# Joint Committee on the Draft Mental Health Bill

## Oral evidence: Draft Mental Health Bill, HC 696

## Wednesday 16 November 2022

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Written evidence from witnesses:

- British Association of Social Workers [MHB0026]
- AMHP (Approved Mental Health Professional) Leads Network [MHB0057]
- Royal College of Psychiatrists [MHB0060]
- Royal College of Nursing [MHB0087]

Watch the meeting

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

Questions 138-162

**Witnesses**

Panel 1: **Robert Lewis**, Vice-Chair, Approved Mental Health Professional (AMHP) Leads Network; **Dr Gareth Owen**, Special Adviser to the Royal College of Psychiatrists on Mental Health and Mental Capacity Law, Royal College of Psychiatrists; **Dr Ruth Allen**, CEO, British Association of Social Workers; **Carol Webley-Brown**, Council Member, Royal College of Nursing.

Panel 2: **Dr Camilla Parker KC (Hon)**, Legal and Policy Consultant, Just Equality.

## Panel 1

Witnesses: **Robert Lewis**, Vice-Chair, Approved Mental Health Professional (AMHP) Leads Network; **Dr Gareth Owen**, Special Adviser to the Royal College of Psychiatrists on Mental Health and Mental Capacity Law, Royal College of Psychiatrists; **Dr Ruth Allen**, CEO, British Association of Social Workers; **Carol Webley-Brown**, Council Member, Royal College of Nursing.

Q138 **Chair:** Good afternoon, everyone. This is the 10th session of the draft Mental Health Bill inquiry, which will explore the response of a number of professional bodies to the Bill, in particular the practical impact it will have on the work of mental health professionals, their concerns about implementing its changes and how they might be mitigated, if necessary.

I welcome all our witnesses. We are extremely grateful to you for your giving us your time. I ask each of you to introduce yourself and say who you represent.

***Dr Gareth Owen:*** I am a special adviser on mental health and capacity law at the Royal College of Psychiatrists. I am also an academic psychiatrist at King's and at South London and Maudsley NHS, and I am providing evidence today on behalf of the Royal College of Psychiatrists.

***Robert Lewis:*** I am a social worker, an approved mental health professional and a service manager of an approved mental health professional service. I am here in my capacity as vice-chair of the AMHP Leads Network. I was also a member of the topic group on carers and confidentiality, which included the nominated person considerations.

***Carol Webley-Brown:*** Hello there. I am a mental health nurse, and I am here representing the Royal College of Nursing.

***Dr Ruth Allen:*** I am the chief executive of BASW, the British Association of Social Workers, and I am it representing here. My working life has been primarily in mental health as a social worker and as a manager, and I was involved in the 2018 Wessely review.

Q139 **Chair:** As the witnesses will know, we have a series of questions that take us into some detail of the issues surrounding the Bill. My first question is: in a few sentences, what is your organisation's overall view of the Bill?

***Carol Webley-Brown:*** Broadly, we are in support of the Bill. We believe that it will take us further, but there is a lot of work to be done. I appreciate that that work has begun and has taken place; hence this is the 10th session of this inquiry.

***Robert Lewis:*** As a network, we do not see the Bill fully living up to the promises of the review. Neither do we think that it will positively impact on levels of racial disparity.

We support and are pleased to see the tightening of criteria on CTOs and commitments on racial disparity. We would really like to see more consideration of Section 13, which I hope we can come on to.

We are concerned about some of the changes for learning disability and autistic people, which I know this committee has looked at already and which we will come on to.

You have also been having debates about the principles being embedded in the Act, and we would like to see that human rights commitment in the Act.

We are concerned that, in effect, we are again amending very old legislation that has all the same structures and assumptions about mental disorder treatment. From that point of view, we are not overly optimistic that we will see the changes that we all want.

***Dr Gareth Owen:*** The Royal College of Psychiatrists views the Bill as a positive direction of travel, but we also think that it has drifted too far from some of the key recommendations of the independent review. We are concerned about legislative complexity and the overuse of legislation to solve wider challenges. Overall, we would like to see further clarity and simplicity as this Bill proceeds.

***Dr Ruth Allen:*** Our position at BASW is that some provisions in the Bill are welcome and that the principles that were set through the Wessely review were valuable. However, we share quite a lot of the misgivings of the AMHP Leads Network that this is largely amending old legislation. As has been mentioned, there is a lot of complexity in it.

We do not think that some of the most significant aims of the legislation will necessarily be met by this Bill, particularly without significant new attention to the opportunities for people to receive services in the community and avoid the potential for detention—such as alternatives to admission, earlier support and prevention. That cannot be ignored.

We are sorry that this whole process did not start from a position of considering a more social model for supporting people with mental health needs more broadly. It started from quite a medicalised model.

We would like to see some of the provisions that were in the Wessely review brought into this Bill. We would like to see many of its valuable provisions enacted, such as the augmentation of advocacy, but we are sceptical about the impact of the Bill in bringing about changes in racial discrimination, disparities and some of its other stated aims without that consideration of how we better support people in the community before, during and after admission.

**Chair:** You have all raised a number of issues, so let us get further into the detail.

Q140 **Baroness Barker:** Robert Lewis, in your written evidence, your network suggested that you consider the nominated person scheme to be unworkable in its present form. Will you elaborate on why, and tell us whether and how you think it could be improved?

***Robert Lewis:*** To be clear, we absolutely support people nominating their own key person. It is a key safeguard. In practice, we know how complex it is to apply that in reality, so adding that nomination creates an awful lot of complexity. Going right back to the topic group, when we were trying to play all these things out it was always clear that this would be incredibly challenging legislation to put together, but, fundamentally, we are behind it.

The main issue is that it is overly bureaucratic. As I think we said, it is akin to getting your first mortgage, rather than being something really practical, so clinicians in particular will be tied up with the to-ing and fro-ing of witnessing signatures.

I sometimes use this example: you could have a patient who is in Brighton and their brother is in Newcastle, and somehow we are supposed to witness all these things in a timely way to ensure that the patient has a nominated person as they cross the threshold of the hospital. That has to be the aim of this; we need to make sure that we are promoting the nominated person so that it is meaningful at the point where somebody goes in.

So the issue is fundamentally about the bureaucratic process and the witnessing arrangements currently in the Bill. We have to separate the nominated person into two things: the patient nomination, and what is currently called the AMHP nomination process. They have two different considerations. In trying to help and make those things work, we need to try to return to the original review and the interim nomination process, which was quite pragmatic but was very much about that ease of choosing somebody. Having talked about this with colleagues, we do not think that this should be overly burdensome, but we need a whole system buy-in.

When somebody comes into secondary mental health services, you need that consideration to happen at that point. You do not want to make it too burdensome. When we are doing an initial assessment, we might ask someone a whole load of demographic and personal questions, including, for example, “Who is your next of kin?” I do not see why asking, “Who is your nominated person?”, should be any more difficult than that. The patient states who they want, and they get some information about what that means.

Given that the vast majority of people in secondary mental health never see the inside of a hospital, why would we tie our systems up trying to sort that out? If there are issues later on down the line, that is when you need that legislative cure—if you like—for a difficulty. We would really like to see a very straightforward nomination process. I know there are issues around children, young people and capacity, which you have explored to quite a degree. I am happy to take questions on that.

With regard to the AMHP-nominated person, again, we need to remove some of the assumptions being made that we should do that only if somebody lacks capacity, for example. We are talking about Mental Health Act assessments: really difficult, tense situations, sometimes in a person’s home, where the police may have just knocked the door down, and we are being asked to follow this really complicated process.

We should be being empowered in what we currently do: we determine who the nominated person is—it is a really complex piece of legislation, but we work our way through it—and we sign on a piece of paper, the application, to say, “This is the nominated person”. It comes with a code of practice that says that we should talk to the patient about certain aspects and give them information.

We should take out the capacity thing, because we can quite often agree with the individual, and say, “Okay, you say you want your mum to be the nominated person. I’ll just sign that on this form, and then you can confirm that later, or, if there is any other follow-up, let’s do that then”. It has become so bureaucratic and really difficult to work in practice.

There are other things that we can definitely do to make it more meaningful. I am sure some of this will be code of practice stuff, but there is something about the provision of information to people. One of the big criticisms that we get from NRs—nearest relatives—at the moment is that they do not get enough information, or understand it, usually because in a really tense situation they are just not able to absorb it. There need to be obligations on the services to provide that information.

We will probably come on to this in a while, but we should also look at when somebody is being considered under the Mental Health Act. At the moment, it is quite a loose concept and idea—at Section 13. In some cases we never see the person because we have managed to get it into another direction, but we need to encourage services to think about how they then reflect back to the individual and provide them opportunities to create nominated people by saying, "A process has been going on here, you did not end up detained, or you may not even have been aware of it, but you are still at risk of that".

We should be putting in some of these things as must-dos to help to promote that choice and right later on down the line through the provision of information.

Whatever the scheme looks like, one of our big concerns about managing this is the database issue. How on earth do we know where to go to get that information? Some 150-plus local authorities and all the different trusts are all running different systems. If I am working on a late shift and I need to find out who is the person who came from Liverpool who has been picked up on a train and is now in a local place of safety, where on earth do I go? The management of that, and updating it, will be really difficult. Again, I fear that the overcomplication of it will mean that people just cross the threshold of the hospital without the protection we need to aim for.

There were some other bits and pieces—probably more technical issues about AMHPs being given the power to override a Section 3 objection, for example—but that is probably a conversation for another time.

> **Chair:** Would anybody like to come in on that question, or would anyone on the panel like to add anything to that?
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> **Baroness Berridge:** We are hearing from Dr Parker later, but may I ask you, from a practical point of view, about what you said about the complication with young people—when somebody with parental responsibility might not be the nominated person? Practically, how would that work out in the situations that you walk into, which you have described?

***Robert Lewis:*** It partly depends on what we understand those roles to be. If we go back to the drive around the review, we see that it was about extending choice. What we are doing in this process—I know that we have to—is saying, "But if we give choice to people, what do we do?"

You have to work from the basis that, if you are going to give choice to people, you either give it or you do not. If you are going to give choice to children, give them the choice, and if they make a choice that is not about parental responsibility, let us follow through and think about that. Too often, we are trying to solve too many problems too soon. This is a trap that we got into in the topic group, to be honest. We were trying to solve every single problem.

Clearly, there could be tension between the person with parental responsibility and the individual, but we do not have to assume there will be. I hope that, as clinicians and people wrapped around the care of a child, we work in a way that brings that together, and where there are challenges we think about what mechanism to use. At the moment, we have Section 29 for displacement and other things.

If we are going to have choice, we should support it. Does that make sense? Choice should come first, and then let us work out what we do when it creates a problem, not let us not do it because of the problems.

> **Dr Ben Spencer:** Building on that exploration of choice in the nominated persons of young people, one of my concerns is that there is no mirror of this in the physical health setting: the nominated person is an exceptional role in mental health settings, so a child cannot try to shift parental responsibility away from their parents. We are concerned about the conflict where parent and nominated person are in conflict or the child elects someone who is not a parent. We do not allow that in physical health, so why should we try to give even more choice in mental health than a child would otherwise have in a physical health setting?

***Robert Lewis:*** I guess it comes back to the principle of extending choice. I am not necessarily arguing that it needs to happen; I am just saying that if you are going to go down that line, that is what we need to think about.

There are loads of knock-ons there, because there are loads of parts of the Mental Health Act that do not have capacity for adults. There is no consideration about their detention or anything else, so we are introducing the concept of capacity, or competence, in one small part of the Act, but we are not applying it all the way through. There are lots of incoherences even in the Bill itself.

From a practical point of view, when you are assessing children, you want it to be as simple and straightforward as possible, but we do interview very sophisticated, educated children and young people who very clearly know what they want. It is a really delicate balance. I do not quite know the answer to that directly, because it is about other legislation that I am not involved in on physical care health and how you deal with those issues. It creates a new tension, but would we deny them an advocate, for example?

> **Dr Ben Spencer:** But the advocate does not have statutory powers.

***Robert Lewis:*** No, of course.

> **Dr Ben Spencer:** That is the concern about it.
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> On a previous panel, I asked about the example, which was raised by the panel, of a young person who chooses, let us say, a trusted teacher. Teachers are fantastic; this is not against teachers. But it is an example of someone who could then conflict with the parent. Bearing in mind that the parent does not lose parental responsibility on discharge, and, by definition, one of the main powers a nominated person has is the power of discharge in the context of Section 3, if they choose for a child to be discharged, where does the child go? Where does the parent fit in all this? How can the parent discharge their parental duties to the child in the context of somebody else who is outside the family making the decision to discharge the child? That is what we are worried about.

***Robert Lewis:*** I absolutely understand that. As I say, I am not necessarily advocating that; they are the difficulties that we would face. Again, I guess it comes down to the current resolution at Section 29: understanding what the conflict is about. As clinicians we need to try to ameliorate that all the time anyway. We very rarely go down Section 29 lines. It does not happen too often in those circumstances, but, yes, what do you do when the teacher says, "I want them out of hospital"? At the moment, our standard would be to ask whether they are acting in a way that is dangerous to that child or person. If that is the case, obviously we can step in at that point.

**Dr Ben Spencer:** I will try to pin you down on this one, if that is okay. Do you share my concern that when it comes to children with nominated persons, too much choice is perhaps a bad thing, that we should be looking at the structure of family units and people with parental responsibility and, given those roles, that children perhaps should not have the ability to deviate from someone with parental responsibility as a nominated person?

***Robert Lewis:*** I guess it also depends on the child, because families can be dysfunctional. Families are not always in the same space as each other. This is one of the main problems of the nearest relative; going back to your nearest relative might be the brother you have not seen in 20 years.

It probably also comes back to exploring the next of kin thing in the set-up of the nominated person and whether your child has competence. I know you have talked about whether you introduce statutory competency and all those things, which is such a large area. I do not know.

**Dr Ben Spencer:** In the current set-up—please help my understanding—adults have quite a lot of discretion in determining the nearest relative.

***Robert Lewis:*** No.

**Dr Ben Spencer:** Is that not the case?

***Robert Lewis:*** No, they do not have discretion at all. They are following the statutory process, the hierarchy, the subclauses and any clarifications that have come out of case law. You have only one nominated person, except in a couple of instances.

If that person is not acting in your best interests or is getting in the way of the care, we move to Section 29 and think about what to do with them, but we cannot choose; the law is clear about who should be the person.

**Dr Ben Spencer:** Thank you for that. I was thinking of, let us say, an emergency application for a Section 2, in the middle of the night, when you are concerned that somebody who may be the nearest relative in the hierarchy is an abuser, or someone who—

***Robert Lewis:*** We are covered in case law on that. We do not have to engage that person. We have some choice about that, but we do not have a choice who the person is.

***Dr Ruth Allen:*** I support what Robert said. We agree that we must not lose sight of the fact that the nearest relative provision needs to change and that the choice must be extended so that people can choose who their nominated person is.

The issues we are wrestling with are the ones that we want to wrestle with: how do you extend choice in a meaningful way that is also supportive of the staff who are having to work with that person, and help ensure that that decision is made in a proper and prompt way?

I am sure you all know that the vast majority of AMHPs are social workers. Their role needs to be fully supported. It could perhaps be supported more overtly in the Bill in this process of assessment and of working with people in this crucial legally complex, and often clinically complex, situation, and helping them to make choices, potentially at a time of distress. That is how it would be in eliciting who the nominated person is.

That process needs to be clear enough and supported enough through whatever the guidance is, and the protocols that you have been discussing, so that the AMHP can do that work really sensitively—not just legally but in discharging their overall duties towards protecting the rights of the person they are working with, be it an adult or a child.

Of course, there are complexities with children. If this is extended to children in the same way as to adults, I completely understand the dilemmas about where parental responsibility and a different nominated person come in. Children do make decisions that are not necessarily the parents' decisions through the principle of their competence; we have that example in physical health care. There is an analogy there.

Overall, we must not lose sight of the point of this part of the proposed change: to get away from this incredibly old-fashioned, out-of-date and non-rights-protecting approach to nearest relative and think about putting in place what helps the professionals and, crucially, the person in making the choice about a nominated person.

***Dr Gareth Owen:*** The college has been welcoming of the principle, but the point is very much taken about working through the detail.

There are two things to flag. One is that this is very welcome in a forensic context. Patients who come into contact with the forensic services have often been abused. It is not uncommon for there to have been abuse from a nearest relative, so flexibility there would be very appreciated.

The flag about under-16s is a very real one. This area is highly complex. Extending capacity principles into the under-16s without a lot of thought raises a lot of problems. The principle of participation is very well understood and accepted. On the notion of the best interests of the child being paramount, we would certainly wish to see consistency with the Children Act.

**Chair:** That is very helpful.

***Carol Webley-Brown:*** I would like this to be seen in the light of the patient being at the centre of it and for there to be flexibility and adaptability. Right now, the whole process can bear heavily down on the patient. They are already going through a very hard time, and having someone they can choose, rightly or wrongly, has to be part of the relationship they have with the service. Otherwise, everything in the system and structure bears heavily down on someone who is very vulnerable and in need.

It is very difficult with children, because we need them to engage. The way to engage them is to let them have a choice, even if it is a bad choice. It is so important to have that flexibility.

**Chair:** Thank you very much indeed. We must now move on to grounds for detention and detention rates.

Q141 **Dr Dan Poulter:** I draw the committee's attention to my declaration of interest as a practising NHS psychiatrist at a London hospital.

Thinking of your current day-to-day working practice, and leaving aside any changes that may be in the draft Bill, what do you think could be changed to reduce detention rates?

***Dr Gareth Owen:*** Thank you for asking that. One legal matter is informal admission. We think that informality is valuable in some circumstances and should be an option when patients would prefer it, when psychiatrists and AMHPs consider it appropriate and when a patient can consent to it. Section 131 of the Mental Health Act recognises that, but it is rather tucked away in the statute. We agree with the chairs of the independent review that that could be brought into more prominence and put at the head of Part 2 of the Act.

***Robert Lewis:*** Sorry, may I clarify the question? Is this about aspects of the working practice?

**Dr Dan Poulter:** Yes, it is purely on working practice as things stand at the moment.

***Robert Lewis:*** As they stand at the moment, from the point of view of approved mental health professionals, how the legislation works and what we can do to support that is probably our major issue. As approved health professionals, clearly we make the final distinction as to whether somebody should be detained. In doing that, we are responding to requests under Section 13. The legal language at the moment is "consideration". Our role is to consider. That consideration is really elastic—rightly so.

What we are not doing is request, assessment and detention; it is request, and then we are beginning to bring in the European Convention on Human Rights and to think about the existing principles and case law. We are trying to look at that individual, the clinical picture and all the circumstances of the case, because, fundamentally, if we make an application we are signing to say that in all the circumstances of the case this person should be detained in hospital.

The vast majority of our work has not really been the focus of any of the discussions here. From what I have seen, I do not think the committee has talked about what in the process is already working to reduce the tensions. If you look at the statistics that we can access—there is not brilliant data on this, which is a major issue for us—from regions and areas, if you want to reduce detention rates, which we all want to do, you need an understanding of how we are doing it now, because we are doing it to a great extent. We are doing that through lots of negotiation, pushing back, doing lots of different things, trying to mobilise different resources to meet the needs of the individual and to clarify matters, because often the information that we are getting is unreliable. Even though it is coming from professionals, they are themselves under lots of different pressures. I think that ADASS did a deep dive on a two-week snapshot a few years ago; 24% of requests made of AMHPs resulted in compulsion.

There is a whole bunch of stuff that we need to think about. What is it? We know that it is not all about the AMHP. It would be brilliant if we were that great. It is about lots of different factors that are going on there, but a big component of it is that, in effect, you have a gatekeeper, although I do not like that expression.

Some of the difficulties that arise for us are that in trying to avoid detention and move away from compulsion and to hold that person, if possible, within their community, at the moment the only people who are legislated to make those considerations are us. No mirror duties are placed on any of our partners. It is a real struggle to try to bring other services to the table. There are bits in the code of practice about supporting little bits and pieces, but there is nothing in that statute. Under Section 13 it is our duty to consider, but there is no second line that says that it should be the duty of every integrated care board to ensure that the AMHPs are supported in this process through the provision of services, personnel or whatever.

As a result of that, we are constantly in this battle. When we have this high level of acuity that is going on at the moment and systems that are not working with us generally—there are some great examples of practice, so I am making some very general points—we do not have any levers in statute with which we can work with our partners. There is no obligation on them to provide a Section 12 doctors' list, for example; there is no obligation on them for anything.

We would want to see some mirror duties, possibly in Section 13, on those boards to support us in our decision-making so that we can do more of the things that we are doing to lessen the prospect of detention. The number of detentions is clearly going up because of the level of acuity.

> **Dr Dan Poulter:** What you, and indeed Dr Owen, are saying leads to the second part of my question. What you are suggesting, if I may paraphrase it, is that at the moment you are forced to moving down to detention because the other options are not available pre-admission.

***Robert Lewis:*** It is not just about the resource but about the attitude. The Scott report is 1,000 pages long—I have not gone all the way through it—and there is a helpful statement that if culture and legislation moved together you could do really good, lasting things. We do not have those cultures and we are not supporting it with the legislation. The desire to do that is there, but we need the legislation to support us in that.

It is not really about resources, although they are incredibly important, particularly when you are looking at least restrictive options, which is one of our main roles. It is also about the obligations placed on others to see Section 13 as a serious thing. Therefore, you need to come to the table with us and support us so that we can find those alternatives.

> **Dr Dan Poulter:** You are saying that we need a legislative lever that means we have less restrictive options that are practically available to us.

***Robert Lewis:*** To bring services and professionals to the table to see the seriousness of what it is they are asking us to do.

> **Dr Dan Poulter:** I presume that is an issue in discharge as well. It is about facilitating appropriate discharge when someone has been detained and having more legislative levers to ensure that there is perhaps appropriate housing or something available that is appropriate.

***Robert Lewis:*** I had not linked it to the same process of bringing somebody in and thinking about that process, but I cannot see anything against that.

> **Dr Dan Poulter:** It is recognising that, unless there are levers for the whole system that are available for detention and potentially to reduce the length of detention—there are some levers available—it makes the job of finding less restrictive options, more appropriate options in some cases, harder, so that pushes people effectively.

***Robert Lewis:*** I absolutely acknowledge that it does make it harder, but I am talking about the finer detail in practice and our colleagues in other parts of the system turning and facing the person when they are being considered under the Act in the same way. Most AMHPs will tell you that the services tend to fold away and disappear a little bit sometimes—more than sometimes—and that we need to use the code of practice and those kinds of things to remind people about what their obligations are to the individual and to give some guidance and support before you consider detaining somebody. We can do some of that in the code of practice quite effectively. It is only a few paragraphs, but, for us as AMHPs, please do not forget that you cannot just walk away from this person because it has been passed to us. We are not care providers; we are here to consider what else we can do.

Perversely, because of resources being so tight, with beds not being available within two weeks of an assessment or whatever, by pushing on other services to support that individual they find out sometimes that they do not even need to come into hospital, because with the commitment to that person while awaiting a bed they have managed to turn it around. We see that a lot, but it is not supported particularly with the code of practice. That is the culture change that we would like to see.

> **Dr Dan Poulter:** You mention beds. Dr Owen, you mentioned potentially highlighting or pushing informal admission more effectively, but is that made very challenging due to the scarcity of available beds? I see Mr Lewis nodding. Does that mean that the scarcity of beds pushes the use of the Act? It might be well-wishing to increase the desirability of informal admission, but the clinical reality is that the lack of beds pushes professionals towards using the Act.

***Dr Gareth Owen:*** The trends on bed reductions are, I am sure, known to you. The trend is very clearly reducing over time. That does have an effect; it increases acuity and the options of informality shrink, but they are still there.

In some specialist inpatient settings, informality is very common, so it is something to think about. It is there in the law under Section 131. One issue is that it has been too tucked away in the legislation and, if we are thinking about least restrictive alternatives, we need to be thinking about informal options as well.

The points about resources, options, community alternatives and the conditions for them are all very well made and accepted, but these are big issues that extend well beyond this piece of legislation.

***Carol Webley-Brown:*** Before patients come to hospital to be detained, it would be nice if we worked the other way round. In the community, we need more resources. The whole of mental health has to be better resourced. No longer should it be the poor relative of acute mental health needs, because the numbers are increasing and patients are very much in need of services.

Community nursing services have been starved. Home treatment teams are depleted and we need to put more resources into the community so that nurses can look after their patients in the community. That would be the preferred route. Where patients need to be in hospital, the majority of them have black and minority backgrounds. Somehow, it seems that they are always detained. There is no other way of treating these patients, which is so unequal.

There are other ways to meet the needs of the patients in the community where they come from. For a start, we need more nurses on the ground. With all the problems that we have, if there are more nurses who are representative of the community, the needs of the patients are better met; the choices are better met. As a nurse, I know that fewer mental health nurses are being trained; fewer mental health nurses are staying in the profession, so there are fewer people—foot soldiers, if you like—in the community meeting the needs of patients.

When nurses work very hard and get up to consultant level, they are not valued enough to do what they need to do for their patients, by which I mean that if we are prescribing nurses we still need a doctor to sign off things. It is not that we do not like our colleagues—I love them very much—but we need to be seen in our own right as professionals and to be valued. We can make a definite difference in the workplace and community.

In particular, I would like primary care to be utilised much more. General practices are the first port of call when somebody is mentally unwell. Early intervention, particularly for patients with psychosis, stops the longevity of the illness; we can reach them much sooner and save a lot more money and a lot of heartache for families.

If we are able to provide more mental health nurses in GP surgeries it will go a long way to help to take away some of the pressures. A&E is an awful place to be if you are mentally ill; it is just a nightmare. Sometimes, you see police officers on a 136 with patients; sometimes the number of ambulances bringing in patients who are mentally ill almost makes it feel like an acute ward rather than an A&E department, because there are so many mentally ill people. Those numbers are going up.

What happens is that because we are so short of staff, even though A&E is a core service delivery area, security people are utilised in the restraint of mentally ill patients, which is not a good picture. These patients are traumatised in getting the help they need in an environment that is so chaotic and so explosive. We need to look at community resource and how we can help patients before they get to the point of being detained.

**Dr Dan Poulter:** We welcome the responses, but we have a lot to get through, so I will ask for briefer responses. Ruth Allen, do you think that the proposed changes to the detention criteria will make a difference to the number of patients being detained?

***Dr Ruth Allen:*** I do not think that in and of themselves the changes to the detention criteria will necessarily have the impact that was hoped for in the review and in the Bill, for all the reasons that have already been stated, in many ways. I was in the group involved in changing detention criteria. I think those changes are the right thing to do ethically and are appropriate. The bar should be higher. The counterbalance is having alternative ways of enabling somebody to make choices, to be safe, and to have their mental health needs met, even if they are not reaching the detention criteria.

That requires shifts in the system, some of which we are beginning to see with the new community mental health framework—that is an important thing to say—under long-term plans. Some of those changes in ways of working are very important to the ideal of wraparound support in the community. In urgent situations when referrals come through, AMHPs and others involved in the process of assessment need to have ways of reliably drawing upon those alternatives to admission—bear in mind that we are talking about detention and admission, which are not exactly the same things—to enable people to be supported in the community.

It is the right thing to do to change the criteria, but will it shift? The appreciation and management of perceived risk and the possibility of risks turning into harms is affected by what you can literally put in place to help to support somebody. That is about materials resource and duties in the system across health and social care working together much more, clearly mandated in statute and code, to provide those supports. It always has to be seen as a system, which I am sure we are all doing. Those are some key areas.

I would like to make a point about informal admission. It is very interesting. Our wards now are so acute that they are often very unattractive in any sense for people to consider going in informally, or it may be that a local ward that they are used to is not available and there is the possibility that they will be admitted far away in a strange place at a point of crisis. Those things militate against people being able to make choices about informal admission.

We know that quite a lot of informal admissions become detentions. We need to think about the extent to which that is about the unacceptability of those as places of recovery as much as it is about the person’s deteriorating mental health in them. I do not think that the change in criteria is the right thing to do, but it is not enough to achieve a change in detentions.

**Dr Dan Poulter:** Will the change to the intervention criteria make a difference to the number of patients detained? Are there any unintended consequences of the changes proposed?

***Robert Lewis:*** It would be nice to have some research work done very quickly. You look at current detention and then you ask clinicians, “Would you not have detained had you had the new criteria?” to understand whether it will make a difference. Our suspicion is that it probably will not make much of a difference, because we are still talking about a resource gap. We will still be in that position; we still have not really dealt with the last set of amendments that we had when we were looking at appropriate treatment. I do not think we have caught up with those yet. I do not think it has really impacted on practice.

Do we want higher thresholds? Yes, we do, but that means that there has to be something to fill that gap. Those are all the resource issues, which have already been well rehearsed. From that point of view, there are a number of things in the description that raise question marks for us, which may or may not be for here, but, certainly in terms of wording, nature, degree and likelihood of harm seem to have become a sentence rather than nature or degree. Some of those things have real impact on the ground when you are trying to make a decision. Do you need all three? We need clarity about some of those things. That would be helpful.

We are concerned about the impact of the risk on the health of another and how that in itself can be a detaining criterion. We will then have to think about the balance for the individual. Are we just doing this to protect somebody else? Obviously, you want to protect the other person. There are those kinds of issues as well.

There are so many social drivers behind levels of acuity: the pandemic, cost of living and everything else. If you push the criteria up, you will still end up with the need, so I do not see how that will change.

If it is a rainy Thursday night and you are outside someone’s house, or you have seen them and are trying to make a decision and there is nowhere else to go, I think people will make the criteria fit because the individual is there. That is what happens. It is that fluid. We need to be honest about this stuff.

Q142 **Baroness McIntosh of Hudnall:** The moment may have passed, but some of us might need a little more clarity on the issue of formal versus informal admission. We have heard very clearly what the benefits are of preventing people from getting to the point of needing to be admitted, whether formally or informally. I understand that. What possible downsides are there, if any, for somebody who is presenting in crisis and could be detained but is persuaded, or in some other way gives consent, to being admitted informally? What are the possible downsides for that person after a period of hospitalisation? Let us leave aside for the moment the nature of the circumstances in which they might be hospitalised, which is quite alarming given what we have just heard. Will you talk to us briefly about what happens to an informal patient in relation to aftercare?

***Dr Gareth Owen:*** It is a big area. At the point where there are these mental health crisis assessments, the most important thing is to have options. For some people, informal admission is a preference. To have a law that does not allow it any longer would be restrictive. I just make that point.

You may be referring to Section 117 aftercare and entitlements, which is one of the very few examples of a lever in the legislation that we were talking about earlier, but it applies only if the person is detained under Section 3, so it has that particularity to it. Such an important aspect of being involved with these assessments is to have options.

**The Chair:** I do not want to go back over ground we have covered. If any of the witnesses wish to say anything further, perhaps they could write to us, or they can add something very briefly.

***Dr Ruth Allen:*** May I add that people need to have access to other routes to care and support in the community, which is predominantly under the Care Act, as well as health needs? I do not see the interface with the Care Act made clear in this legislation. It is not in the legislation because it is not what it is about, but for that social care support it should be very clear that there are routes in, even if somebody is not eligible under Section 117.

Where is consideration of the access to ongoing social care support under the provisions of the Care Act for people with mental health issues? It needs to be much more centrally considered.

**The Chair:** We will move on to tackling racial inequalities.

Q143 **Baroness Berridge:** We are going right back to where we started on this journey with our concern about the disproportionate detention rates that you have partly outlined for us. Do you think that the changes in the draft Bill will tackle those racial inequalities? Are there any further direct changes that could be included in the Bill that you think could help mental health professionals to achieve this in their day-to-day role? Any comments on what was in the review that made its way into the draft Bill would be helpful.

***Robert Lewis:*** I will try to be as quick as possible. Do we think it will make a difference at this point? No. There are some really good things coming out of the review. We need to be pushing culturally appropriate advocacy. I know that that is not necessarily in the Bill, but we need to think about it.

We think that PCREF has huge potential to be able to create that cycle of experience in the trust to change practice. We are very supportive of that. On 19 October you had before you colleagues such Jacqui Dyer and Maurice McLeod, who talked about this in great depth. We would certainly associate ourselves with those responses in terms of their experience and what they see in the structures and difficulties around some of that stuff.

My only point about further direct changes is that it comes back to data collection and being clear about who is being referred and who is referring that person. What are the outcomes for those individuals? We do not have access to that level of data. What we have is the counting of pink pieces of paper at the end to see who has had compulsion applied. We have not had the rest of it, so we do not know the rest of the picture. That is where I would go.

***Carol Webley-Brown:*** Who is more detained than others is very visible without collecting the data. Unless you have anti-racism threading through the whole of the legislation, we will not solve the problem. A lot of the structures and systems mean that it leans heavily on that racialised group. Until you unpick the things that seem to weigh heavily on those individuals, it will not change. More choice, greater use of the community and people who serve and deliver the services looking as they do will make a difference, because if you come from the same or similar background you have a better understanding. If I was unwell and ended up in, say, Brighton or somewhere like that and I needed my hair to be combed and things like that, it would not be possible. We need to look at how we look after our patients holistically. Nurses from the local area will deliver for local people. That is crucial to this.

***Dr Gareth Owen:*** The point is taken. There is not much to add to that. This is a big issue.

Some further direct changes to the Bill could be included. We think that CTOs could be revisited. The ACD policy could be boosted with specific attention to cultural understanding of black people and ethnic minorities. They may not be addressing the big wider issues that are up for discussion, but in terms of finding at least some options we think that further direct changes could be considered.

**Baroness Berridge:** You think that advance choice documents could be used.

***Dr Gareth Owen:*** Yes. We are talking about choice.

**Baroness Berridge:** I just did not hear you properly.

***Dr Gareth Owen:*** Yes.

***Dr Ruth Allen:*** I support the sentiments that have been expressed. The role of culturally appropriate advocacy and advocacy generally could be quite significant. The augmentation of advocacy, if put into operation, could be quite transformative both for individuals and for the culture of organisations, potentially bringing individual advocacy into more structural advocacy and harnessing that.

If advocacy is commissioned, as it currently is, through local authorities, it is one of those ways in which local authorities, trusts and the NHS need to work together on the delivery of service, outcomes, findings and the way in which that can lead to service improvements.

Culturally appropriate advocacy is not the answer, but it is very important as one of the potential professions that might help in the Bill.

Q144 **Marsha De Cordova:** For me, tackling racial disparities is crucial, because that is essentially the key function of the review.

Would it be right to assume that the Bill in its current form—for example, not including culturally appropriate advocacy, which a number of you have alluded to—will not tackle the structural racial inequalities that exist in mental health? They are societal, but let us focus on the Bill itself. The Bill does not seek to do that given that was the whole intention of the review to begin with. Unless the Bill is strengthened by making those direct changes—ACDs, culturally appropriate advocacy or even having some of those guiding principles set out in the Bill—it will not take any steps to delivering the role of trying to tackle racial inequality in mental health.

***Robert Lewis:*** I agree. The structures of this old piece of legislation are pretty much untouched, so it is broader than just psychiatry; it is broader than just mental health. We can put things in, such as culturally appropriate advocacy, which would be markers of change, as would be the principles, but fundamentally we are starting from a position of polishing something we already have rather than starting with a blank page where the rights issues would be right at the beginning. You would be talking about detention way down—voluntary admission in 131.

At the moment, Section 1 says that mental disorder is what we say it is, Section 2 says that we will detain you, Section 3 says we will detain you, Section 4 says that we will hold you.

For me, that is the structure and the message it sends out. That is what influences all of us as professionals in how we approach these things. You start writing it the other way round with the person first and then you start to be able to put those things into the statute, the code of practice and other things.

There are lots of good things that we can do around this, but my concern is the same: it will not address anything in a major way unless we can get it into the Bill. Even then, is it in reality just a nod to what we were concerned about when the review was looking at it?

**The Chair:** Perhaps I may raise something that might appear to be a bit of a red herring but has been concerning me since we had a session when we talked to service users. A young black girl had been moved five times in as many months and she had no idea why. She seemed incredibly lucid, articulate and thoughtful online. Does this happen particularly to black and ethnic minorities, or does it happen to everybody, and why?

***Carol Webley-Brown:*** When I worked on an acute unit not too many weeks ago we had difficulty with beds. We breached all the time. There were four-hour breaches and 12-hour breaches to the point where sometimes patients were with us for nine days, when that unit should have patients for only up to 12 hours.

All of a sudden, beds arrive. This could be at 2 am, at midnight or whatever. I said, "How can these beds come up?" It is not like acute medicine, where patients may die and all the rest of it. Patients have been moved out of their beds at midnight or 3 am to go somewhere else so that another admission can take place. We play these games with beds and move people around and around. It seems like we are providing a bed for someone, but we have moved them somewhere out of area.

**The Chair:** She was moved to different areas.

***Carol Webley-Brown:*** Five moves are very possible, and that is the way it is done.

**The Chair:** We are covering some of the questions in some of the answers. We turn now to Baroness Hollins on the question of care and treatment plans.

Q145 **Baroness Hollins:** I should declare an interest, because I chair the independent oversight panel to review the care, location and treatment of people with learning disabilities and autism in long-term segregation. It is not quite the same, but it is related.

How practical is the draft Bill's proposal to place care and treatment plans on a statutory footing, and what could we recommend to improve the effective and timely implementation of care and treatment plans that would increase patient choice and autonomy? Carol, would you like to start?

***Carol Webley-Brown:*** I will let somebody else start. That is such a big question.

***Robert Lewis:*** I have just a few comments to make. From an AMHP point of view, it is not something we would be involved in directly, although we may have some indirect involvement. Ruth would probably want to talk more about the role of the Care Act in making sure those considerations are included, so that this is not just about the individual in that environment; it is much broader and seeks to do that. That is the only comment I would make.

***Dr Ruth Allen:*** The important point here is to think about a person who may need support before, during and after. The care and treatment plan needs to be located in other statutory opportunities for care to be provided, particularly the Care Act and the Social Services and Well-being (Wales) Act in Wales. To our mind, coming at this from a social care and social model of disability perspective, we would see those frameworks of support being the ones that absolutely need to see through the period of admission and discharge.

As for care and treatment plans being placed on a statutory footing, the Care Act provisions are also on a statutory footing for those who are eligible. They need to articulate; they need to work together so that there are no clashes and there is clarity about who is taking the lead on what, and they chime and are seamless between admission and discharge.

On the idea of the care and treatment plans being on a statutory footing, I was part of the review. That feels like a potentially very important development, but it needs to be seen in context. It is episodic and should be episodic if admissions are as short as possible. How does it relate to the person's ongoing care and support?

The whole issue needs to be driven by the person at the centre of it. We have talked about that and the extent to which this Bill is keeping the person and their choice-making at the centre of it.

One thing that we have discussed in the social care sector and mental health leadership groups in the social care sector of which I am part is a fundamental issue about having dual running of frameworks to provide support. You have the Care Act and care and treatment during hospitalisation; you have other frameworks in the NHS.

This creates confusion in the system about people's access to ongoing support, which will be primarily social care support. They will need medical, nursing and other kinds of support, but that social care support includes the non-statutory part of that: the role of community support, the role of the voluntary sector and so on, which is absolutely crucial in localities, particularly upon discharge.

It is important to ensure that we have frameworks of care and support that are clear, are not overconvoluted, do not clash with each other and provide clear, evident and understandable programmes of support for a person to know how to get their needs and rights met.

**Baroness Hollins:** It is the connectivity, follow-through and integration of health and social care.

***Dr Ruth Allen:*** Yes.

***Dr Gareth Owen:*** The college welcomes care and treatment plans that are central to good clinical practice. Putting them on a statutory footing risks overmanagerialism. I guess that would be the risk, but we think that it could be mitigated with a good code of practice and liaison with the CQC.

There is a question about whether they should be extended to informal patients, but we think that on balance that is probably best left to liaison with the CQCs and that we should not try to do it in a statutory way.

Advancing choice and effectiveness is where progress can be made and you can make some recommendations. Clause 9 of the Bill introduces the so-called Section 56A on choice, particularly of treatment. Those proposals are positive. Whoever drafted them, they are very good, but they relate to treatment. What we are talking about is care and treatment. That is the essence of the care and treatment plan.

The advance statements, advance choice documents or co-production activities—however one wants to characterise them—which Section 56A is so good at capturing, can come into the care and treatment plans to advance the choice autonomy agenda.

It is important to recognise that that good co-production work, which will have to be done before hospital and in community settings, should extend to care. That is something that you can point out. You can make a recommendation that advance statements or advance choice documents extend to both medical treatment preferences and care preferences. Those can make a big difference to the experience of compulsion.

Q146 **Lord Bradley:** That leads us on to a more specific question about advance choice documents. As you know, as envisaged by the independent review, they are not included in the draft Bill. If they were, what would be the consequences for your work? If they were put on a statutory basis, how would you ensure that they did generally effectively increase patient choice and consequential actions?

***Dr Gareth Owen:*** We think that more can be done. They have been watered down in the period between the independent review and this Bill. If they were implemented, what could we hope for?

The hope would be progressive realisation—it will not happen overnight—of the positive outcomes stakeholders associate with advance choice documents. They include reduced coercion, improved communication, therapeutic alliance, and self-management. People associate positively quite a wide range of things with advance choice documents.

Detention reduction can be expected, if well implemented. International meta-analytic studies put that as large as 25%, so if implemented over time this is an area where one could expect reductions in detention.

***Carol Webley-Brown:*** I believe it would increase patient choice and autonomy if they were included in the bill.

**Lord Bradley:** On a statutory basis?

***Carol Webley-Brown:*** Yes.

***Robert Lewis:*** I have nothing else to add other than from the perspective of how robust they are when it comes to the decision-making point. People can already express, informally if they want, lots of treatment options and preferences. That will not mean an awful lot if we are left with the power to override those at whatever point, so we have to put it into that context.

We have to try to get that choice through and, we hope, to identify alternative approaches, going back to some of my previous comments about tying people into looking at other ways of doing things. There is definitely some potential around those.

***Dr Gareth Owen:*** I have one small point on this. I emphasise that they are really about informing good care and treatment plans rather than fettering them. That is the objective here. The link between advance choice documents, or whatever they may be called, and advance statements in the Mental Capacity Act is a very natural link. You could recommend that that is made clearer to people.

Q147 **Baroness McIntosh of Hudnall:** Could I ask a very quick follow-up about the practicalities of advance choice documents? I did not mean to interrupt, but if I can get this in perhaps it can be answered by everybody. We have heard evidence from people about the mechanisms for helping patients to create an advance choice document. Do you have any views about optimum ways of doing that?

Secondly, to your point, Mr Lewis, about how robust they are at the point at which they are needed, accessing them, knowing who is in charge of them, and that kind of thing, can you tell us anything from your experience about the practical viability of advance choice documents?

***Robert Lewis:*** Access will be a major point. I keep going back to the rainy Thursday night and all that kind of stuff, because that is when you need that information. For those documents to have meaning for the individual, they need to see that they tie into something and are meaningful to them, and it is not just an exercise that we go through, which would be quite time consuming for a lot of clinicians to do.

Is this primarily about all treatment decisions and all options, whether you are going to go into hospital or not? I go back to the point that the vast majority of people in secondary mental health care do not see the inside of a hospital, so how much effort do we put into that given that they are available for people to use? I am concerned about the drag in terms of the practicalities of that, what they would look like and how you would access them, but the principle is fine. I do not know if that answers the question.

**Baroness McIntosh of Hudnall:** It does. If it is not practicable, the principle is just a principle, is it not? Thank you, that is very helpful.

Q148 **The Chair:** We have heard from others that technology out there supports something similar in other fields. Speaking as an optimist, we have heard from so many witnesses that the combination of better data and technology, which is improving all the time in this area, could make a huge difference. Of course, we do not want to put into legislation something that ties down and—I like your word, Dr Gareth Owen—fetters exactly what form these documents would take. Is it not more about a right to have such a thing, which may vary? Would you suggest we need to keep it flexible?

***Dr Gareth Owen:*** To follow up on your point, having them in the statute would put pressure to develop it in the code of practice seriously. Commissioners read off the statute, so it would encourage commissioners to facilitate them in the community with various forms of co-production and to enable the access issue through digitisation. We are undergoing major transformations in relation to digitisation.

**The Chair:** I was thinking that digitisation of all this would make an enormous difference. Dr Ruth Allen, I think you want to come in too on this point.

***Dr Ruth Allen:*** I wanted to lend support to the importance of advance choice documents and their link to practice around shared decision-making, and a point made earlier about how legislation coming together with culture change can really make a difference. How professionals work with people around their prior choices, their lifelong choices and their previous choices of care and treatment, and how that becomes part of shared decision-making within an ACD framework, is really about how to improve the quality of people's experiences. So we do support it.

We have made some notes about how some people may find it easier or they may be more supported to make advance choice documents than others, and there is a potential advocacy role for people in preparing advance choice documents, particularly people who have had multiple admissions or multiple episodes with services. We need to see that it is a reasonable adjustment about people who may be less advantaged being able to create for themselves a more level playing field so that it does not exacerbate differentials in people's experiences in mental health and social care.

**The Chair:** Okay, thank you very much. We will move on to definitions of learning disabilities and autism.

Q149 **Marsha De Cordova:** As a committee, we have heard that a lot of concern has been raised about the proposals in the draft Bill to remove autism and learning disabilities as conditions justifying civil detention beyond 28 days. In your view, what do you think could be done, if anything, to make those proposals workable, coming to you first, Ruth?

***Dr Ruth Allen:*** We certainly have some concerns about the provision of alternative forms of support. That is the bottom line with this. The proposal to remove autism and learning disabilities from the Mental Health Act as conditions is logically and ethically right. There are lots of concerns that people could perhaps be diverted down other routes. They may be using the Mental Capacity Act inappropriately; people may end up in the criminal justice system. We have heard those sorts of concerns.

Not the only thing but a very important thing to mitigate this is how that change relates to the development of autism and learning disability services, particularly for those with the most complex needs, both in healthcare and in social care, and how they work together to ensure the best practice models in wraparound support to prevent people from being in hospital and institutional settings so that they are able to live independent lives. We are concerned about that.

It is one of those areas where it might be quite right for that to come out of this legislation, but the resourcing, practice and cultural changes that continue to be needed to be made, particularly for people with more complex issues, have to be developed alongside it.

**Marsha De Cordova:** Thank you. Carol, would you like to comment on this?

***Carol Webley-Brown:*** At the RCN, we are very concerned that, due to the lack of appropriate alternative services, the Mental Health Act is being used to treat individuals who are autistic and have learning disabilities. Although we are supportive of the direction of the draft Bill, we have concerns about the provision of community services and the nursing staff needed to deliver them. Evidence shows that secure units are often faced with shortages of learning disability nurses, and in some situations they are replaced by mental health nurses, who have different skill sets and professional skills. That is our concern.

***Robert Lewis:*** I do not have much to add on this. You have had so much opinion already in this committee, have you not? You have had a lot of really good input on this. The resource gap is our primary concern, and the distinction with somebody who may need a hospital admission needs to be sorted out. We have Section 2 and then we get into the Section 3 issue. We do not know where else we are going to go. That has led to "warehousing", which is what we are really concerned about because of the institutional issues that brings up.

There is a slight divide in our thinking about whether you should remove it. It is possibly more about the protections of long-term use rather than shorter periods of time—maybe periods over 28 days. Do you write specific legislation for a category of person, which does not seem to be the way to go?

On the review or extension of Section 3s, at the moment how independent is it, and, apart from the RC, when they are extending Section 3, who else might need to be involved in that to bring some more independent view into it? That was something we thought about.

**Baroness Berridge:** Can I just draw out your interesting comment there? Why would we not, though, have a special category? It may be accepted that in certain situations a minority, who do not have comorbidity, need to be detained—I want another word for that, but I will use that for the moment—but we do not want them going down Part 3 and we do not want them under the MHA because they are not mentally ill. Why would we not have a bespoke power for learning disabilities and autism—not comorbidity—specialist services? You could not place them in your normal secure unit, which we know for sensory reasons and so on is not the right place. Why would we not have a power to do that?

We hope, with great community provision developing in the future, that fewer and fewer of that LDA group would end up under our new power, but why would we take it away? They are not ill.

***Robert Lewis:*** Yes, absolutely. It is that hope of the provision in order to fill that gap, which is what we would point to. That is a transitional thing. There is a long period of time for that.

**Baroness Berridge:** Transitional power in the meantime. It is not the MHA Section 3 power; it is a different power until we get to that promised land of those resources, nurses, social workers and units—

***Robert Lewis:*** Absolutely.

**Baroness Berridge:** —or community support that would be provided.

***Robert Lewis:*** I agree.

**The Chair:** Let us move on to community treatment orders.

Q150 **Baroness Berridge:** We have heard a lot of evidence about the problems with CTOs and some limited evidence that there is a small group of people they might benefit. Should we keep them? Should we abolish them? Should we keep them just for forensic? If we do keep them, are you satisfied with the safeguards in the Bill, or are there other things too? It is on open options question for you on CTOs, please.

***Robert Lewis:*** I have quite a few things to say on this. It is a really thorny issue for AMHPs, because we are signing them off. For us, it is understanding what that is about; how are we getting into a position where most AMHPs would probably say that we should abolish them and yet we are signing them off?

With regard to the processes around how we come to get to hear about those things, we are often very late into the mix here. I know that from personal experience. Even last year, I was involved in the creation of two CTOs and came into a situation where, long term, a person had been in and out of hospital, quite defeated by their experience; there were a lot of people in the room, and there was already a lot of control around them, and expectation. They were pretty much being told before I even got involved, “This is your route out. Your specialist placement wants that in place, because it feels safer”. We have to be honest that there are an awful lot of clinicians who use it because they feel safer having it, even if it actually does not do an awful lot.

The title itself is community treatment order, but it is a recall order. You are not treating people in the community; it is a power to recall somebody. That sets things off for the individual. It almost trains them into thinking that this is all part of a continuation of hospital, and, yes, we see it that way a bit. Everyone always has a story about the one person it works for, but why are they so prevalent?

One of my colleagues, Dr Debbie Martin, has done some research on this, looking at the decision-making process. I could try to get that and share some of that. There are lots more things going on than just the pure application of law. The criteria are so loose.

**Baroness Berridge:** Can we balance it though? There might be a handful of people, as the review concluded, for whom these are working, but we have 11 times disproportionality. In your view, the lesser of the two evils is that we would have a very small group who would still need them, but we have deteriorating trust in services and all kinds of implications. In your thinking, is there a balance? You have one person you can think of, but think of the damage over here that we are doing to trust in services and racial disparities.

***Robert Lewis:*** Absolutely. We need to be working harder. It goes back a little to my earlier point that the CTOs were another amendment and we have still not got to grips with it. We are talking about more amendments on top. Yes, tighten the criteria, please, and make it so arduous to get to that point, and then people really have to go through hoops. We have to be honest that it is just seen as a very easy option in some cases. Then we come into perceptions of dangerousness and the experience of black and minoritised groups, where they are more likely to be used, and all that stuff you have all heard about.

***Dr Ruth Allen:*** We support the abolition of CTOs, and the evidence is fairly strong that they do not work in reducing recalls. I think they have been used in place of proper community support and services to enable people to have trust and remain in contact with services in disproportionate numbers.

Q151 **Sir Charles Walker:** The Government set out plans for an impact assessment on the 10-year plan, which seems like a very sensible measure. Do you think there are sufficient resources earmarked for that ambitious programme to allow it to succeed?

***Carol Webley-Brown:*** No. Next question.

***Robert Lewis:*** No. As the Bill has developed and changed, some of the original impact assessments need to be looked at, and any of the impact assessments that you are going to recommend hopefully would be picked up on as well. It is obviously part of a bigger picture in terms of not just funding around this Bill but how it connects with wider services.

From an AMHP point of view, one question is whether guardianship, which is quite small at the moment, becomes increasingly used, because it is seen as another pathway for some of the exclusions and things that we have talked about and you have heard about, and whether that unintended consequence comes in. That will have a knock-on effect for us.

As with most of the professions in this business, our numbers are reducing and demand for us is getting higher, so there are workforce issues and all those things. It is well rehearsed here, I think.

***Dr Gareth Owen:*** Context here is obviously important. Mental health services have been under intense pressure for many years. It is only going to get worse as we understand the full impact of the pandemic on the services.

The current workforce constraints mean that the proposals as they are at the moment—and the ones that will have most resource impact relate to tribunals—cannot be absorbed into the existing workforce. The college commissioned some modelling on this, and, even on fairly moderate assumptions, it looks as if 494 extra psychiatrists would be needed to be able to effect the proposals. So they do not look deliverable at the moment.

**Sir Charles Walker:** If resources are fixed at, let us say, current levels, and you had to take a scalpel to the Bill, what would you remove or amend, at least to allow some of it to happen, so as not to overburden the resource that you do have?

***Dr Gareth Owen:*** It is probably best to focus on the area where the costs are major. Those relate to the increased amount of tribunal work and the anticipated expansion of the SOAD service—the second opinion appointed doctor service. One approach to that might be to use secondary legislation so that you could try to understand what will be possible. You do not fix it now; you leave it to the Secretary of State.

We are also concerned about some of the proposals in relation to Clause 11 of the Bill. As those proposals are developing—and we understand they are not settled yet—they strike us as very confusing and potentially unworkable, and they could generate lots of additional work activity.

This is an area where the Mental Health Act and the Mental Capacity Act are interfacing in quite a fundamental way. One of the High Court judges said it is like putting your head in a tumble dryer. We think in that area it is very important to try to achieve simplicity and clarification to avoid spiralling costs or a burden on systems that it just cannot manage.

***Dr Ruth Allen:*** In terms of cost and resourcing, the workforce issue is huge. We know that we are losing large numbers of often experienced staff across different professions. There is some evidence about there not being enough new people coming in through qualifying routes. That is certainly true in nursing and social work at the moment. The time it takes to train effective mental health professionals has to be built into a longer-term workforce plan. That needs to start now to have resilience in the workforce, and that cannot be done without investment. Also, we need to retain our experienced staff because it is a huge waste of resources and expertise if we lose people.

I hope the Government will think about how we stabilise the mental health system, let alone bring about these changes, through supporting more stability in the workforce. That includes AMHPs and social workers, as well as all the clinical roles.

**The Chair:** Thank you very much. It is not a new problem, but it seems to be exacerbated now.

Q152 **Dr Ben Spencer:** I draw the committee’s attention to my register of interests and my membership of the Royal College of Psychiatrists. My question builds on Sir Charles Walker’s question about resourcing. The independent review and the Government argue that the measures that they have brought in to reduce the number of detentions will offset any prospective increased workload. How far do you share that view in terms of the resourcing answers?

***Dr Gareth Owen:*** We do not really share that view, perhaps because we do not see that the provisions will make a great impact on detentions. The offsetting case can best be made with advance choice documents where you can see a virtuous cycle developing. As we discussed earlier, those have been watered down from the independent review.

***Robert Lewis:*** Similarly, I do not really share that view. When you look at some of the fallout of the Bill, if we look at the other services and the gaps that we have already talked about, there seems to be an assumption that we know how expensive hospital is, but really good, decent community provision is expensive as well; and there is the training and specialism that you need around people who present with a lot of complexity. I do not know how you can arrive at that, but I am sure there are lots of figures behind the scenes. From our perspective, we do not share that view that somehow that will magically work.

**Dr Ben Spencer:** I want to go back to one of your earlier answers in terms of thresholds of the modified detention criteria relating to reducing detentions. So that I can understand it, the argument that you made was that, at the moment, because of the set-up of the services, the threshold for detention is so high that any increase in the statutory criteria to raise the threshold is superseded by what is actually happening on the ground, which is that, by the time you get to the point of doing an assessment, the acuity is so high or the need is so great that that is way above where an adjustment in terms of statutory criteria is going to.

***Robert Lewis:*** Yes.

> **Dr Ben Spencer:** Is there an argument nevertheless, playing devil's advocate on that, to change the criteria and say that, regardless of what we are looking at in terms of resources and our laws and rights, we should adjust the threshold even though in practicality something else might play out?

***Robert Lewis:*** Yes. You can put the threshold higher, absolutely, but there are still those gaps. I am not quite sure I understood the question fully.

> **Dr Ben Spencer:** It was more from a perspective of what sort of society we want to have—what is on our statute book as to the thresholds and criteria that we use for detention. Even though part of the intention of changing it is to try to reduce detentions or adjust the detention ratio, should that be the only concern? Do we also feel, looking at our laws and criteria, that these are the right criteria, even though the secondary drivers are not necessarily going to be realised because of the environment in which they are applied and in which people operate?

***Dr Gareth Owen:*** This relates to the Clause 3 wording on detention criteria. Something that is important here, which is not about changing detention rates—I do not think it will make a huge amount of difference on the ground—is conceptual clarity. Clause 3 introduces new words. I know you have been discussing this. The term "serious harm" needs clarification. The terms seem to imply that assessors will have to produce probability statements about individuals, and that is very problematic. It is extremely difficult to do that for individuals, and probabilities, conceptually, apply to groups.

This form of words has drifted in the passage. You need a form of words that encourages risk assessments which incorporate the notion of health—I know this has been discussed. It should encourage not pseudo-exact probability statements about individuals that everybody will disagree on and get confused about, but fact-based, narrative risk assessments that speak straightforwardly to the situation that somebody is in and inform a care and treatment plan, which is about mitigating those risks.

Something could be done on wording around conceptual clarity, so you do not get very unproductive disputes about the detention criteria and questions on what serious harm or probabilities or likelihood are meant to mean in relation to individuals. That is a slightly different point, but it is important.

> **Dr Dan Poulter:** I want to pick up on what Dr Owen said about the health criteria, which we are very familiar with under the current legislation. How important do you think it is to maintain something like that in the grounds for detention?

***Dr Gareth Owen:*** It is very important. Serious health neglect and health deterioration can result from mental illness, and those risks need to be recognised so that people are not seriously neglected.

The other point about this is that people can have patterns of illness where it becomes clear that early intervention is helpful in their cases. When certain signs emerge, it is not wise to wait until a risk has become overt, and it is least restrictive for that individual not to wait till a risk has become imminent. Information like that is often held in community teams in relation to individuals who have been known and are known across periods of time. It may also be in an advance choice document that somebody puts forward that knowledge about their personal understanding of how their illness goes, so risk assessments need to be able to accommodate that kind of information.

***Robert Lewis:*** Could I just bring in one point on the significant harm criteria? I tried to catch much of the discussions you had yesterday about whether some of these concepts should be better defined and things like that. My concern about them often being just about health to the body or mind all the time is that there are other significant harms that we need to be thinking about, such as the reputational harm of somebody who is left unwell in the community for a very long time with their neighbours, the family breakdown and the financial issues. Those are really significant harm issues for people that are not just about whether they hurt themselves or somebody else. I wanted to make that point.

**The Chair:** That is a good point. Thank you very much.

Q153 **Baroness McIntosh of Hudnall:** Mr Lewis, I just want to ask you to take us back to your very first observations at the beginning of this session when you talked about the Bill and you implied—I will not put words in your mouth—that in a way it was shoehorning stuff into a mechanism that was so set and goes back so far that, actually, there was a limit to what you could do to improve it. Is that an unfair representation of what you said?

***Robert Lewis:*** Our position is that there are definitely things that can be done with it. So, yes, you can.

**Baroness McIntosh of Hudnall:** My question to you in the interests of speed—forgive me for interrupting you—is this. There is a fixed amount of resource available that has been attached to the Bill. It could be applied in other ways within the mental health system. We have to assume that some version of the Bill will hit the statute books. Is there any version of it, given the resources available, that will actually represent a significant improvement on what would happen if you simply put all those resources into making the Bill work better in its present state?

***Robert Lewis:*** That is quite a question to answer in the sense that—

**Baroness McIntosh of Hudnall:** Have a think and come back to us.

***Robert Lewis:*** We are talking about the resource gap. We are talking about mental health services covering a huge range of individuals. Where do you target resources? Definitely into community services. On whether we should move the resources from this process to another, I could not say without having some guarantee that that will even fill that hole, because that is a massive hole to fill. Given that we are so far down the line, I would not want to stop this process. If you say to me, “Shall we stop this?”, I am not going to say, “Stop this”.

**Baroness McIntosh of Hudnall:** I understand that. I am not asking you to say that.

***Robert Lewis:*** There are definitely things we can work on, particularly around nominated person and those sorts of choice issues. That would be really good. I do not know if the money being diverted elsewhere will fix that problem.

**Baroness McIntosh of Hudnall:** That is helpful, thank you.

***Carol Webley-Brown:*** I would like it to be diverted to the community and definitely to increase the workforce in terms of nursing. Recruitment and retention are key in the Bill.

**The Chair:** Am I right in thinking that at the moment people are required to have a degree in order to train to be a nurse?

***Carol Webley-Brown:*** A degree or diploma, yes.

**The Chair:** That puts some people off who want to train as nurses. That could be something we might consider.

We are moving on now to Part 2 and Part 3 differences.

Q154 **Rosena Allin-Khan:** Thank you everyone for coming. It has been utterly illuminating listening to everything you have been saying. We have heard concerns that some changes in the draft Bill do not apply to forensic Part 3 patients—for example, the removal of learning disabilities from long-term detention. I have two questions on this. What are your thoughts on these proposals? If they are retained, what effect will the proposals have on working practices?

***Dr Gareth Owen:*** Some of this relates to some of the questions around the autism and learning disability exclusion in Section 3. You have heard evidence from the royal college on that from my colleague, Professor Odiyoor, so I do not need to go into that again, other than to reiterate that we have serious concerns about that as a college, and they relate to unintended consequences. One of them is around the effect it would have in the criminal sphere. It would result in a displacement of people into the criminal justice system.

***Robert Lewis:*** You have had a huge amount of input on this. There is very little to add on some of the submissions that you have already had for the learning disability part of that. There is a suggestion that there is the potential to move people out of prison settings who should not really be there.

In terms purely of AMHP Leads Network, there is not really a demand on us in particular. There is all the stuff about moving more people through from the prison estate into forensic. It is just looking at the impact of social supervision and things like that once the person is discharged. A lot of AMHP services are involved in that process. We would have things to say about how they are managed and how they are managed across boundaries, but I will not add those.

***Carol Webley-Brown:*** The vacancy rates of registered nurses in social care are the highest of any staff group—currently at 14%. Without additional funding to expand capacity and workforce in social care, there is a risk that support for people with learning disabilities will not be available.

***Dr Ruth Allen:*** I made some points earlier about the vital importance of more community support for people with learning disabilities and autism. The main issue is the transition that we are trying to achieve. It has been very difficult moving people with learning disabilities and autism out of long-stay hospitals of all kinds. We are still struggling to do that, and that is a lot to do with a lack of investment and practice developments to support people with learning disabilities and autism in those circumstances. It is our duty to have those services in place.

**Rosena Allin-Khan:** Does anyone have anything specific that they would like changed or added to the draft Bill that would address any concerns?

**The Chair:** In this particular area?

**Rosena Allin-Khan:** Yes.

**The Chair:** I think you have stumped them. It is difficult.
**Rosena Allin-Khan:** Thank you.

**The Chair:** We have touched on supervised discharge, but Lady Barker has a little more on this.

Q155 **Baroness Barker:** CTOs were sold to legislators on the grounds that they would be a less restrictive option, they would be very rarely implemented, and they would be developed in an ethical way, but they have turned out to be disproportionately brought into play for black and minority communities. Given what we now know about that, do you think that there is a risk that supervised discharge could go the same way? If so, what could be put into the Bill to mitigate that, if supervised discharge is deemed to be a less restrictive option for a very small number of patients?

***Robert Lewis:*** The logic follows that we would see the same kind of discrimination. We are talking about people coming through criminal justice and forensic routes who are already disproportionately represented, so therefore it is highly likely that they will be equally disproportionately represented in those kinds of arrangements.

As to how you would change that round for the individuals involved, as well as looking at the population as a whole, we come back to those notions around culturally appropriate advocates and trying to get in the system those supports for individuals to make those cases and to try to steer. That is really based on lots of culture and practice that is already there, so it is just replicating, I would imagine. It would take lots of other changes to eventually feed through. We are talking about people who are on quite a long trajectory through the system. I imagine it would take some time before you saw that improve.

**Baroness Barker:** I think I am right that earlier witnesses have said that there is a lack of reliable data on CTOs. Given that this would be a change that would be brought in now, what could be done to make sure that the future data collection on supervised discharge is not done equally badly?

***Robert Lewis:*** It may just be my reading of it, but I am unclear as to how they are created. Are they created through the tribunal routes as conditional discharge?

**Baroness Barker:** Yes. What we understood from previous witnesses is that there is no reliable data about the extent to which CTOs have been used as less restrictive options, why there is a disproportionate number of people from minority communities, and the fact that those people tend to be on them for longer than other people.

***Robert Lewis:*** The data issue is massive; of course it is. It comes back to some of the Section 13 stuff I mentioned earlier. We do not know what proportion of requests for CTOs actually end up becoming a CTO. We do not know how effective that process is at even trying to combat some of the disparity. It might be that it is not a bad way of doing it, but the numbers are still so high that it is effectively a floodgate, for want of a better phrase. Collecting data on those requests needs to look at not just the pieces of paper that have been signed but the requests that have been made.

I would argue that is the same for every single piece of compulsion or request to compel somebody to do something or think about detaining somebody. You need to understand who is referring, who is being referred, what is being requested and what the outcome was, not just what proportion of people ended up being detained or subject to compulsion. Does that make sense? That then gives you some quality data you can look at to start targeting locally, regionally and nationally what those trends are.

I know consultant colleagues who have absolutely refused to use a CTO and others who will quite readily make those requests. That might be looked at within that region, but you need the data to be able to pull that out. We need support as AMHPs in particular, because we are primarily doing the role and we need that system support behind us. We do not always get that, partly because the requests are going to a local authority that is not necessarily tied in with the health trust that it works alongside, so the data collection systems are not always the same. It can range from quite sophisticated systems down to an AMHP lead with a spreadsheet. That is why it is really hard to pull some of those things out.

***Dr Gareth Owen:*** I may be able to give you a bit of data that contextualises that. In answer to your question on whether there is a risk of a pattern of disparities similar to that of CTOs, yes, there is. We are talking about a pool of people who are restricted patients. How big is that pool? Taking data from the end of last year, we are talking about 7,740 people, of whom 70% are white, 18% are black and 8% are Asian. That just gives you a sense of the pool. From those, the supervised discharge could be applied.

Why are we discussing this? We are discussing it in the light of the Supreme Court judgment in the MM case, which is around there not being a provision to authorise the deprivation of liberty for that group, although everybody wants to move them on, from hospital into the community. That is a legal gap. It is a gap I am sure you are all familiar with in relation to Bournewood. We think it probably should be filled. What can be done in the Bill to mitigate the sorts of risks that you are referring to? It is difficult to see a solution.

***Carol Webley-Brown:*** The RCN would like the CTOs abolished, and we would like to improve the mental health provision at the point of access to promote early intervention in general practice. We think that having more advance-level mental health nurses who are independent prescribers working alongside GPs would be the answer for the future.

**Dr Dan Poulter:** Just picking up on Ms Webley-Brown's point about abolishing CTOs altogether, my understanding is that there are limited randomised control trials in this area, but the randomised control trial evidence shows no benefit of CTOs except a reduced incidence of crime to the individual on the CTO. Would there be strong feelings if this committee were to make some recommendation in that direction?

***Dr Gareth Owen:*** A recommendation to remove them?

**Dr Dan Poulter:** Yes. We heard from Simon Wessely about some forensic cases where there may be some benefit. I just wondered whether, Dr Owen, the college, in particular, had any strong feelings about that.

***Dr Gareth Owen:*** I should declare that I have submitted a written document on this as an academic at King's who has reviewed the evidence. I am speaking now as a representative of the college. It is helpful to give a bit of history of the college view on this.

We said earlier that they were introduced in 2007, which was an amending Bill. The Royal College of Psychiatrists was critical of them during that amendment process. The college supported the independent review position on CTO in 2018 that recommended more restricted use.

What do members think? When surveyed, there is variation in views. Some members see a case for keeping them and some do not. We have discussed this. Surveys are always difficult because of response rates, but we think that, overall, the best characterisation of the predominant view within the college is not a strong one either way. That might help just in terms of understanding how the college sees this.

The independent review has recommended restrictions. It is probably also important to note—we covered this earlier—that they are restrictions by increasing administrative hurdles, and that in itself will have costs for tribunals and clinicians.

The other recommendation that the independent review made was to commit to reviewing them in five years' time and removing them from the Mental Health Act if the numbers detained and the racial disparities that we are concerned about do not change. That was a recommendation of the independent review.

**The Chair:** Thank you very much. Now we move to our last question with Lord Bradley. Apologies that we have run over a little.

Q156 **Lord Bradley:** I will be brief. As you know, the draft Bill introduces a statutory 28-day limit for individuals with severe mental health problems to be transferred from prison to hospital, but we have heard—you may be surprised—that this has considerable resource implications. I would be interested in your views on the proposal in itself and your views about what the resource implications may be.

***Robert Lewis:*** From the AMHP point of view, we are not directly involved in any of that process, so it is not a big area of focus for us, although we absolutely support the intention behind the measure. That would not be an issue.

On changes that could go into the draft Bill, there is something about the commissioning pathways—others can probably talk about this better. From what I have heard from colleagues across the country, there are different pathways for moving people from prison into hospital. For some, it is embedded into the process, and for others it is a much harder process, so there needs to be some attention around that in order to meet the aim and that intention. There needs to be consistency around that. Apart from that, we do not have a particular view.

***Dr Gareth Owen:*** This is a painful one. We think it is almost certainly not achievable. Prisons are getting worse. There is no likelihood of adequate increased funding for hospital beds. That is really the issue. While we support the aim fully—it is important and laudable—there is a difficult question about the purpose of a statutory target when the settled view is that it is not achievable with the current resources.

The other consideration is that, with the introduction of these sorts of targets, you can sometimes get perverse effects whereby you degrade clinical thresholds, so people start to think that somebody who needs to be transferred does not. You get into a difficult situation whereby people feel that they need to game in order to achieve the target. It is a difficult one for us, but I think it is important that we are honest with you about our view that we do not think it is achievable.

***Carol Webley-Brown:*** It is about investment, capacity and an expanded workforce. There is an exceptional circumstances clause outlined in the Bill that means that the 28-day timeframe can be adjusted. It also means that this is needed, inappropriately, as beds and staffing to facilitate the transfer may be unavailable. Unless there is additional resourcing over and above what is committed—and that is not forthcoming—it will be difficult. But in essence, the 28-day idea is good.

**Lord Bradley:** Do you think the exceptional circumstances proposal could be used in the way that Dr Owen is describing, as part of the game?

***Carol Webley-Brown:*** Yes, I forgot about that bit.

***Dr Gareth Owen:*** What are exceptional circumstances? For me, they are natural disasters.

***Dr Ruth Allen:*** It is vital that people get out of prison and into appropriate treatment as quickly as possible. Could it be part of the Bill, or part of an Act that has a later enactment date? Then there is a specific direction towards the transitional arrangements that need to be put in place to enable this to be achieved and progress to be made towards it. That is not what we would like to do. No doubt, all of us would like this to happen immediately, but clearly the system is under so much stress that we have to be honest about transitional arrangements and keep the momentum towards improvement rather than just pushing things out of the Bill.

**Lord Bradley:** There is also the issue of investment in prison healthcare. That is underfunded as well, so you are leaving people in very difficult circumstances if you do not meet the 28-day transfer.

***Dr Ruth Allen:*** Yes.

**Lord Bradley:** Okay.

**The Chair:** Thank you. I thank the witnesses very much indeed for their really important contributions this afternoon. Thank you for your time and your thoughts. We are extremely grateful.

Panel 2

Witnesses: **Dr Camilla Parker KC (Hon)**, Legal and Policy Consultant, Just Equality.

Q157 **The Chair:** Good afternoon. Welcome to Dr Camilla Parker, who has joined us at short notice to explore legal issues around children and young people in the draft Bill. Thank you very much indeed. Could I ask you to say, top line, what your role is and who you represent?

***Dr Camilla Parker:*** Thank you very much for inviting me to speak to you today. I am honorary King's Counsel, and I am a lawyer specialising in mental health and related law. I work through my consultancy, and through that I engage in policy development, legal training and legal research in mental health and human rights. Much of my work is focused on the care and treatment of children and young people. I am also a long-standing member of the Law Society mental health committee and a member of the Children and Young People's Mental Health Coalition, but today I am speaking in my personal capacity.

**The Chair:** Thank you very much indeed. I will move straightaway to Lady Berridge for the first question.

Q158 **Baroness Berridge:** We know you have received the questions in advance, but I will put it on the record and I want to supplement it with a scenario that I hope will blend with things you have heard in and out of questions.

We have heard that the change from nearest relative to nominated person or persons may conflict with the rights of people with parental responsibility, as outlined in the Children Act. Is that the case? If so, is there a way to maintain the rights of those with parental responsibility and the right for children to choose the nominated person? Is there a way to hold that together?

The Government have said that conflicts between those two will be addressed in the code of practice. Is that the right place for it or should it be done in the Bill? Finally, what would be the consequences of any conflicts not being clarified in the draft Bill?

Can we flesh this out into an example of someone who is under 16 years of age? I know there are many scenarios where it is all perfect, but this is a common situation. Parents ask for detention. The child is assessed and is Gillick-competent to appoint a nominated person. You end up with that nominated person not being the parent. Then we have the scenario that the nominated person either objects and the clinician changes their mind, or it goes to tribunal and the under-16 is discharged.

That can obviously be fine. It could be that they harm themselves. It could be that the parents refuse to take them back home, so you are into the care proceedings route, or they go home and they harm a sibling or someone else in the home. It is important for us to flesh out that that is the scenario we are dealing with and many of the consequences. What is your response to this, please?

***Dr Camilla Parker:*** Can we come to that scenario? Perhaps I could widen out what we are looking at, first, because it is important to be clear about what we are talking about. It is incredibly valuable that this committee has raised this as a point because it has given people an opportunity to look and think, "What does this all mean?"

My first observation is that we need to ensure that we are not thinking about the nominated person as an advocate. That is not their role. So far as I can see in the proposals, there is nothing about the nominated person having to consult with the patient about what he or she does, using those powers. The powers are pretty wide, including, it is important to note, that the nominated person can apply for someone to be detained.

When we think about the nominated person, it will be important that they have a particular role under the Act. However, they are not an advocate, and that is certainly something children and young people will need to know when they are being told about their right, if they have a right under the Bill, to nominate. They need to understand that they do not necessarily have any control over what the nominated person does or does not do. They are not an advocate; they are not necessarily representing them.

The second issue, when we look at the changes in the Act in relation to choice of nominated person, is that it makes a huge amount of sense to change that in relation to adults. Adults will often find—because you have that strict list—that the nominated person could be someone who has nothing to do with the patient or even someone whom the patient does not want to have anything to do with, whereas under the current Act, in most circumstances, but not all, the nearest relative will be someone with parental responsibility. That is the issue.

One of the issues raised by the committee's questions is that we need to go back and ensure that when young people are thinking about their choice of nominated person, they understand what it is, according to the wide powers the nominated person has, which they will not necessarily have any control over.

We are rightly focusing on the examples raised. It is very important to look at what happens if the child or young person has not nominated the nominated person. It is then going to be for the approved mental health professional to appoint that person when the mental health assessment is carried out. If you look at those provisions, there are definitely conflicts with the Children Act.

First, regarding young people, the AMHP has to consider whether the person has a donee—somebody who has been appointed under the lasting power of attorney. A young person aged 16 or 17 cannot appoint. The other person would be a deputy. You might have a deputy appointed under the Court of Protection for a 16 or 17 year-old, but again, it is about whether the deputy has a role as appointed by the Court of Protection that covers being a nominated person. The likelihood of that being relevant is slim.

For 16 and 17 year-olds, basically, there is nothing there. The AMHP will take into account the wishes and feelings of the patient; that is it. There is no reference to parental responsibility for a young person.

As regards children aged under 16, there is reference to the local authority if there is a care order. After that, it is just somebody with parental responsibility. That completely fails to recognise that under the Children Act you could have people appointed under, say, a child arrangements order or a special guardianship order, which give them parental responsibility. I am particularly concerned about the special guardianship order not being referred to. When there is a special guardianship order, that effectively takes away the decision-making powers of parents.

Under the Bill as it stands, you could have an AMHP, who is not necessarily going to know about these issues, thinking, "Who do I appoint? I appoint the parent", when a court has made a special guardianship order and given that person, perhaps the grandparents, the status of parental responsibility, with effective control over the day-to-day decisions about the child, with a parent effectively not having any. Then, because the AMHP is not aware of that or the Children Act, and it is not in the Bill, the AMHP has appointed the parent. These issues are not simply about the child or young person appointing a nominated person.

Going back to your scenario, if someone under 16 has been detained under the Mental Health Act, that would be because it has been considered that they cannot be admitted informally; they are not consenting, either because they do not have the competence to do so or are refusing, or it is a situation where it is felt that the parents cannot consent, which I know we are going to come on to. You have the use of the Mental Health Act. The child has appointed someone other than the parent and that person has applied to discharge the child. Under the Act—it has not changed—the nominated person would need to give 72 hours' notice to the hospital. Within that time, the responsible clinician could issue what is called a barring order report if the responsible clinician considers that the child will act in a manner dangerous to him or herself or to others.

There is an issue there in what we mean by "dangerous". It could include self-neglect. That would be an issue that perhaps would be looked at if that application was made. I would hope, if nothing was changed, what would happen would be that the parents would be informed and the local authority, if necessary, would be informed as to what arrangements can be put in place for the child.

> **Baroness Berridge:** Is there any duty at the moment when you have a nominated person who is not the parent to inform the parent that this objection has been made and the child could be coming out of hospital?

***Dr Camilla Parker:*** No, I do not think there would be. Generally, it would be someone with parental responsibility. It is more likely that these scenarios have never been thought about, which is one of the issues. It is so incredibly valuable that the committee has asked to talk about these issues, because for people working in this field, working in relation to children and young people who might come under the Mental Health Act, one of the frustrations has been that these issues have never been given the attention they need and deserve.

A lot of issues come up where people are struggling to understand the Mental Health Act and how it relates to the Children Act. Some of these come about because we have become very siloed regarding people's knowledge. You have people who know an awful lot about the Mental Health Act. You have people who know an awful lot about the Children Act. When you are talking about mental health, you are less likely to have people who know about the Children Act. Because they have historically been a minority, there has been little attention given to the experiences of children and young people. We are moving towards trying to address that, but we are very behind.

If you go ahead with the scenario where the under-16s are able to appoint the nominated person, it will be really important that the powers of the nominated person are explained to the child or young person so they know this is not an advocate. They have an entitlement to an advocate. That is another separate right. The fact that they have nominated somebody as their nominated person does not take away the role of their parents or others with parental responsibility. Therefore, we need to work through the role of the nominated person and those with parental responsibility.

First, we need to ensure that the child or young person is clear as to what they are doing.

> **Baroness Berridge:** They are ill.

***Dr Camilla Parker:*** They would be appointing a nominated person only if they have the competence or capacity to do so. Part of ensuring that they are able to make that decision is to give them the information pertinent to that decision. There is a lot that they will need to know about.

One of the things that could be done, perhaps, with this 72-hour notice, is introduce what you were suggesting; you could introduce a provision that, if that happened, then the parents would be notified. That will be important if the nominated person has nothing to do with the care of the child. Let us say you had someone in your scenario. The nominated person is AN Other. It is the parents to whom the child will be going back. If the parents are saying, "We're really concerned. We recognise that our child is very unwell. We have concerns about that. We do not think at the moment we're able to give our child the support they need at home", what we could do is build into the Bill a provision that the parent is notified and they would have an opportunity of objecting. Perhaps we also need to look at the dangerousness issue.

> **Baroness Berridge:** Before we pass on, one point that is clear in the law, from the Family Law Reform Act 1969, is that 16 and 17 year-olds have a statutory right to consent. We have clarity there, but there is this situation for under-16s. Am I correct in that understanding?

***Dr Camilla Parker:*** Yes. The Family Law Reform Act relates to medical treatment.

> **Baroness Berridge:** Yes.

***Dr Camilla Parker:*** That is what it concerns. It says that young people aged 16 or 17 can consent to their medical treatment as if they were an adult. With that, and with the presumption of capacity under the MCA, you start from the position that the young person has the capacity and the legal authority to make that decision about medical treatment. In relation to under-16s, the importance of Gillick competence comes in. Where the child is assessed to be competent, they can make the decisions about treatment or other things.

The provision under the Family Law Reform Act is specific to medical treatment. Again, talking about a young person and whether they are able to appoint a nominated person, you would be starting from the position that they have capacity to make that decision. Again, it is ensuring that they have sufficient information to make the decision.

**The Chair:** Dr Ben Spencer, we have several questions, but you wanted to say something on this.

**Dr Ben Spencer:** I am trying to think through solutions to these problems.

***Dr Camilla Parker:*** Yes.

**Dr Ben Spencer:** I am a bit old-fashioned and I think parental responsibility is very important. Would it not be easier, in terms of the legislation, to say, "Look, in this situation people with parental responsibility have the powers of the nearest relative and nominated person. Full stop"?

***Dr Camilla Parker:*** It would be easier. Perhaps we need to go back and think about what children and young people would really like. Do they want to nominate a nominated person? That would be part of revisiting this. If we are saying that young people would like to have the choice of nominating someone, do we want to go along with that and say, "We want to do that because that is what we are doing with adults", or are we saying, "Because they are aged under 18, there is something called parental responsibilities, and under current provisions they would normally apply to the nearest relative"? It is not always the case—there are exceptional circumstances when they would not be—but, normally, you would see someone with PR being the nominated person.

You could say, "Let's leave it as it is". The question I would like to ask is, "What do young people think about that?" That is certainly something we have been trying to do with the Bill—to engage with people who will be subject to the Mental Health Act. We could say, "Would it be better to leave things as they are and work with someone with parental responsibility?" We would still need to work out how we identify who that is, because you would have a number of different people who have parental responsibility. You have to decide who, among them, would be the nominated person.

The key issue and what we need to revisit for those who are keen to enable children and young people to make that choice is what we are trying to ensure. If it was thought that the nominated person is an advocate, and we say, actually, they are not an advocate but you do have a right to an advocate, is this something that children and young people would want to do—to choose somebody other than their nominated person?

**Dr Ben Spencer:** That is genuinely very helpful. The question I am trying to answer is: why is mental health different from physical health in this situation? Children cannot decide, "You are no longer my parent and you no longer have parental responsibility". We do not allow the circumstances by which parental responsibility can be removed. What is so special about mental health care and treatment that we want to have another mechanism by which children can get another decision-maker with incredible powers—to force the discharge of a child against the views and wishes of the doctor?

By definition, the doctor and the treatment team want them to stay in hospital. That is why they are under section. There is a higher threshold to go through, admittedly, but still it is against clinical advice. Presumably, it would also be against parental advice, unless there is a conflict. What is the driver to introduce this new mechanism of, in effect, a pseudo-parental responsibility? What is special about mental health that this is where it is being explored as opposed to a physical health setting?

***Dr Camilla Parker:*** I will attempt to answer that. I would suggest it is just how mental health reform has developed. We are in this position because, as we were saying earlier, no one has given attention to how the Mental Health Act applies to under-18s. Your question is premised on the idea that someone has sat down and thought, "Oh, nearest relative, how does that apply to those aged under 18?" I do not think they did.

**Dr Ben Spencer:** No.

***Dr Camilla Parker:*** I am sure we could have an interesting discussion about how "nearest relative" has developed. It probably was thinking about the person who is close to the relative. The arrangement for discharge would be with the idea that the person who is seeking the discharge of the patient would be the person who would then be caring for the patient.

Certainly, "nearest relative", so far as I know, has been around since 1959. We are looking at something that was probably developed with an eye to adults, not under-18s, but we are seeing more of those aged under 18 being admitted into hospital. That is why we are here. How we then move on from that is where this is welcome and we can start to look at how this applies to under-18s.

Those who are looking at this from a children and young person's perspective would be keen to have a look at this again. I am not speaking for any organisations. My sense is that it would be useful for us to go back and revisit that and perhaps come back with some suggestions. Certainly, if we went down the route of recognising the right of children and young people to choose a nominated person, we can put in some provisions that pick up on the scenario just raised—for example, a notice being given to the parent.

In addition, other powers of the nominated person do not take away the role of people with parental responsibility. They can still be involved in their child or young person's care. If there were concerns about the nominated person, there are mechanisms for going to court to seek the termination of that appointment. There is that safeguard. However, what needs to be looked at is: is that going to be accessible for parents? Going back to the scenario of the parents who are very concerned about that, under the Bill, yes, the parents could make an application to court. The court would say the nominated person is not suitable, but are the parents going to be informed about that? Are they going to have the resources to do that? How long would those proceedings take? Those issues would need to be looked at.

**Baroness Berridge:** To clarify, legally, when a child has been detained, and it is clear about the nominated person and communications there, are clinicians still legally obliged to communicate to those with parental responsibility as well, or does the nominated person process cut them out?

***Dr Camilla Parker:*** It does not cut them out.

**Baroness Berridge:** Okay.

***Dr Camilla Parker:*** It would be about whether the under-18s wished their parents to be involved. Having an appointment of a nominated person does not cut out the role of parents. That needs to be made very clear. They are two separate things. You have the nominated person, who sits under the Mental Health Act with various powers under the Act. You have parental responsibility that sits under the Children Act and powers around parental responsibility. They are separate responsibilities. The fact that a child will have appointed a nominated person does not remove someone with parental responsibility.

**Baroness Berridge:** Under PR, though, they cannot apply to discharge any longer under the mental health tribunal. That power rests only with the nominated person.

***Dr Camilla Parker:*** With regard to the right to go to a tribunal for the nominated person, if they have applied to discharge the child or young person, and that has been stopped by the responsible clinician, the nominated person can apply to a tribunal. I would need to double-check but I think that is in relation to Section 3.

**Baroness Berridge:** A parent could not apply because they are no longer the nearest relative. That little section of what would have been parental responsibility because they would have been the nearest relative has now gone. That power rests just with the nominated person under the Act.

***Dr Camilla Parker:*** In seeking to discharge the patient, yes. That would be for the nominated person.

**Baroness Berridge:** For the nominated person. Thank you.

Q159 **The Chair:** Forgive us, we are short of time. What would be the benefits and drawbacks of setting out a statutory test for competence for under-16s as opposed to relying on case law with the Gillick competence test? Is the draft Bill the place to do this? Would setting out this test in this statute have wider implications in children's law? We have heard suggestions that such a test could be adapted from the test in the Mental Capacity Act. How could this test be developed and adapted for children of this age? A top-line answer would be amazing.

***Dr Camilla Parker:*** It is absolutely essential that we have a test for determining whether the child has capacity to make the decision. We should probably move away from competence and talk about the child's capacity.

**The Chair:** Yes.

***Dr Camilla Parker:*** It does not make sense not to have it in the Bill. So much of the Bill is premised on giving people greater autonomy and greater rights to be involved in their care and making decisions. We have a situation where that is meant to apply to under-16s, but without a test for determining whether the child or young person can make the decision.

Before we talk about what the test is, what we are seeking to ensure is that that child is able to make the particular decision, whether on admission to hospital or treatment. The ability of that child to make that decision determines whether the child can give the legal authority for that decision. If the clinician is seeking the child's consent to treatment, the clinician will be looking to see if that child is able to make that decision and obviously willing to make that decision to give consent. If the clinician is satisfied that that is the case, that child can give consent.

The issue about Gillick and why we talk about Gillick competence is because one of the issues put forward to the House of Lords was that, because of their age, the under-16s could not make decisions for themselves. In that case it related to contraceptive advice and treatment, but the issue is broader than that.

The House of Lords rejected that. That is important because the House of Lords was saying, "The fact that you're working with someone aged under 16 does not mean that they cannot make that decision. What you need to establish is whether that child has sufficient understanding and intelligence to make that decision". We need something in the Bill because, 40 years later, we do not have a consistent, clear way of determining whether the child is able to make that decision.

**The Chair:** No.

***Dr Camilla Parker:*** Judges over the years have taken various different approaches in assessing that. While, yes, it is understood that we recognise that as a child grows and develops they can make decisions for themselves, we do not have a clear, consistent means of identifying whether the child can make that decision.

If we are talking about a Bill that has so much riding on whether you are able to make a decision, I find it astounding to suggest that for people aged 16 and over we have the test that people are very used to using, but for the under-16s we have nothing. It is giving with one hand, saying, "We're going to give you these extra safeguards", but taking away with the other, because we are not setting out a clear way of determining that.

I do not know whether that will influence other areas of law. It might do, but that will be up to the judges and the development of case law outside the Mental Health Act. Again, it is very important to think, "What are we doing here?" We are looking at how the Mental Health Act operates. We can make it very clear that a test in this situation relates to the Mental Health Act and how it operates.

Of course, I am pretty certain that people will look to what is in the Act and say, "Can we use it elsewhere?" That is a good thing. This is an opportunity for this Bill to set out something that people would like; it will be helpful for children and helpful for people looking at this issue. We have the people who are making decisions about whether the child can consent to their admission and their treatment. Their decisional capacity is relevant to appointing an independent mental health advocate or whether you want to have an independent mental health advocate. As we have just seen, it is a nominated person as well.

So much of the way the Bill operates rides on issues around decisional capacity. The area of particular importance is in relation to treatment. It is very much about whether there are the enhanced safeguards that everybody is saying are really important. But again, as a child you will not have those enhanced safeguards unless you have been assessed to be competent to do so.

It is taking away something from children, which is incredibly unfair. It is also going to be unworkable in the sense that you have very clear procedures for those aged 16 and over, but nothing in relation to under-16s. It absolutely needs to be in the Bill. Let us start by looking at using the functional element of the Mental Capacity Act or a variation of that. You are using that to determine whether the child is able to make the decision. The issue about the diagnostic bit—an impairment of, or disturbance, in the functioning of mind or brain—is not relevant. All you are looking for is a way of determining if this child can make this particular decision at this particular time.

I am sure we could work up something more focused on the child, if that is deemed useful. Certainly, we want to look at how you can ensure principle 2 of the MCA, which is about helping people make decisions for themselves. That can be incorporated, thinking about it from a children's rights point of view, thinking about how you support that child making that decision, recognising that we need to listen to the child and work within what they feel comfortable with.

Q160 **Baroness Barker:** If statutory advance choice documents are in the draft Bill, how does that work for the under-18s?

***Dr Camilla Parker:*** The question is on whether, because the Mental Capacity Act gives the right to make an advance decision only for those aged 18 and over, we should just reflect the Mental Capacity Act. But we need to move back a little from all this and think, "Why is that the case?"

The reason for that was because, when the Law Commission was looking at what became the Mental Capacity Act and working up draft legislation, it thought it would not be appropriate to give 16 and 17 year-olds the ability to make advance decisions to refuse treatment because the courts have consistently said, and are still saying, "In relation to under-18s, even if you had someone under 18 who is able to make that decision, if they are refusing life-saving treatment, then we can override their refusal if that is in their best interests". Although the cases tend to be around life-saving treatment, the principle is broader than that.

In this context, we are talking about how it works within the framework of the Mental Health Act. Even for adults who have made an advance refusal of treatment, that does not mean they are not going to receive it. What it means is that there are enhanced safeguards for either the person who has the ability to decide and refuse or somebody who has made an advance refusal. An adult could have made an advance refusal of treatment but still have that treatment given because the provisions of the Mental Health Act permit it.

In the context of under-18s, we need to remind ourselves to give the under-18s the same facility to make decisions in advance. However, like adults, there will be circumstances in which the Mental Health Act has provisions that could override their decision, whether it is their decision at the moment because they have capacity to make it or decisions made in advance. We can say that we can work with this because this is in a different scenario.

**Baroness Barker:** I think we understand the legal principle.

***Dr Camilla Parker:*** Yes.

**Baroness Barker:** Could you follow up in writing and tell us how you think it might work in practice, if there is any distinction between the two?

***Dr Camilla Parker:*** You heard about this last week, talking about competence again. We need to have a test for the under-16s in terms of enabling them, and consider how we can test the child's capacity to make this decision. We need to have something in the Act for that. We need to think about how to ensure that there is sufficient information and other support in order for the child or young person to understand what the advance refusal is—or what the advanced decision documents are—why they might want it, what it means and what are the consequences of making one.

**The Chair:** Thank you, that is very helpful.

Q161 **Sir Charles Walker:** Both parts of this House, the Lords and the Commons, are very concerned, rightly, about children being detained on adult wards and being moved huge distances out of areas for treatment. This has been raised repeatedly on the Floor ever since I have been an MP, which is 17 years. I am sure it is the same for Lord Bradley, who expressed his concerns at the last meeting along with others of his colleagues.

What can we do about that in this legislation? Does the Bill go far enough? Should it go further? Has it missed an opportunity? What is your considered view?

***Dr Camilla Parker:*** I suspect it is not going to surprise you to know that I say no, the Bill does not go far enough. Yes, something can be inserted in a Bill. If I may, I would like to broaden this out. The committee has rightly identified issues around under-18s on adult wards and being placed out of area. Other issues of huge concern are the numbers of under-18s being placed on paediatric wards. When they have mental health problems, they are on general paediatric wards. Then it is very difficult sometimes to find an appropriate CAMHS bed for them. Last week you heard the broader issues about those under-18s who, for whatever reason—sometimes it is not entirely clear—are found not to be eligible for a tier 4 bed. Then there are huge problems in finding alternative placements for them.

There is a bigger issue—which the discussions around the Bill are flagging up—that we need to look at in the wider context, particularly for under-18s. There is a huge need for specialist care, to support the specialist services for under-18s with complex needs. At the moment, there is a huge problem because there are insufficient services for them.

In thinking what we can do about that, it might be a clause bringing in the various agencies to look at what services should be provided. There is investment in that. It is also thinking about why someone is on an adult ward. It is not necessarily one agency's problem why they are on an adult ward; it is a bigger issue about lack of resources.

Q162 **Sir Charles Walker:** A previous witness has said that the level of acuity on adult wards is now much higher. I am probably misquoting, but they said they are horrible places. They are not full of horrible people, of course, but full of very sick and distressed people. That is no place to send a child. It makes the period of their own detention even more distressing and disturbing.

Could there be statutory obligations in the Bill, or should we suggest that statutory obligations should be placed on mental health trusts to have a minimum level of beds and quite a high minimum obligation to those aged 18 and under?

***Dr Camilla Parker:*** Yes, but I think I am right in saying that it would not be the trusts that would have that; it would be the commissioning agencies. In relation to tier 4, it is NHS England's overall responsibility, although increasingly it is the provider collaborative arrangements. It is about the commissioning bodies ensuring that there are sufficient beds for under-18s.

It is also about community alternatives and developing specialist services that will be closer to home and more directed towards the needs of individuals. Certainly judges are saying there is a huge problem in the lack of resources for those under-18s with complex needs.

At the moment we have provision in relation to the age-appropriate environment. Pushed into the shadows was the report that led to the amendment to the Mental Health Act that young people should be admitted into only suitable and age-appropriate environments. We have that and it does need to be strengthened. When that provision came into being there was a lot of work done, first, to try to ensure that that did not happen and, secondly, that if someone under 18 was admitted to an adult ward, there would be a safe space for them, with staff with sufficient skills, CAMHS skills, education and routine directed to the child. That is not happening.

**Sir Charles Walker:** Will it be strengthened?

***Dr Camilla Parker:*** Last week, it was suggested you could bring in something about "not to be admitted unless it is demonstrated to be in their best interests". The code of practice has specific examples where admission to an adult ward could be appropriate. One is where there is an emergency—for example, "This person aged under 18 needs hospital admission and there is nowhere else". The other one is in a rarer case where it is thought to be appropriate, such as a young mother who needs admission to one of the few-and-far-between mother-and-baby units. It could be strengthened that way.

It is also thinking about how we can monitor that and make sure that this is seen as collective responsibility. It is not simply about the trust that is holding that child on an adult ward; it is thinking about how they got there. The CQC is given information when someone aged under 18 is admitted. It does, from time to time, publish information. It did that earlier this month. However, information in the notifications is very important, such as: why did they get admitted to an adult ward? If we have that on a regular basis, that should inform commissioning, going back to your point about commissioning appropriate services. That is ultimately what all these things are about. The out-of-area placements, use of paediatric wards and admittance to adult wards are a symptom of a very significant concern that needs to be addressed. It is not just health; it is local authority and probably also education.

**Sir Charles Walker:** I notice my colleague Lord Bradley nodding. I know this is my question, but, Lord Bradley, you feel strongly about this; we all feel strongly about it. You raised it in the last meeting.

**Lord Bradley:** I was nodding in agreement with commissioning arrangements. Perhaps the ICB commissioning role, strategically within its areas, would be a vehicle to address specialist services at a local level. As you rightly say, this comes under NHS England, but the commissioners can be at the local level through the ICB.

***Dr Camilla Parker:*** Yes. Would it be possible to take these comments away and come back to you with some practical solutions?

**Lord Bradley:** That would be really helpful.

**Sir Charles Walker:** That would be lovely, yes.

**The Chair:** Could you include in those comments the relevance to learning disability and autism, which is relevant to children and young people?

***Dr Camilla Parker:*** Absolutely. That is one of the areas for the under-18s for whom it seems there are huge problems finding suitable placements for. I know that, today, we are focusing on people who come within the Mental Health Act. Increasingly, we are seeing under-18s who, for whatever reason, do not and then it is not clear what services and support they will receive. Absolutely, I am very happy to do that.

**The Chair:** Thank you very much indeed. I feel that we have rushed you. We are so grateful to you for coming to us at short notice. If there is anything else that you might like to say to us in written evidence with respect to safeguarding the interests of children and young people, please do; we would be extremely grateful. However, we have this time constraint. Thank you so much for coming.