usable. You could envisage a “serious harm” definition that runs to many pages and still does not include everything it has to; that is where something like the code of practice can come in to try to assist practitioners in making those judgments on the ground. That term is going to be a key battleground in some cases.

Dr Dan Poulter: I am sorry but, as this is very important, I want to push you on that, given your drafting experience. In other legal contexts, such as criminal law, serious harm would be tantamount to something such as GBH; that is my understanding. Is that fair?

Justin Leslie: It is difficult to define in the abstract but a serious harm is more than a harm. The division between those two concepts is quite blurry.

Dr Dan Poulter: Understanding this is really important. You are the lawyer but my understanding, if I think back to when I read law many years ago, is that serious harm is certainly beyond ABH in terms of criminal law. The best legal definition of what serious harm may be is probably to be found in criminal law, when we are talking about harm to self or harm to others.

Justin Leslie: As a matter of statutory interpretation, your starting point would not be to try to construct a definition from what criminal law provides and import it into here. The question is about the text of the Mental Health Act, as amended by the Bill. What do those words mean? If there is not a definition of it in the Act, you are reliant on a court stepping in to provide you with a definition.

I am not a criminal lawyer but I am not aware of there being a bright line beyond which certain crimes are dealt with as serious harm crimes. There is a distinction in some cases between serious offences and not serious offences. It is unlikely that we would be comfortable with that list being transplanted by analogy into the mental health context. Any list of offences that was defined as a list of serious offences would not have been designed for this context.

Dr Dan Poulter: I suppose that brings us back to what “serious harm” means. I would be interested to bring in Professor Laing on that. It seems quite problematic not to understand that at the point of conceptualising a change in legislation.

Justin Leslie: Yes.

Professor Judy Laing: You are right. This is quite knotty, is it not? There is considerable ambiguity. It is not helpful, as a matter of interpretation, to borrow criminal law principles and definitions when we are looking at civil law. I do not know whether the courts would be inclined to do that either but that is what we have in terms of thinking where that benchmark might be. My understanding of GBH is that it is more like really serious harm but, again, that points to the subjective nature of this.

We currently give a lot of discretion to professionals at the point of admission to interpret those concepts. The reality is that it is often at the point of crisis when people end up coming into contact with the Mental Health Act. My understanding from a lot of your professional witnesses is that they are already working towards this kind of threshold. Certainly, looking at some of the evidence sessions you have already had, they say that it reflects what is already happening in practice. I am not sure whether that is based on their own experience or more broadly.

The difficulty of having a definition is that it then becomes the definition. You could risk it being too narrow and not allowing people access to the care they need at that point. Of course, it is not in isolation. Harm is psychological as well as physical. You also have to consider likelihood. I get the point. Perhaps this is something where the code of practice could provide guidance on and examples of scenarios but that would not be exhaustive; you would have to do it in consultation with the relevant stakeholders and professionals who use the Act on a daily basis.

I would think it unhelpful to borrow from criminal law because the legislation is doing something very different here. I did a bit of research. There was a deportation case called Mahmood, which looked at the definition of “serious harm” in the Criminal Justice Act and at whether somebody had committed serious harm in the context of their Article 8 rights. In that case, the Court of Appeal applied a broad definition of “death or serious personal injury, whether physical or psychological”. I do not necessarily think that is any more helpful but it

does suggest that it needs to be serious. How serious is of course open to debate, but that does not really answer your question.

Dr Dan Poulter: No, although that was quite helpful. One of the things we have been grappling with a little is the patient—this is not uncommon, particularly in central London—who has chronic and enduring poor mental health, particularly psychotic illness. For whatever reason, they may come off their medication and begin to become unwell. They may begin to be unable to function at work or pay their bills. They then become quite profoundly thought-blocked and begin to self-neglect, not to the extent that they are not eating but perhaps that they become homeless.

At the moment, we would be able to briefly detain that person if we needed to in order to re-establish treatment and get their life back on track. If this began to be focused on personal injury or harm, it would miss the wider collapse in someone's life because they are profoundly thought-blocked or because they have schizophrenia. The anxiety around putting in “serious harm” is that we would potentially begin to make it difficult to intervene and help that person to restore their health through a brief period of detention.

Professor Judy Laing: That is important. If we were talking to an AMHP now, they might say that they would want to try to address the homelessness and social care determinants of ill health rather than relying on the Mental Health Act, although I realise that that might not be as easy because of the elephant in the room. You end up falling back on the Mental Health Act as a short-term measure in that situation.

Dr Dan Poulter: It is about helping someone who does not have insight, because they are unwell, to reinitiate the treatment that would help them. It is because they are unwell that the other social determinants have gone wrong more than because they are a factor in themselves. We see those patients quite regularly. That is the anxiety. Is raising the threshold going to make it more difficult to use the Act in the right way to support those people? That is what I am worried about; I see that Mr Leslie is nodding. Do you think that that is the sort of case that might become more challenging?

Justin Leslie: Yes. I take Judy's point that, in practice, there may well be places where a serious harm test is in effect being applied by some professionals because of the circumstances in which they work. By making that the legal test, there will be this cohort of people in the situation you describe who would potentially fall outside the Act and therefore not be capable of being admitted on any basis. That little but important short-term nudge that could be provided under the Act would be lost.

I am sure that those of us who work in the area have come across lots of patients where their interaction with a mental health hospital is ongoing but stop and start. They need a little bit of time inside to help them re-establish things, then they can go back into the community. Although that can sound quite unsatisfactory on the one hand because their engagement with the Mental Health Act is continuing, on the other hand, it seems better that they are spending more time in the community than in hospital. One of the overall aims of the Act and this Bill

is to minimise the amount of time people are in hospital. If that is one of the Bill's aims, this aspect of it may not necessarily achieve that.

Kirsty Stuart: I was just going to add, on behalf of the Law Society and our members, that clearly defining some of these terms is really important. We need to be able to explain them in practice to clients so that they can understand why they are in the situation they are in or what has happened.

There are some members who might look after only Part III patients, whereas some might look after Part II. You may well get a difference of subjective opinion about what equates to serious harm if it is not clearly defined. That might affect the way you describe it to your client, based on your own experiences of what you have done. Defining it more clearly so that patients can understand it would make it a lot easier and more user-friendly as a whole.

Baroness Berridge: I have a quick supplementary for Professor Laing. You mentioned Brenda Hale before. Are the powers and principles on which the Act is operating not more akin to the powers that operate under the Children Act? It is a protective Act of the state. Under the Children Act, there is a good definition about the level of harm to the child that justifies going in; it is quite comprehensive. Is that not more where we should look to if we were to put something in the Bill or recommend that as a definition of serious harm? There has not been that much confusion in those cases about when it is right for police, which it usually is, to go in and get a child out of harm's way.

Professor Judy Laing: I am not a child law expert. I am familiar with the Children Act to the extent that it applies in this context. I do not know how well applied and understood it is but you could look for evidence to see that. It would seem like a good place to start.

Brenda Hale was certainly the architect of the Children Act and very much involved with that. She would probably say that the role of the Children Act is more akin to that of the Mental Capacity Act, given where it comes from with the *parens patriae* jurisdiction. The Mental Health Act is doing something different. The association with risk is there, will remain there and always has been there. That protection of the self and others makes it a different piece of legislation; that is not to say that we should not look to those definitions to help us.

Baroness Berridge: Rather than criminal law.

Professor Judy Laing: Yes. My preference would be to look there rather than in criminal law, if we can.

The Chair: Thank you. All these submissions are really helpful.

Dr Dan Poulter: I wonder whether, with your indulgence, Baroness Buscombe, it might be worth asking one other definitional question.

The Chair: Yes, but I am watching the clock.

Dr Dan Poulter: I apologise for seeking your indulgence.

The Chair: No, it is all important.

Dr Dan Poulter: In determining whether treatment was appropriate, would “manifestations” cover self-harm and harm to others? If so, will clinicians be able to detain on the basis that treatment can be given not to treat the mental illness as such but to prevent people self-harming or harming others?

Justin Leslie: My reading of the word “manifestations” in the draft Bill was that it did cover self-harm and harm to others. The criteria for detention are about providing appropriate medical treatment and so on. I am not sure we can necessarily make any leaps from the conclusion that “manifestations” includes self-harm and harm to others.

Treatment is about trying to treat an illness. There may be difficult cases around the edges where the self-harm risk effectively is the illness in how it presents but, in the main, I feel like that question comes from a place that suggests that the Act, as amended by the Bill, could somehow be used as a way of containing those who are at risk of self-harm or harming others, and that we could characterise the treatment they are getting as containment. That is not what the Act is aiming at. My reading of how the Act would operate if amended was that the wording ought not to allow for that because that is just housing people who are a threat. That is not what the Mental Health Act is or should be about.

Dr Dan Poulter: No, absolutely. We had this discussion in previous witness sessions about personality presentations and personality disorder. They were saying that, in Northern Ireland, that was specifically taken out of some of the legislation. I suspect that it is probably that context, where someone may be perfectly capacitous at first presentation but has quite complex personality presentations, that they are trying to tease out here.

Justin Leslie: Yes.

Professor Judy Laing: Reid v Secretary of State for Scotland suggests that, under the legislation, we would already use a structured environment to manage somebody such as you describe. I do not see this as a marked departure from what is already permissible under the Mental Health Act.

If we look at the code of practice, paragraph 24.5 states that medical treatment “includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder”. An example is given: “treating wounds self-inflicted as a result of mental disorder”. I do not see that this would be any different from what happens already. There is significant case law that suggests you can treat the manifestation of the underlying illness. It points to that dividing line between mental and physical treatment under the Act not always being that clear, but there is case law that would confirm that it would be permissible.

Dr Dan Poulter: If those with autism and learning disabilities were subject to guardianship orders, how easy would it be for such patients to get transferred to hospital under Section 19 of the Mental Health Act? Should the Mental Health Act provide a greater degree of protection?

Kirsty Stuart: This has not been an area of focus in the Law Society's response to the draft Bill but it is an important issue that needs to be considered. It should also be recognised that guardianship cannot be used for those who do not have capacity to consent to those arrangements to deprive a person of their liberty.

Consideration should also be given, alongside those issues, to the impact of people with autism or learning disabilities being detained in hospital under different legal frameworks in that same vein. We would struggle to add anything further to that.

Justin Leslie: I endorse Kirsty's comments. The guardianship regime is not particularly well used nowadays. I did look into this. To the extent that it would be possible to find a back route into admission for those with autism and learning disabilities, there is a loophole. If the Government's intention is to remove them from the operation of Part II, and that has been identified as a possible way in, I would expect the Government to want to try to shut that down.

Professor Judy Laing: I do not really have much more to add about Section 19. In relation to guardianship, it is little used. Since CTOs have been introduced, they have become more popular. You also had the DoLS framework. The guardian's powers are quite limited. You cannot force somebody to have that treatment or insist on that treatment. Other routes have been used to facilitate that.

It would be useful to have more research on how well guardianship works. Again, I had a look at the data on this before I came. The latest NHS Digital data says that it is continuing to decline but 21 providers did not submit any returns about the use of it. That points, again, to the need to force providers to let us know what is happening and to get hold of the information about how it is used.

I am not quite sure what the benefits of guardianship are. We need more information and transparency about its use. It is more difficult to monitor as well. If guardianship is going to be used as a potential route into hospital, we need more information to know whether that is going to work.

Dr Dan Poulter: To some extent, you are suggesting that, in practice, the mental capacity framework—the DoLS framework—has effectively superseded this.

Professor Judy Laing: Yes.

Kirsty Stuart: When I was a practising mental health lawyer—I practised for around six years—I only ever had about three guardianship cases. It is rather rare in terms of what is happening on the ground. Further research into that would definitely be helpful.

The Chair: That is really helpful. We have touched on monitoring and scrutiny a bit but we have a couple of further questions.

Q135 **Marsha de Cordova:** Are there any statutory duties that should be in legislation with which both NHS and social care providers must comply in terms of collecting, reviewing and publishing data? I am thinking here about race and ethnic disparities in particular. What could or should this look like in the draft Bill?

I also want to touch on the Care Quality Commission. Could there be greater powers for it or anyone else to monitor and regulate the MHA?

Kirsty Stuart: The Law Society recommends that the Care Quality Commission should be notified within 24 hours of a child or young person being admitted to an adult ward. As we understand it, it is currently 48 hours. We recommend that that be reduced, that the CQC should record the reasons for the placement and its proposed length, and that this should form part of the Act.

Further, the Law Society recognises the purpose of Section 131A of the Mental Health Act, which is to prevent the inappropriate admission of under-18s to adult psychiatric wards. The CQC plays a really important role in the monitoring and implementing of that provision. Those are the kinds of things that could be looked at in the Bill.

Justin Leslie: What the Law Society says about the CQC provisions is very sensible. On the statutory duties to collect information and so on, there are lots of precedents in other legislation about duties to collect, gather and publish information. I was involved in the Mental Health Units (Use of Force) Act 2018, which contains a clause that is specifically designed to identify the information that should be gathered then publish it in relation to the use of force in mental health units. One challenge of drafting a provision such as that is identifying exactly what information is most helpful and what information can be produced by providers straightforwardly.

As we heard earlier, there is a challenge in this sector, in certain areas in particular, around being able to say clearly what information points are needed to construct helpful data overall. In the context I was talking about, it was the protected characteristics of the Equality Act. They are reasonably easy to identify and to number-crunch, particularly year on year. Normally, a duty such as that is accompanied by a duty to publish or perhaps to lay reports before Parliament.

The NHS has its own information data centre, which could have that duty. You would expect information from a trust to go to a body such as that then go from that body to Parliament, rather than Parliament being inundated with information about this sort of thing. Those duties are important and provide an evidence base over time to allow something such as the Mental Health Act to be analysed more properly.

You can always ask for more data. We are a data-hungry world. There is a possibility that a statutory duty to collect data might be outstripped by further demands for more data in future, but that is not a reason not to do it. It ties in with the point I made earlier: there is some value in reviewing the operation of the Act, particularly in relation to the removal of those with autism and learning disability from Part II. To do that, you need information; statutory duties to provide information are what can give effect to that.

Professor Judy Laing: I would like to pick up on the Care Quality Commission point. I endorse everything that has been said about data and exploring a statutory duty.

I have a role as an expert external adviser on the Care Quality Commission's Mental Health Act monitoring group. That involves giving it advice and input into its annual monitoring reports and the work it does. I am aware of how the CQC works. It has an important oversight function and produces an annual report that has to be laid before Parliament. It is also able to

interview patients in private. That is really important in terms of not just its duty under the Act but its role in the national preventive mechanism under OPCAT, which is not well publicised or well known. It is one of 21 members of the UK NPM; that adds an extra layer, meaning that human rights are far more central to the work it does.

Since the CQC took over from the Mental Health Act Commission, its predecessor, it now has the bite that the MHAC never had. The MHAC had lots of people going on visits but it did not really have the bite to impose sanctions. We are seeing the CQC do that, for example in relation to mental capacity. Not long ago, it took sanctions against a mental health trust for not following the Mental Capacity Act. It clearly can exert that pressure.

I would be worried about giving powers to other people. If you look at other bodies—part of the question mentioned “anybody else”—you could risk things falling through the gaps, with different approaches and a duplication of work. That is a problem. The CQC does a pretty good job of monitoring the Mental Health Act. The report has been diluted from what it used to be under the Mental Health Act Commission.

Where it fails and does not do as good a job is in relation to the Mental Capacity Act. This is linked to the point we have been talking about, which is around the worry that these changes will then impact on people being funnelled elsewhere. I was fortunate to be able to give evidence earlier in the year to the Joint Committee on Human Rights. It was looking at human rights in care homes; the session I was involved with was around the LPS and the impact of that.

I felt quite concerned that the CQC does not have the same monitoring function in relation to the Mental Capacity Act or the LPS. We talk about the fact that the safeguards are weaker. The oversight is also weaker. If you look at what the CQC produces around the Mental Capacity Act, it is a really small part of its big *State of Care* report. It seems to have gotten lost. That is a shame and a worry when we look at the unintended consequences of the Mental Health Act changes. If people are being funnelled there, the oversight of the CQC is not as great. That is a concern.

My final point is in relation to the complaints process; the CQC raised this in its written evidence to you. It has an important complaints function. There is a bit of confusion about who to go to with which complaint because there is the ombudsman as well. Giving patients clarity in the information about their rights and who they can complain to would help to strengthen that because I am not sure that it is always as effective as it could be on the ground at the moment.

Marsha de Cordova: Thanks, that was useful. The different datasets that are being collated should be standardised across all the bodies that are collecting this information. For example, whether it is the NHS, the Home Office or the CQC, it all needs to be standardised. When we are looking at race and ethnicity, for instance, everybody is collating the same data. If it were joined together, there would not be any differences or disparities.

Professor Judy Laing: That is what the independent review recommended based on the evidence that it collected. This is essential if we are going to be able to keep track and work out how the Act is being applied. There are also other disadvantaged groups that we also need

to be aware of, to the extent that we can get more granular data. You do not want it to become overly bureaucratic and cumbersome, of course, but this is an important dataset that we need to get hold of. We are being asked now to make decisions about changes to the Mental Health Act, which relies on us filling in the gaps around what is happening on the ground. If we are going to look at the law and how it works in future, not having a reliable and, as you say, standardised dataset will make that very challenging.

Justin Leslie: I agree with everything Judy just said.

Q136 **Baroness Berridge:** This is the final section. I am mindful of time but this is a specialist area: children and young people. We are going to receive further evidence so the answer can be that this is not your area. I have two quick questions.

Can you comment on whether we should have a statutory test for competence for under-16s? Do you have any specific evidence on the potential legal uncertainty around a child choosing a nominated person who is not their parent or guardian? Again, we are back to the Children Act. How does that interrelate, potentially, to the Children Act? Please feel free to take a pass on this one, if you need to.

Professor Judy Laing: We talked about this outside. We said that we do not necessarily feel that we have any evidence. You will have evidence tomorrow from Camilla Parker. She really knows her stuff so she might be more helpful. I do not want to speak for everybody; the Law Society may have something to add.

Kirsty Stuart: The Law Society did include this as part of its written submission; I can talk to it to that extent, if that would be helpful. We consider the statutory incorporation of a test of competence necessary and justified. We recommend that this be supported by clear guidance for practitioners applying the test. The assessment of competence is essential because the law takes it that under-16s are unable to make decisions for themselves, in contrast to the presumption of capacity for those over 16.

The Law Society has not necessarily focused on the impact on other services. In taking that into consideration, one would need to consider access to resources and the funding of representatives.

We suggest and recommend that setting out a test in the Bill would ensure that those working with under-16s have a clear and consistent understanding of how to assess competence and thereby support under-16s in exercising their rights, although further consultation may well be required around some of those points.

I apologise—may I ask for the second part of your question again?

Baroness Berridge: It was about whether there is any interface between a child choosing a nominated person who is not their parent or guardian and the Children Act parental responsibility.

Kirsty Stuart: The Law Society's view on this is that the process for identifying who would take on the role of the nominated person when someone is unable to select their own must be detailed in the Bill. Introducing in the Bill a test for competence, which would assess whether somebody under the age of 16 has the ability to choose their own nominated person, would

assist health and social care professionals in determining whether the patient lacks competence and, therefore, whether the AMHP needs to appoint a nominated person.

We also take the view that the power to overrule or displace should sit in the mental health tribunal or Mental Health Review Tribunal for Wales because of their specialist knowledge, as we described earlier. We believe, as a rounded point for our members, that representation in any such proceedings should also be funded via a non-means-tested legal basis, in line with other tribunal proceedings, to ensure access to justice.

I understand that you are getting further evidence tomorrow. I do not know whether that assists.

Professor Judy Laing: Can I just add one thing? I am not an expert but I teach medical law and have done so for a long time. If we really want to rebalance this, children are impacted by the Mental Health Act. I know you have had a lot of evidence to suggest that their needs have not been given the thought they need to be given.

I know that the subgroup that looked at this issue for the independent review suggested that we should have a statutory test. It was along the lines of the functional test in the Mental Capacity Act. If this is being considered, from the point of view of promoting the rights of children in line with the CRC, then yes, it is absolutely a good thing.

However, we need to be clear about what the test would look like. We use Gillick competency in relation to adolescents. It sets the bar very high for competency when you look at the way it has been interpreted by the courts. It largely gives children who are competent the right to make a wise decision but not necessarily the right not to make a wise decision. We need to be clear about what that test would look like. I suspect that going down the Mental Capacity Act route would ensure consistency and clarity and not be as complex for practitioners, but I cannot really comment on how that might work in practice.

The worry is that it might filter through to other areas of decision-making. This is a very distinctive statutory framework so you could perhaps limit that statutory test's application to this area. You do not want it perhaps to filter through to common law or other areas.

Justin Leslie: As a matter of legislative practice, the current legal framework is very complex, particularly through the Gillick competence approach. There could be real benefits to putting statutory tests for competence in legislation if we got it right. The devil is always in the detail. If you get it wrong, it can create more problems.

One of the benefits, if you like, of the current situation is that Gillick competence is a relatively flexible test. It provides some fluidity that can be useful in some cases. A test in statute that does not have a similar level of flexibility can lead to hard cases that fall on what everyone would agree is the wrong side of the line. Trying not to shackle oneself too much by way of a statutory test is really important.

Q137 **The Chair:** Can I ask one other quick question? I know that we are out of time. It is not in the papers or anything but the Government are disinclined to have advance choice documents in statute. They are saying, "We don't want to have something where everybody has to have a written statement". What would you think about something saying that everybody has a right to an advance choice document without



the shackles of saying exactly what that might contain or demanding that everybody has a written statement?

Justin Leslie: Such an approach could well work. One of the features of the Mental Capacity Act is that advance choices can sometimes fail because they do not meet the requirements of the Act. That can be frustrating for people who thought they had made a valid advance decision when they did not. We would want to avoid being overly prescriptive in this context about what counts as a valid advance decision.

I note that, in their response or one of the documents they provided, the Government talked about issuing a form that could be used. Even if a non-mandatory form is available, practitioners can sometimes get nervous about advance decisions not being on the form.

The Chair: Yes, deviating from the form.

Justin Leslie: That is right, yes.

The Chair: I am suggesting that something much looser that makes sure that everybody has a right to an advance choice document, in whatever format that might take, should be in the Bill.

Justin Leslie: Yes, that seems like a sensible compromise.

Professor Judy Laing: I agree.

The Chair: Thank you all so much. This has been incredibly helpful. Your deliberations will form a huge part of our thinking in the coming weeks. We have only weeks before we have to produce a report based on our discussion. Thank you very much indeed; you have been incredibly helpful. This session is now closed.