

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Wednesday 23 November 2022

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Written evidence from witnesses:

- [NHS England \[MHB0051\]](#)
- [Department for Health and Social Care, and Ministry of Justice \[MHB0094\]](#)
- [Department for Health and Social Care \[MHB0095\]](#)

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

Questions 177-202

Witnesses

Panel 1: **Professor Tim Kendall**, National Clinical Director for Mental Health, NHS England; **Dr Roger Banks**, National Clinical Director for Learning Disability and Autism, NHS England.

Panel 2: **Maria Caulfield**, Minister for Mental Health and Women’s Health Strategy, Department of Health and Social Care; **Caroline Allnut**, Deputy Director, Mental Health Act, Serious Mental Illness and Offender Health, Department of Health and Social Care; **David Nuttall**, Deputy Director, Neurodiversity, Disability and Learning Disability, Department of Health and Social Care; **Damian Hinds**, Minister of State, Ministry of Justice; **Anna Lacey**, Deputy Director, Female Offenders and Offender Health Policy, Ministry of Justice.

Panel 1

Witnesses: **Professor Tim Kendall**, National Clinical Director for Mental Health, NHS England; **Dr Roger Banks**, National Clinical Director for Learning Disability and Autism, NHS England.

Q177 **Chair:** Good afternoon, everyone. This is the final oral evidence session of this Joint Committee scrutinising the draft Mental Health Bill. The aim of this session will be to hear the views of NHS England and the UK Government on the proposals in the draft Bill, to test out some of the views and proposals the Joint Committee has heard during the inquiry, and particularly to test the Ministers.

In addition to the 14 evidence sessions the committee has held, it is important to note that the committee has also held private events with service users and visited a mental health setting.

Can I begin by welcoming our two first panel members, Professor Tim Kendall and Dr Roger Banks? First of all, could I ask you to set out very quickly who you are and whom you represent?

Professor Tim Kendall: I am national clinical director for mental health at NHS England. I also work clinically with homeless people with mental health problems in Sheffield.

Dr Roger Banks: I am national clinical director for learning disability and autism with NHS England. I am a psychiatrist with the speciality of learning disability by background.

Q178 **Baroness McIntosh of Hudnall:** Good afternoon, gentlemen. This is a very quick and high-level question. It is about the issue of the principles that the independent review set out. As you know, the review recommended that those principles be incorporated in the Bill. The draft Bill does not include them. We would like to know what your view is on that decision.

Professor Tim Kendall: It is the wrong decision. It would be right to have them in the Bill. I am not underestimating how complex that might be because of legal changes that might need to be made to other parts of the Bill, but this is heralding the beginning of what we hope will be a major change in the way we deliver mental health care and care for people with learning disabilities and autism.

At the centre of this should be choice and autonomy, therapeutic benefit, the principle of least restriction and the person as an individual. These could be taken as just words, but, if the Bill had them solidly in it as principles, it would have a much more powerful effect.

Dr Roger Banks: I completely agree with what Professor Kendall has said. We are expecting an important cultural change, particularly in the field of learning disability and autism. We feel the principles should be included to make clear the change we are aiming for, both professionally and culturally.

It certainly would be consistent with the aims of the learning disability and autism programme, which very much align with those principles. We feel it is important to have them in the Act, as a basis for understanding the way in which the Act is applied and the way in which people work with it.

Baroness McIntosh of Hudnall: Just to be clear—your answers are very clear—neither of you is convinced that putting the principles into the code of practice, for example, would be a good enough alternative.

Professor Tim Kendall: It gives a much more powerful message to have them in the Act. A short while ago I was asked to appear in a public session of NHS England’s board following the Edenfield horrors, and I was told that they believed the current model for mental health—the in-patient model with closed communities and an excessive dependence on compulsion—was broken. Now, I do not think it is not entirely broken, but we have to do something about it. This heralds the right message for major cultural change.

Dr Roger Banks: I have been involved in recent discussion about this, together with Professor Kendall and others. We believe that the process of putting principles in the Bill would help in how the Bill is refined and amended to ensure that other parts of it are not inconsistent with the principles it is setting out to achieve. It could become almost a test framework for ensuring that the rest of the Bill is operating to support those principles.

Chair: That is quite interesting. It is almost diametrically opposite to what the Government have said. They are concerned that placing the principles in the Bill would possibly cause an issue around clarity for practitioners. You do not agree with that.

Professor Tim Kendall: No. The principles should be at the heart of these changes. I am no great expert on legal matters, but my understanding about having principles in an Act is that they become the lens through which you interpret the rest of the Act. That would be a phenomenal change, in my view.

Chair: That is very helpful. Thank you very much indeed.

Q179 **Dr Dan Poulter:** You say in your written evidence that it is important that the workforce implications are properly understood and accounted for. We have heard particular concerns raised about the resulting extra workload in three areas: community services, second opinion appointed doctors—SOADs—and tribunals. Have the Government accounted properly for these additional workforce pressures?

Professor Tim Kendall: This needs to be set in the context of understanding where mental health is. When I first started this role in 2016, we were able to see only one out of four children with a mental health problem. Three out of four did not get seen at all. That was because we had set the bar sufficiently high that those with lesser problems were not seen. There were similar outcomes for adult mental health.

There has been a programme of investment in mental health to try to change that. By the end of next year it will be up at £3.3 billion extra. In that context, you can see there is bound to be a shortfall and there is some pressure on community services. The biggest investment we have made is about £1 billion extra into community mental health. I am convinced that we are going in the right direction, but there is still a treatment gap.

With regard to SOADs and tribunals, the Department of Health, NHS England and Health Education England are working out a plan for how to meet these needs. The implementation of the Act may need to be phased to ensure that we meet those problems.

Dr Dan Poulter: You mentioned phasing. Are you suggesting that we would need additional full time equivalent hours in, say, the consultant psychiatric workforce and the like in order to meet the tribunal commitments, for example?

Professor Tim Kendall: We need to grow the workforce. Those specific areas will need specific attention. That is what the workforce plan will address.

Dr Dan Poulter: Do you have any idea or analysis you could share with us about how many additional full time equivalent hours that would mean in, say, the consultant psychiatric workforce?

Professor Tim Kendall: I wish I could, but, no, I cannot.

Dr Dan Poulter: There is still quite a lot of work to do on this

Professor Tim Kendall: No, indeed. The work between the Department of Health, Health Education England and NHS England is in process. As this unfolds, we will have to meet those needs.

Dr Dan Poulter: Is it entirely satisfactory that a piece of legislation is going to be put in place before the workforce consequences and the practical consequences have been worked through?

Professor Tim Kendall: No. They have to be done hand in hand because we do not know the precise endpoint for the Bill. Until we do, it would be hard to work out exactly what the workforce considerations are. It is my view and the view of NHS England that this is a really important step and we need to find the means for supporting it.

Chair: Do you think the impact assessment the Government have done accurately or even closely reflects what is needed?

Professor Tim Kendall: Yes, I do.

Lord Bradley: Sorry, are you saying that you do think the impact assessment accurately reflects the resources that are going in over the timetable they are setting out?

Professor Tim Kendall: Yes, but I could not give you the exact number of doctors and second opinion doctors you would need at this point.

Lord Bradley: The timetable would have to reflect that.

Professor Tim Kendall: Yes.

Dr Roger Banks: Talking about workforce, there is capacity, but there is also quality and capability of workforce. In the learning disability and autism programme, we too are very involved in talking about future workforce in the context of not just the Mental Health Bill but how we continue to develop the appropriate support for people with learning disability or autism where they are.

That is also about the training of that workforce and the different roles that might be required or the different emphasis in roles going forward to be able to support people without reliance on hospital admissions. Workforce impact is not just about quantity; it is also about quality, training and the investment in that.

Chair: On the point about the impact assessment and the reality of needs on the ground, if I can call it that, we heard from CQC yesterday that it had real concerns about SOADs and the ability to have sufficient support in that area, for example. Were they right to be concerned? Do you feel, Professor Kendall, they are perhaps too concerned? Is the resource there?

Professor Tim Kendall: As I say, we have to find a way of doing this because it is too important not to. I could not tell you at this time exactly how we do it. If they have concerns, we need to take those seriously in terms of what training and funding there would be for ensuring we have enough SOADs.

Baroness Hollins: We have been hearing a slightly pessimistic view from some quarters that the community provision is not practicable. This is with respect to learning disability and autism. That might be part of the training you are speaking about, but are you confident that the resourcing will be there?

One of the witnesses yesterday said that it would probably need pump priming and perhaps double funding for a period to enable new services to develop while the traditional services were being wound down. I wondered whether you had any comments about that.

Dr Roger Banks: I can understand those concerns. As you will know, there is an ongoing programme of investment in the community. We are investing about £40 million in 2022-23 with an indicative expected budget of £80 million going forward. There are clear ideas and plans for how that should be invested, but one could always do more with more funding.

Chair: Thank you very much. We might touch on more of that when we come to that particular question about learning disabilities and autism.

Q180 **Baroness Barker:** The issue of the disproportionate impact of mental health legislation on people from black and minority communities is an enduring one. The independent review pointed out to us that there is nothing inherent in mental health law that is discriminatory. It is understood that it is the implementation of the law that leads to problems. That also been reflected in the non-legislative work by the NHS in programmes such as the advancing mental health equalities strategy, the workforce racial equality standard and the long-term plan.

Will those programmes be continued in future? Given the express aim of this legislation, what other workforce strategies will need to be put in place?

Professor Tim Kendall: This whole area is a major problem that has dogged mental health for years. We are currently in a position where people from black and black British backgrounds are subject to the Mental Health Act about four to five times more than

expected. For community treatment orders, that is even worse, where on the latest data it is elevenfold.

I do not underestimate what a big task we have. We are doing some important things at the moment. We have done some pilots on the patient and carer race equality framework in four trusts. The learning from that is that we need to train a workforce that not only matches the population it serves ethnically and culturally, but has co-produced ways of ensuring equality of access and of experience. One of the issues coming out of that is that people need a much better understanding of human rights. In all our work, particularly the quality improvement work that will go around this, we will be focused very much on inequalities.

Baroness Barker: We heard on our visits yesterday that it is lower-grade staff on the front line who very often bear the brunt of any difficulty in the system at all and that perhaps there is an undue expectation on them. Would you agree with that? Does that understanding of the interface and the dynamic around front-line staff need to go higher up the professional chain?

Professor Tim Kendall: It is different in different settings. Where I work, on the street, I would be a front-line member of staff. I would see people sometimes in food outlets, sometimes on the street itself and so on. That applies to a number of community-based teams. They are led by more senior people.

I am aware that on in-patient units they find it quite difficult to recruit band 5 and band 6 staff. In some places, they have 40% vacancies. It is a serious issue, and there is not an immediate way of solving this except making in-patient services a more attractive place to work.

Q181 **Baroness Berridge:** We have been looking at the evidence behind these proposals. One of the few areas, if not the only area, where there is peer review evidence to say that a change would benefit ethnic minority and black communities is that of advance choice documents. They are now not included in the Bill. I was just wondering whether you had a view on that. The Government's view, if I am fairly saying it, is that they do not want to constrain the procedure in order to do these, but there is very good evidence to say they help reduce detention, particularly in black and minority ethnic communities. What is your view of the lack of ACDs in the Bill?

Professor Tim Kendall: I would be more in favour of ACDs being in the Bill.

Dr Roger Banks: I support that view. Particularly thinking about discrimination and inequality with respect to people from black and ethnic minority groups who have learning disability and autism, advance documents would help.

That is also in the context of other measures to improve how we inform, empower and support people to take a collaborative approach to their care and treatment and to give them a greater opportunity, wherever possible, to question and challenge what they may see as being unfair or unreasonable.

Chair: Can I just pick up on the point about advance choice documents, Professor Kendall? Do you feel comfortable that there is the infrastructure to manage the production of advance choice documents?

Professor Tim Kendall: At this time, no. This would be a major change. The whole Bill sets a tone and an approach to mental health that we really should embed in the system. Advance choice documents are one way in which we could ensure our relationship with patients is much more collaborative, respectful and so on.

Chair: In a sense, that is to adhere to the four principles of the independent inquiry. You also mentioned human rights. Do you see that also as part of what should be embedded in the system, more so in terms of people working within the system?

Professor Tim Kendall: Yes, I do.

Chair: That is really helpful.

Baroness McIntosh of Hudnall: Could either of you say any more about this issue of collaboration? The Government's position, as we have so far understood it, on advance choice documents is that creating them and making them statutory means they will trump every other kind of collaborative interface between patient and clinician or patient and supporter.

Is there any validity in that fear? In practice, if there were a statutory requirement to have advance choice documents, is that all there would ever be? Would some people be disadvantaged by that?

Dr Roger Banks: I find that very difficult to forecast and project. What I was alluding to in terms of collaboration is that there is a wider sense, not just within the Bill but in healthcare generally, of trying to move towards much greater engagement and choice with identified patients, and dialogue between clinicians and patients about treatment, benefits and outcomes. There would be a concern that, if you have an advance choice document, it may have too rigid an interpretation or application.

Baroness McIntosh of Hudnall: I do not hear you saying that is a reason for not having them in the Bill.

Dr Roger Banks: No. This is about how you go forward and implement it, how you get people to work with those and how you lay out in a code of practice what would be best practice in working with an advance choice document.

Chair: We have heard from previous witnesses that digitisation is making a difference in other spheres. I am looking at Professor Kendall because I know you are very focused on technology and how it can be applied to support the system as a whole. Perhaps that is a way to ease it.

Professor Tim Kendall: I am sure there are ways of easing this, but I need to be quite clear. Mental health has a Mental Health Act, which no other part of medicine has. That always threatens to make the relationship between the professional and the patient very asymmetric

and one that you would rightly consider to be a power relationship. Patients often find that difficult. What this Bill does is transform that relationship. It is our job to embed that in the system, and it will be a big change.

Dr Dan Poulter: Professor Kendall, would you be suggesting that every patient who came into contact with secondary mental health services should have an advance choice document?

Professor Tim Kendall: No.

Dr Dan Poulter: Could you just explain which specific groups or who should have them?

Professor Tim Kendall: The number of people who are subject to the Mental Health Act is remarkably small by comparison to the number of people coming through mental health services.

Dr Dan Poulter: You would say that only once the Mental Health Act has been triggered should we be thinking about advance choice documents, in case they were detained a second time.

Professor Tim Kendall: I am thinking on the hoof here, but in my view it would be people who are likely to be detained.

Dr Dan Poulter: I am just thinking about the workforce implications, which we come back to again. You could argue that this would affect quite a few people. The threshold for referral to secondary mental health services is fairly high. If someone is taken on to the caseload, there is always going to be a chance that they might be detained. Are we going to end up in a situation where, de facto, anybody who is under the caseload of a community mental health team needs to have an advance document done for them?

Professor Tim Kendall: No, I do not think so. We would have to think through how to do this and how to put some structure around it. There are people I work with who are homeless, who I do not think are ever likely to be detained, but a small proportion might be. I have detained only six people in 15 years. I would be able to work out reasonably which ones are most likely.

Dr Dan Poulter: You are saying that is a matter of your clinical judgment. That is much more difficult to put into statute, which is coming back to the point Baroness McIntosh was asking you about.

Professor Tim Kendall: It is difficult, but I would not say it is impossible.

Dr Dan Poulter: It is very difficult.

Chair: It is probably about how you craft the wording of the statute to keep it broad so you do not fetter too much in terms of detail.

Professor Tim Kendall: Then you put more detail on how that would be done in the code of practice.

Q182 **Baroness Hollins:** Your evidence, in common with others, supports the direction of travel with people with learning disabilities and autistic people, and the changes proposed in the draft Bill, while expressing concern about diversion to other routes, especially under Part III. What can be done to minimise these risks, especially the risk of diversion to prison?

In terms of alternatives, you might be thinking about what needs to be commissioned by ICBs, for example, or perhaps for people who are on dynamic support registers. I would be very interested in how you think the risk is going to be minimised.

Dr Roger Banks: Just to reiterate, yes, we do support the proposal because it is certainly consistent with the aim of the programme to reduce reliance on hospital admission as a solution to supporting people who are experiencing mental health or behavioural problems and crises.

To mitigate that, what investment is there to support people at the right time and in the right place? How can we intervene early? How can we support people in their own homes and communities? In addition to the general investment into community learning disability teams, we would think about people who might be at risk of offending, early intervention with young people with autism, psychosocial interventions, the work of forensic child and adolescent community teams, the work of forensic teams generally, and increasing awareness and knowledge within the wider health system about learning disability and autism. These are all investments that we are making already and will continue to do so.

There is reference to care, education and treatment reviews, which we regard as important ways of giving some scrutiny and enabling people to look in some detail at the support needs people have, potentially as a way of avoiding admissions.

We made reference to our work on dynamic support registers. Again, the idea of there being registers is raised in the draft Bill. We are about to produce a refreshed policy on care, education and treatment reviews and dynamic support registers, which are there to be pre-emptive, enabling local systems to be aware of people who may be at risk of admission and put in appropriate support, in a timely and proactive way, to try to avoid crises developing where people may need to be admitted or may be at risk of offending.

Baroness Hollins: We already have quite a high number of people with learning disabilities and autism in prison. How worried are you about an increase in people not getting enough support and going to prison? I only ask this question because it has been raised by so many of the people we have spoken to. How worried should we be? Can we be reassured by the measures you are taking through NHS England? Professor Kendall, do you want to come in?

Professor Tim Kendall: In terms of learning disability and autism, I would have to give way to Roger. With something like this, there is always a risk that you will end up with more people going to prison and that kind of thing. We need to be sure that those unwanted consequences do not happen. We will need a lot of very good data as we go into this.

Dr Roger Banks: One should continue to be worried and to act on that worry by scrutinising this. One should continue to look at the evidence, look at the data and find ways of proactively working with that.

It is reassuring to hear from colleagues working in the health and justice system about how much progress is being made within the system on finding ways of supporting people with learning disabilities and autistic people, particularly within prison services, where there are some very interesting developments very specifically aimed at autism, for example.

We need to be vigilant and aware of that, and we need to work closely with those clinical colleagues who, quite rightly, raise concerns about how they may be able to work with a future Act in order to respond appropriately to people who may be at risk of offending or those who have offended. Inevitably, there will be some people with a learning disability for whom a custodial or criminal justice route may be appropriate, but there will also be people who need further help and assistance, and a better assessment of the nature of their offending.

Q183 **Lord Bradley:** Professor Kendall, we have heard much evidence about the problems in A&E departments and the gap in the Mental Health Act that covers A&E departments. The staff in those departments are spending a huge amount of time looking after people who are not covered by the Mental Health Act. A huge amount of police time is also taken up with supporting those staff. What is your view about extending the Mental Health Act to cover that gap in A&E departments?

Professor Tim Kendall: I think it would be a disaster, quite literally. I have a programme of work where we are trying to reduce out-of-area placements and 12-hour waits in A&E for people with mental health problems. We have had some quite good success. We brought down out-of-area placements by 60% to 70% over the last 18 months. I did that in my trust when I was medical director 15 years ago. There are ways of doing it, but you cannot stop. You have to keep working at it.

It amounts to having a really effective urgent and emergency care pathway for mental health with crisis teams, crisis houses and crisis cafés, all as alternatives to admission, so you never end up in a position where you do not have a bed. Then people do not wait. If you introduce a holding power into A&E, one problem is that you will find police take people to A&E far more readily than they perhaps might otherwise.

Secondly, there are people who go to A&E with mental health problems, who have perhaps taken an overdose or self-harmed. They would not go because of the fear they could be detained. The perverse consequence of this would be really unwanted.

Lord Bradley: You would therefore support Sir Simon Wessely's view that the way forward is to have increased crisis services and additional facilities away from A&E departments to deal with that crisis point and try to ensure they do not become embedded in the A&E system.

Professor Tim Kendall: Yes. Because of the pandemic, we advanced setting up crisis lines in every part of England. Everywhere now has them. That was done two years earlier that we otherwise would have done it. We have crisis lines; we have £300 million of additional investment per year into alternatives to admission, including crisis houses, crisis teams and so on. When that works well, you do not have people sitting in A&E for 12 hours.

Lord Bradley: Sir Simon Wessely also supported increased investment in liaison and diversion services, linking with the teams in police custody. That links also to the point on learning disabilities and autism about early intervention, early assessment and awareness of them, so they do not go down that pathway into the criminal justice system. Would you agree with that?

Professor Tim Kendall: I would, yes.

Chair: Dr Banks, could you say very quickly whether you agree with what we have heard? Do you want to add anything?

Dr Roger Banks: I agree, particularly with the last point about liaison and diversion and about supports. This is a problem writ large particularly for people with learning disability and autism. A&E departments, unless appropriately welcoming and reasonably adjusted in terms of the Equality Act, can be very distressing places to be. There is a real risk that you may end up detaining people because of their response to a frightening, overstimulating and unwelcoming environment.

Q184 **Dr Ben Spencer:** My question is about supervised discharge. I will keep it very brief and get to the point. It is my understanding that the provision to detain someone of unsound mind but who has decision-making capacity in the community and not in a hospital setting is a new power we have never had in 200 years of mental health law. I just wanted your reflections on crossing that Rubicon and moving from the Mental Health Act being a power that detains in a hospital setting to a piece of legislation that can also detain in the community setting.

Professor Tim Kendall: Do you mean community treatment orders?

Dr Ben Spencer: I mean the new supervised discharge power, building on the back of the case of MM in the Supreme Court, whereby somebody is conditionally discharged into an environment that effects a deprivation of liberty. It can be authorised in the context of someone who lacks decision-making capacity under the DoLS, but when someone has decision-making capacity there is a gap in the powers.

Professor Tim Kendall: As I understand it, the Bill puts greater emphasis on collaboration between the community and the in-patient consultants where these things apply, which would be good and important. They would be more subject to regular review by tribunals.

I am concerned about extending these kinds of powers into the community. When community treatment orders were introduced, a lot of consultants pursued these and had lots and lots of patients on community treatment orders. That is in spite of the fact that there is randomised control trial evidence showing that there is no specific benefit from them. I am keen that we should ensure that supervised discharges of any kind are subject to close scrutiny.

Dr Ben Spencer: That is a really interesting point because one of the pieces of evidence we have received is that, although it is a change, we should not be so concerned about it because it will affect fleetingly few numbers of people. Yet we have had already in the inquiry—I was not here, but several of our members were—this same discussion about CTOs.

Would you anticipate that there is a danger, with any of these changes, that what might be intended to apply to a fleetingly small number of people opens up a Pandora's box to become a new form of discharge planning for forensic patients? One could start thinking about these halfway house settings, where one can be discharged through detention in the community under these powers.

Professor Tim Kendall: I would be very cautious about these things. It is very important that we set up an effective quality improvement programme around all different aspects of the Act. How different consultants use the Act varies hugely. You can have two consultants working in comparable communities with very different rates of detention or supervision et cetera. That needs to be explored and explained, and people need to be able to say why they do it and why others do not. Our response to this has to be to put it into the open air.

Chair: Thank you very much. Thank you to both of you very much indeed. I am sorry the time has run out so quickly. We are extremely grateful to you for making time to come to us today. What you have had to say is a really important contribution to our deliberations. Thank you so much.

Panel 2

Witnesses: **Maria Caulfield**, Minister for Mental Health and Women's Health Strategy, Department of Health and Social Care; **Caroline Allnutt**, Deputy Director, Mental Health Act, Serious Mental Illness and Offender Health, Department of Health and Social Care; **David Nuttall**, Deputy Director, Neurodiversity, Disability and Learning Disability, Department of Health and Social Care; **Damian Hinds**, Minister of State, Ministry of Justice; **Anna Lacey**, Deputy Director, Female Offenders and Offender Health Policy, Ministry of Justice.

Q185 **Chair:** Welcome, everyone, to the second session of our final panel. If I may ask each and every one of you just to say who you are and whom you represent, that would be marvellous. We will then go straight into questions. Could I begin with our Ministers, please?

Maria Caulfield: I am the Minister with responsibility for mental health and learning disabilities.

Damian Hinds: I am the Minister for Prisons and Probation at the Ministry of Justice.

Anna Lacey: I am a deputy director at the Ministry of Justice responsible for offender health policy and female offenders.

Caroline Allnutt: I am deputy director at the Department of Health and Social Care with responsibility for serious mental illness and reform of the Mental Health Act.

David Nuttall: Good afternoon. I am the deputy director for neurodiversity, disability and learning disability at the Department of Health and Social Care.

Q186 **Sir Charles Walker:** We will start with Minister Caulfield on this question. When we have been looking at the draft legislation, it has significant impacts on community



services, tribunal work and second opinion appointed doctors. We all agree that all three of these things are a step in the right direction, but we have heard from a number of witnesses that this will create resourcing and funding issues.

Are you confident, Minister, that there is not just the funding but the personnel resourcing and the will to deliver these changes when they come into law, as we hope they do?

Maria Caulfield: I want to reassure the committee on that point. Outside of the legislation, this is the direction of travel we want to go in anyway, providing support and care for patients with mental health problems at a much early stage of intervention and making sure that the principles behind the Bill are in everyday practice, not just as part of the legislation, so that patients get treatment where they want it, when they need it, and they have a voice in that. That means investing in resources across the board outside of the legislation. That is why £2.3 billion a year of additional funding is going in from next year, to resource financially the work we are doing.

Sir Charles, you made the point about staffing. We have committed to 27,000 additional mental health workers. We are making good progress on that. By June this year we had 6,900 additional workers. We also have capital programmes at work so that we can improve facilities in the community. The long-term aim is to use in-patient mental health facilities only when absolutely necessary, which means resourcing community services.

Whether that is the finance being available, the staffing being available or the facilities being available, we are working up those plans to make sure they are in place. That will underpin the work that needs to happen as part of this Bill, but it is part of a wider reform of mental health services.

Sir Charles Walker: We have heard from witnesses that retention is an issue in the area of mental health. It is an issue across the wider NHS, but we believe there are particular pressures in mental health specialisms. Given that those can often be the most demanding areas for people to work in, do the Government have any specific plans to aid and improve retention of their qualified workforce?

Maria Caulfield: There are a number of factors around that. This goes across the board; it is not just for mental health. If you look at maternity, retention is as important as recruitment. Minister Quince, who is responsible for NHS workforce, is leading work on that in a number of areas.

One example is apprenticeship routes into nurse training and for mental health nurses. We are trying to expand that, because it often recruits people who have worked in the sector before so have a good knowledge of what it is like. They do not take on the debts that traditional training would involve. There are a number of workforce initiatives. We heard from the Chancellor last week about the workforce strategy being put into train with planning over five, 10 and 15 years. That will have to involve retention as well as recruitment.

In particular, mental health is a very difficult sector to work in, as I know a number of committee members will already be very aware. We want to look in particular at the culture of working in mental health facilities. We hear concerns from lots of people who work in the sector about feeling valued, being able to flag issues when they are happening and the

resources and skill mix available. Those are particular areas that I know Minister Quince is looking at as part of his workforce plans, which we are feeding into.

Sir Charles Walker: Am I right in thinking that Think Ahead is a mental health social work programme? I will put a plug in for that. That is an excellent initiative. We should try to promote similar initiatives to attract bright, talented people into the area of mental health provision.

Maria Caulfield: Yes, absolutely.

Lord Bradley: I have a very short supplementary on the impact assessment and the current profiling of the implementation against the investment. Are you confident that the current profiling matches that investment in all aspects of the Bill? Will you have to reprofile it when the Bill is introduced for legislation?

Maria Caulfield: If the Bill is passed, it will be rolled out over time. It will not all come into force immediately. There are some easy initiatives to put in place, such as the nominated person or treatment requests, which are not very resource intensive. There are other parts of the Bill where there will need to be further long-term planning.

Not all of that will be achieved in this spending review, so we may have to work up plans for future spending reviews to ask for further resources to support this. That is factored into the work in developing the Bill and making it happen in practice.

Lord Bradley: Yes, so there may be parts of the Bill that are not implementable within the current timeframe because it goes through another spending review, and you will have to get resources, whether that be in healthcare or the interface with the criminal justice system.

Maria Caulfield: I do not want to speak for the criminal justice system.

Lord Bradley: No, that is fine. I was just nodding towards Minister Hinds.

Damian Hinds: I do not have a great deal to add to what Maria set out on this. There is, of course, a lot more resourcing going into mental health provision in general. From the point of view of transfers from the criminal justice system, for example, it is very important to make sure there is sufficient capacity.

As with all things, there is the Treasury's ultimate horizon when it is looking at finances. Things always need refinancing for the next period. That will continue to be the case. The committee should not be unduly nervous as a result of that. There is nothing unusual in this case in that regard.

Maria Caulfield: Just to reiterate, the plan for the Bill is not to get it all in place in this spending review timeframe. We are being up front about that. We will have to look at further spending reviews as the Act is rolled out.

Chair: Minister Caulfield, you mentioned apprenticeships around nursing. At the moment, nurses have to have a degree in nursing, I think I am right in saying. Are you suggesting or saying that in future perhaps they will not have to have a degree

because there is a faster track? Will they have to have the degree in nursing and then an apprenticeship in the area of mental health?

Maria Caulfield: Currently, within the nursing framework, there are degree apprenticeships that are open to nurses. A number of universities around the country are running those. What tends to happen is that a particular trust nominates a number of student nurses that it will put through the degree apprenticeship route. That goes for adult nursing, children's nursing and mental health nursing.

There are also other routes that are opening up now in order to train nurses. There is the associate nurse route. I am showing my age now. It is a bit like the old SEN route, where you can qualify up to a certain point and do a number of roles, but there will be certain roles that you cannot take on, because you will not be a fully qualified registered nurse. We find that there are a lot of healthcare assistants who then upgrade to do their associate nurse training and then often will go on to do the full training or will stay as an associate nurse.

We are trying to open up as many routes as possible to give access to people who would not necessarily traditionally go through a pure university route. Also, it helps financially, because they are not often taking on student loans as part of their training. We want to make it as accessible as possible for people.

Caroline Allnutt: In terms of implementation, as has been said, we are assuming a long timetable, mainly because of the time it takes to train up psychiatrists and get the judiciary that is required in place. The impact assessment currently assumes it would be 2030-31 for full implementation, but obviously that is our best estimate at this point. We will need to continue to review that, taking into account resources but also interdependencies within the Bill, so thinking about the right sequencing and what changes would need to follow from others. It is a detailed programme of work

Chair: That is a real concern for a number of our witnesses as to some aspects of and proposals in the Bill. If we introduce this Bill in its current form, are we going to be able to deliver? Are there going to be unintended consequences and so on? We might want to probe some of that a little more as we go on to our next questions. The next question is Lady McIntosh, who is going to touch on the issue of principles.

Q187 **Baroness McIntosh of Hudnall:** Minister Caulfield, you have already touched on this in your very first response. You may have heard the evidence from your NHS England colleagues earlier on this afternoon, who were asked a question about whether they were in favour of the principles being incorporated in the Bill. They were both very strongly in favour of it. Given that the review itself designed the principles to be incorporated in that way, could you explain why you think, as we understand it, that the principles should not be put in the Bill, but retained in the code of practice? Given that, if they go into the code of practice, they have some statutory force, why is it so important to the Government not to include the principles in the Bill? Some of your other colleagues may wish to address this question as well.

Maria Caulfield: We are very supportive of the four key principles. We absolutely support what was identified in the review. As I said to Sir Charles earlier, we want those principles to underpin changes in mental health across the board, not just in terms of the legislation. I think

that officials will agree with me that we started from a basis of wanting to include those four principles in the Bill, because they are so important.

When it comes to legislation, there was some legal concern about how we embed those in clauses so that they work in practice. With the Bill, we want to provide safeguards that can practically work for clinicians, so that they know explicitly what is expected and what the framework of the law will be. It is very difficult to do that with just principles, if you see what I mean.

We are very clear. If you look at the Bill itself, we have embedded it throughout the Bill. Although they are not explicit in defined categories, if you look at Clause 6, for example, when we talk about appropriate medical treatment, in the Explanatory Notes it makes clear the principle of therapeutic benefit: when considering whether medical treatment under the Mental Health Act is appropriate for a patient, there must be a reasonable prospect that the outcome of the treatment would have a therapeutic benefit. We can go on to various other clauses. The four principles are deeply embedded within the Bill itself.

The difficulty we have with this Bill, unlike the Mental Capacity Act, which was a brand new Bill and the principles were put in from the start, is that we are actually reforming the Mental Health Act, which does not have these principles in it. It is a reform Bill, rather than a new Bill in that sense. That adds to the complexity of this.

We want to make sure that the safeguards that need to be in place and how they should be applied in practice are explicit in the Act. That is the challenge we have. I have heard from Professor Kendall himself, who is very passionate that it should be in the Bill. That is why we will be very keen to hear the evidence from this Committee and the recommendations as well. It is just the technical difficulty of getting the principles in the Bill.

Baroness McIntosh of Hudnall: Could I ask you to consider the other side of that bit of the argument? You say that it is just a technical consideration. You can set against that Professor Kendall's view, for example, as he expressed this afternoon, which is that it is a very important way of expressing values and a determination to make significant cultural change in the way that mental health services are delivered in future. Are the technical difficulties so extreme that they really trump that kind of principled wish to see the principles incorporated? We have heard some evidence to suggest that it is difficult but not impossible.

Maria Caulfield: The issue is around the legal interpretation of each of the four principles and how they could be challenged, in terms of what they mean in practice. That is why we want to see them embedded in the code of practice, where that legal clarity is not as definitive. That is the issue. Absolutely, we want this to be about changing culture and not just setting rules to follow. As I said to Sir Charles, that is why the principles will be underpinning not just this Bill but the changes in mental health services across the board.

It is about legal clarity. This is legislation, after all. It is hard to define what the principles would mean in specific settings, according to different clinicians, but it is why we can put it in the code of practice, where it will guide clinical practice rather than legal definitions.

Baroness McIntosh of Hudnall: I will just say in passing that we have heard that you practically need a wheelbarrow to cart the code of practice around these days.

The danger of this set of principles disappearing into the code of practice and not being either easily accessible to clinicians or readily understood by patients is something that I would at least ask you to consider.

Maria Caulfield: No, absolutely. As I said, reading through the Bill itself you can clearly see that the four principles are there throughout all the clauses. Absolutely, we will consider it, because there is such a wide range of views on this. I know that Sir Simon Wessely put it at the heart of the independent review. I take the point but we have to be guided by legal advice as well, in terms of how open to interpretation they would be in the Bill itself.

Baroness Berridge: Can I explore with you what you are saying? We have an Act at the moment that creates a very asymmetric relationship between clinician and patient in this healthcare. You have said in your evidence, for instance, that for different healthcare professionals in different parts of the country these core principles could be printed on a little card. Why should a patient not be able to say, “When I was treated over there in Essex by that clinician, this was the response. I’m now being treated like this and that’s not the least restrictive way to treat me in your environment”?

There is a positive view for the patient here of having very simple principles. They might not understand 159 pages that we now have of a Keeling schedule, but they can say, “I’m being treated differently and it’s different to these principles”. Is that not a positive thing, rather than a negative thing, to empower patients to challenge very simply? We would have cases to interpret this, but what is wrong with cases to interpret these principles?

Maria Caulfield: You describe the scenario where a patient can say, “These are the four principles, so why am I not being treated this way?” That is absolutely the way we want this to go. That is why the four principles will be clearly stated in the code of practice. There is absolutely no reason why patients could not be given a card with those four principles or, indeed, staff could not have them easily on display in every work setting.

The advice I have been given is that, if we have the principles in the Bill explicitly, as standalone measures, they could be open to interpretation. As I have said, they are explicitly there, embedded in the Bill, nearly in every single clause, whether that is the therapeutic effect, treating people as an individual or giving patients choice. That thread runs through it.

Baroness Berridge: To push back here for a moment, it empowers a patient to say, “It’s the law that says you have to”, rather than saying, “It’s the code of practice”, which is this wheelbarrow document. Do you see how we are feeling? I am a lawyer by background. I understand that it might be difficult to put them in there, but it would empower patients to say, “It’s the law. This is so important it’s in the law”.

Chair: That of course is a reason why you have principles in the Mental Capacity Act. As another lawyer, I am thinking that it may be complex, it may be difficult, but I am afraid it is the Government versus every witness we have heard. Not one witness has pushed back and said, “No, it’s fine in the code of practice”. They must be in the Bill.

Dr Dan Poulter: On this, the courts are going to interpret the different aspects of the Bill and how they are applied. That is going to be the case. We have heard from the very experienced tribunal judge who was part of Sir Simon Wessely's review that having up front the principles of the Bill will give the courts a framework through which to interpret disagreements about what the other clauses mean. In that respect, it would bring greater legal clarity to patients and, indeed, to the courts in interpreting the Bill, surely.

Caroline Allnutt: I think it was Justin Leslie who said it could be quite confusing for practitioners, though. It is difficult for the courts to rule on abstract principles. If you took, for example, the principle of the person as an individual, which we think is a vital principle that should be upheld and be one of the guiding threads throughout all this work, it would be quite difficult for a court of law to decide how that had been upheld. If you look at the specific actions that are designated to practitioners under legislation, it is much easier to know whether they had followed a clinical checklist or had taken into account a reasonable prospect of therapeutic benefit when making detention decisions.

Dr Dan Poulter: I think that what was suggested is that the courts are going to have to adjudicate on how the different provisions in the Bill, when it becomes an Act, should be interpreted. By having the guiding principles at the top of the Bill, they will help guide the court, when there is a decision to be made, as to how we should interpret those principles. They would be able to then come down on the side of what those guiding principles are, in terms of their interpretation of disagreements.

Damian Hinds: Not being a lawyer, my observation would be that this is probably one of those debates that could continue without end without there being an external standard to refer to and assess against. These principles are incredibly important. There is also some tension sometimes within them.

Speaking from the criminal justice system perspective, if we talk about things like least restriction, choice and autonomy, they are not absolutes as rights for people in the criminal justice system, as we are also thinking about public protection. It is definitely true, and a couple of members of the committee have already said it, that this requires a big change in culture and outlook. The question for all of us is how best you create that change in culture and outlook.

I am not sure it is necessarily always to do with the words that are on the Bill as it passes through Parliament. It is far more about how it is enacted through workforces, through all our organisations and so on. The committee can rest assured that certainly we have absolutely heard the points that colleagues have made.

Q188 **Dr Dan Poulter:** We have had a lot of discussion about definitional changes and some of the changes in detention criteria, particularly under Section 2 and Section 3. Minister Caulfield, what do you understand by the term "serious harm"?

Maria Caulfield: I know there is a school of thought that there should be a set definition in the Bill of what we mean by serious harm. We have not set a clear definition other than that a clinician, in order to detain someone under the Mental Health Act or a community treatment

order, must designate that the patient is at risk of serious harm. We feel that what that means is a clinical decision, rather than something to be put in the Bill.

There is a whole range of patients that this will cover. All will have different mental health conditions. Some have eating disorders; some will be schizophrenic. They will come from different backgrounds in terms of previous admissions or medication. A risk of serious harm to one patient may be different from that for another. I do not think that that is for us, as legislators, to define. We take the view that that is a clinical decision, based on the principle that we see each patient as an individual.

Dr Dan Poulter: That is interesting. Only a few moments ago, you said that clinicians need to know explicitly what is expected of them.

Maria Caulfield: Yes.

Dr Dan Poulter: That sounds a little different.

Maria Caulfield: I do not think it is. We are very clear in the proposed Bill that the threshold for detaining someone has to be lifted, such that there is a risk of serious harm and there is a therapeutic benefit.

Dr Dan Poulter: What is serious harm?

Maria Caulfield: It is a clinical decision as to what serious harm would be. I do not think that it is for Ministers to define that.

Dr Dan Poulter: Ultimately, it is the tribunal judge who is going to be making that judgment, rather than the clinician. It will have to be defined legally, ultimately, because, if a patient brings a challenge against the section, which happens routinely all the time, and it goes to tribunal, be that a Section 2 or Section 3, the tribunal judge will be the one who decides whether that criterion is met. It is actually a legal definition.

Maria Caulfield: That would be based on that individual case. We are making law that will be applied across the country to all patients who could be detained under the Mental Health Act or for a community treatment order. When interpreting the law, which is what the judges are there to do, they will look at the individual circumstances to make that decision.

Dr Dan Poulter: Would it not be helpful to have some sort of definition of serious harm, so that a judge and, in fact, the clinician might understand what that means?

Maria Caulfield: Within the code of practice, rather than in the Bill, there will be a non-exhaustive list of the types of threat to life, severe injury or risk to others, or other external risks that may indicate that someone is at risk of serious harm. The code of practice will set out many of those risks, but we still do not feel that we need to define it in the Bill, because it is such a wide variation, depending on the patient's individual needs.

Chair: Is this not going to be one of the single biggest impacts upon the burden, in a sense, of psychiatrists on a daily basis, affecting probably 80% of the patients they see on a daily basis? It is raising the threshold—I think this is where Dr Dan Poulter



is coming from—in terms of that incredibly tough decision that you have to make. Am I right, Dr Poulter, that that is the reasoning behind some of this questioning? Raising the threshold of what we mean by serious harm is going to put clinicians in a very tough place. It is certainly going to make it harder for them to make a decision in terms of detention.

Maria Caulfield: We are taking the evidence and guide from the independent review. Sir Simon was very clear that the current use of detention is of concern. It is used too often inappropriately, either because the threshold has not been met or because there is a question over the therapeutic benefit of that detention. That is the whole purpose of our reforming the Mental Health Act, based on the independent review.

I do not know whether Professor Kendall said it in his evidence session, but he has a concern that detention is used too often. There are risks to detention. When we admit a patient with physical healthcare needs, the longer they are in hospital, the more risk there is of them developing an infection, having a fall or developing pressure sores. It is no different for mental health patients. There are risks to being an in-patient. We know that from our experience of the outcomes for some patients, unfortunately, in certain mental health care settings.

It is not a risk-free decision to detain someone. Our philosophy, in working towards the findings of the review, is that detention is the last resort. With the interventions we are putting into the community, the resources and the extra staffing, we should be seeing fewer patients coming forward who may need detention under the Mental Health Act, but the detention should not be seen as something that is taken lightly.

Chair: I accept all that. What I am trying to suggest—and, Dr Poulter, take it on from me—is that there is an issue of clarity, therefore. If we are changing the threshold, and I appreciate all the reasoning behind that, it is hugely important that there is clarity. I am just putting myself in the position of a clinician on a daily basis having to make those decisions with some confidence that they are the right ones.

Caroline Allnutt: If you look at the current criteria, it is arguable that they are also fairly broad brush. At the moment, the clinician has to decide whether there is a risk to the person's health and safety or to another person. Potentially, we are actually providing a bit more clarity on that. Also, the Minister is right: during the review and subsequently, we heard that people want to take as evidence-based an approach as possible when it comes to risk. It is the perception of risk that means people can sometimes be detained when perhaps they ought not to be or might fare better in a community setting.

Dr Dan Poulter: When you have people who are detained, for example on a Section 2, what evidence do you have to understand the breakdown of reasons, conditions or potential mental disorders people that were detained for? That is quite important in understanding and underpinning your argument.

Caroline Allnutt: It is. I do not think that, as a department, we can collate that evidence, because it is a matter for medical records. We spoke to a huge number of people during the review and subsequently, both clinicians and service users. During the consultation, I think 82% of people were in favour of the changes to the detention criteria.



Dr Dan Poulter: I am not interested in what a consultation stated. I am interested in how this practically plays out for people who are genuinely quite unwell in the community right now if these changes come into place. You do not have an evidence base to understand the breakdown of what mental disorders people are detained for. That is what you are saying, or you cannot point to one.

Caroline Allnutt: I am saying that I do not think we have the data for that, for every detention that happens in a given year.

Dr Dan Poulter: Okay, so you cannot tell us for what they were detained, because there is a difference. For example, I think it would be accepted clinically that the evidence for detaining someone with personality disorder diagnosis in hospital is very limited, in terms of what therapeutic benefit that person would gain from admission to hospital. I am taking the proposed changes to Section 2 specifically. How would these changes potentially play out for somebody who has a chronic and enduring mental illness like schizophrenia? How would it affect my own ability, as a clinician, to detain someone in those situations?

Maria Caulfield: The changes recommended by the independent review, which is underpinning—

Dr Dan Poulter: I am asking about patients with schizophrenia specifically. This is someone with a chronic and enduring mental illness, which is very common. If you visit, as a Minister, mental health teams pretty much anywhere in London, you will see a lot of patients with that. They have a long-term, chronic and enduring pattern with relapse involved, possibly due to non-compliance with medication.

Maria Caulfield: If that patient is presenting at that time, it would be down to the clinician to decide, first, whether detaining them under the Mental Health Act would benefit them therapeutically, and, secondly, whether by not doing that there would be a serious risk of harm to them. If that is not the case, it is for the clinician to then decide on alternative appropriate treatment for them. It is not really for the legislation to determine what that treatment is.

Dr Dan Poulter: The legislation determines how a clinician will be able to act. I want to remind you of the wording for detaining someone under Section 2: that “serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained; and”—that is quite an important word—“given the nature, degree and likelihood of the harm, and how soon it would occur, the patient ought to be so detained”. It is that last bit, about how soon, that is a matter of concern where people have those sorts of chronic and enduring mental illness, such as schizophrenia.

Some 80% of those patients lack insight into their own condition. If they come off medication, they can end up potentially being unable to work, being unable to pay their bills, losing their home and moving out. They would not fulfil the criteria based on the likelihood of any immediate harm to them, but their whole life could fall apart because they have come off their treatment. They could end up perhaps homeless or street homeless; then later on there could be an immediacy element to it, or serious



or immediate harm. I wondered whether we think that this legislation is adequate in terms of allowing proper medicine and care to be provided to that kind of patient.

Maria Caulfield: The independent review did not recommend establishing an imminency test under the revised Act. The immediacy to treat someone is different from the immediacy to detain someone. That is the crux of the Bill. That is why we have not put an imminency test within the legislation.

Dr Dan Poulter: The words “and how soon it would occur” are still, effectively, putting a timeframe on this and an immediacy element. That is the wording in the draft Bill. I wondered whether that is something you need to think about very carefully, in terms of how this is going to play out.

Maria Caulfield: If you are saying that, with you and Dr Spencer being experts in this, you do not feel as clinicians that that is clear enough in the legislation, we are happy to look at that and take evidence from the committee. The legislation is not there to set a timeframe for when that serious harm would occur because the independent review did not recommend that. There is a difference between immediacy of treatment and immediacy of detention, but we are very happy to take evidence from the committee if you feel that that is not clear enough.

Dr Dan Poulter: Of course, no one wants to detain patients. It is not something that anybody wants to do willingly, but it sometimes is in the best interests of the patients. The deterioration in their health can sometimes mean that their whole life falls apart because they come off treatment. They could end up homeless, for example. How much consideration has been given to these changes? I am asking about the definitional issues and how this is really going to play out.

We are not hearing perhaps the full appreciation or understanding of that at the moment and how some of these clauses will actually play out in practice. That is the concern the committee is trying to raise. I think you are saying that there is an acceptance that this may need to be looked at.

Maria Caulfield: That is why we set up pre-legislative scrutiny, to get to the threads of this in advance of taking it through both Houses.

Q189 **Dr Ben Spencer:** This is just a quick question on the definitional issues. Minister, you said that, in a sense, one can rely on the code of practice for guidance on interpretation of serious harm. Ms Allnutt, you have just said that the criteria as currently stand are very broad-brush criteria. I do not understand why we cannot keep the criteria the same but update the code of practice with regard to their interpretation. Why does there have to be change in the Bill in order for the thresholds to be adjusted?

Caroline Allnutt: What came through very clearly during the deliberations of the review was that people felt that this issue of risk needed to be re-examined and that we needed to, as I said, have an evidence base that could be reviewed and tested throughout a patient’s detention when it comes to tribunal hearings, to stress test whether they definitely need to be detained for treatment. In raising the bar in this way, service users and patients that were involved felt that this would help address that issue around risk. Obviously, that is really

important as well when it comes to certain groups, including people from black and ethnic minority backgrounds.

Dr Ben Spencer: The point I am trying to make is that the code of practice could interpret serious harm as being that the bar, effectively, is the same as it currently stands. If the code of practice can do the heavy lifting, in terms of the interpretation, why does it need to be changed in the Bill? Why can we not rely on the code of practice? That would be nimbler, addressing the concerns that my colleague has raised about where this does not work out quite properly, or there are unintended issues for people with chronic, severe mental illness, in terms of what is a slow burn when it comes to harm, as opposed to something very immediate.

That is the concern I share as well. There is a cohort of patients for whom the harm transpires over months to years, as opposed to weeks or days. The concern is that the ability to act when someone is clearly very unwell and creating harm to themselves in all sorts of ways will be limited. I very much welcome what you said, Minister Caulfield, about the whole point of the pre-legislative scrutiny, which is to test and understand that. It makes me think, “Why can’t we use the code of practice in terms of these adjustments to make sure we do not have those unintended consequences?”

Chair: The Minister has already said that you will look at this, which would be incredibly helpful, but thank you for raising this point. I know it is something that has exercised a number of witnesses, as well as members of the committee, so thank you.

Q190 **Baroness Berridge:** If we could go right back to the beginning of all this, pre the review, the Prime Minister said that we are going to do this because we have a big problem with disproportionate use of the Mental Health Act for racial inequalities. We have heard that the strongest evidence, and in fact probably the only peer-reviewed evidence, to support a change from the review for that community is the introduction of advance choice documents. I have seen your reply, which I think says that we do not want to rely on a single document. However, this is about that change helping that community. Why is it that Government have not chosen to go forward with putting ACDs in the Bill when we know that this will reduce the rates of detention for that community and that was the main purpose of beginning this journey?

Maria Caulfield: We absolutely support the availability of advanced choice. That underpins everything we do. Our concern is that the Mental Capacity Act allows advance choice in both oral and written form. We want that to be consistent across the board, with the Mental Health Act reflecting that as well. We do not want to create a hierarchy of documents being seen as the only valid way to make a choice. It is about including all communities and those at the moment who are disproportionately affected by detentions.

They may not feel comfortable filling out documents because of relationship issues with health services in the past. There may be language barriers or they may not be well enough to complete documents. There should be the choice to orally say what your wishes are. It may be that it is at very short notice or maybe when meeting a new team. They should also have that opportunity to make their choices clear.

Advance choice documents absolutely can be used. NHSE is currently working up templates to be used in clinical practice. We are not saying no to advance choice documents, but we do not feel that they should be the only way that a patient can give their choices and preferences in advance.

Baroness Berridge: When the patient is an in-patient they can obviously express instructions. What we are talking about here, though, is resourcing people to get over those issues. That is what the studies have been doing. For instance, once you have been detained, you sit down. We have heard that it is engagement like they have never seen before. It is not just about treatment decisions but about care. The evidence is there that they will reduce detention. Is there not a way to use that evidence to reduce your detention rates without making it the only way to do this? Obviously a patient will be expressing wishes when they are being treated, but that document is there.

Maria Caulfield: We are very supportive of the use of the document. That is why NHSE is devising the template at the moment. It will be in place as soon as the legislation is passed, but we want to give the same legal weight to oral directions as to documents. Caroline will correct me if I am wrong, but I think, in the call for evidence that we had, there was not that same push that the documents be the only way that patients could express their wishes.

Baroness Berridge: Pushing back on that, there is a way to phrase a clause so that you do not make it the only way. You just say “and/or other oral expressions”. This is the evidence base. It is the only thing where you have peer review evidence supporting a change that will affect the black and minority ethnic community and reduce detention rates. We can draft a clause to include that, so I do not understand. During this process, the issues for those communities have not been front and centre. I would really ask you to go away and look at drafting a clause so that we can have this within the Bill.

Maria Caulfield: I would disagree that those communities are not front and centre. That is the whole reason why we are doing this. That is why the previous Prime Minister, Theresa May, asked the independent review to be started. That is why we are taking forward the recommendations of the independent review, because we recognise that there are some communities, particularly the black Afro-Caribbean community, that are disproportionately affected by detentions, whether that is for in-patients or community treatment orders.

That is why we want to make sure that every available avenue to make an advance decision is open to people and that, if they cannot fill in an advance choice document for whatever reason, that does not go against them, in terms of being able to make those decisions. We absolutely support the use of documents, but we want to make that as flexible as possible for patients.

Chair: I wonder if I could make a suggestion to the Minister. We heard early on in our deliberations from a doctor who talked about what is happening in the world of palliative care, where something akin to an advance choice document is being produced digitally. If someone is in difficulty, all you have to do is find their mobile phone, press a barcode and up comes all their medical history, their needs, whatever

care they require, what assessments have been made and by whom. Everything is there in one place.

Maybe we should not be calling them advance choice documents, but just advance choices. It is the word, almost; it is the semantics that is getting in the way of this. As Lady Berridge has said, we have heard from witnesses where it has made an enormous difference to patients when they have been able to say what sort of hair shampoo they prefer. These little things make their lives much more comfortable. They feel much more as if they are being treated well and with care if the little or big things in their lives that matter to them are being taken account of.

Perhaps Ministers could think about changing the terminology. I say, as a lawyer, it would be very easy to draft a clause to say that, in principle, the possibility of an advance choice should be there in statute.

Maria Caulfield: My understanding is that the statutory treatment checklist that is going to be introduced will include making sure that patients' choices are recorded. I think that I have that understanding right in practical terms.

Caroline Allnutt: Looking across the Bill, it affords considerably more weight to advance planning than previously. We are looking to adopt the approach taken in the Mental Capacity Act in doing that, with, as the Minister said, a clinical checklist and a care and treatment plan. We will require that patients' past and present wishes are taken into account.

Chair: If you have the two together, so you have the advance choice whatever and that leads into the care and treatment, you have a flow of information that could transform the lives and support of those patients.

Caroline Allnutt: We do not disagree with that. There is already some really interesting work in the NHS. South London and Maudsley has been using ACDs. The work we are doing with NHS England is not just about creating the form and thinking about how it would be populated, but about how it would then flow into clinical processes and, if we are ambitious, using more digitisation to enable that. That is a whole programme of work alongside the legislation to make this a reality.

Baroness Berridge: This is not on the law, as to whether it should be in the statute, but we have had evidence that, because of what has happened, the relationship between certain communities and mental health services is very poor. We have a responsibility to rebuild that trust. Therefore, the process of sitting down with somebody before they are at the moment of detention, if they have been detained before, for instance, is a really important part of rebuilding that trust between the services and the community. For that reason, it is a relationship repair as well as stating your decisions about care and treatment.

Maria Caulfield: Yes, and there is some really exciting pilot work going on with NHSE in parts of the country such as London and Oxford. I think that they have expanded the number of sites. It is about how to make treatment much more culturally appropriate, particularly for minority communities.

We are waiting to see the results of those pilot studies. If they prove successful—improving the relationship between service users and service providers, for example, or reducing detention rates, because patients feel more comfortable accessing care, so it can be provided at an earlier stage—the aim is to roll them out nationwide. You are right: it is about those relationships from the very start.

Baroness Berridge: I would also point out that research has already shown this. That is the unusual thing about this intervention: we have that evidence. It has been shown to reduce the detention rate, and that was the first line of the Wessely review: we are aiming to reduce detention.

Q191 **Dr Ben Spencer:** This question and a question a bit later on both focus on detention powers in the community, CTOs and supervised discharges. As you know, CTOs are very controversial. They were controversial when they were introduced, some time ago now. Between the predicted usage and their use today, there is a 10-fold increase. We have heard lots of evidence from various groups very much against them, particularly community groups and charities. There are concerns about them being applied in an unequal sense, particularly against people from black and minority ethnic backgrounds.

The review recommended keeping them but leaving the door open by having a review to look at potential for abolishment in the future. I am wondering why the Government have taken a step back from that, been more cautious in the Bill and not given themselves the option, going forwards, to abolish them if the changes being brought forward do not address these concerns.

Maria Caulfield: We have taken most of the recommendations from the independent review on community treatment orders. There are a couple where we did not. There was one about limiting them to two years, but there was concern that that may not be beneficial for certain patients, such as those with eating disorders and forensic patients. We have taken the vast majority of recommendations.

You are absolutely right: the level of detentions under community treatment orders is very high, again disproportionately affecting certain groups that they are being applied to. The changes in this Bill give much better oversight of that procedure. There is now a need for the responsible clinician and those in the community to work better together on oversight of individual patients. The tribunals are going to play an enhanced role in this, reviewing them regularly, particularly for those who lack capacity, as well as ensuring that they are not overly restricted. We are also introducing the nominated person, who can object to a community treatment order.

There are much more robust safeguards for their use and oversight of how appropriate they continue to be for a patient. I do not think that we are opposed to relooking at that in the future if, after the measures in this Bill, there is still concern about their use, overuse and remit. We have to try to put better safeguards in place first and see how those work, rather than abolish them completely.

Dr Ben Spencer: The extra safeguards regulating the use of CTOs are very welcome. I am glad that those are being taken forward. If you do not mind, I am

going to press you a bit. Are you saying that the Government will review them in the future, following the implementation of the Act, or is it more open?

Maria Caulfield: We have not set a formal review. We have taken on board almost all the recommendations from the independent review, and want to put them in place and see how those work. The aim is to reduce the use of community treatment orders and make sure that, when they are in place, they are maintained because they are of therapeutic benefit for those patients, that the nominated person can challenge that and that the role of the tribunal in that is much enhanced. We are not formally setting a timeline for review, but, if it is not working in practice, we have not closed the door on that either.

Dr Ben Spencer: I am very glad that that is being kept open. I think that lots of people and groups would feel reassured if you made that commitment, as part of the implementation of the Act and the post-implementation scrutiny and evaluation, that there would be a review into CTOs, with a view to abolishing them if the improvements we are hoping the measures will make do not come into effect.

When CTOs were brought in a while ago, there were lots of expectations about how they would be used, which turned out not to be true. There is a concern that, even with these measures being brought forward to try to curtail their use, there is a big question about what effect it is going to have. As you well know, this is an area, in terms of the use of the Mental Health Act across the board, that causes a great deal of concern and consternation to many people.

I have presented a fairly one-sided view of it. We also know that there are quite a lot of conflicting opinions. Some clinicians are big fans of them. Particularly in the forensic setting, there is a lot of support for them, against the backdrop that there is no positive evidence that they do what they say on the tin. That is also quite concerning, given the restrictions put on people and the perception of being under a CTO.

Maria Caulfield: Absolutely, the review has identified that there is an issue with CTOs. That is why there is a huge focus in the Bill on them and putting those safeguards in place. We will review the effectiveness of those safeguards, because the ultimate aim is to reduce the number of detentions, whether in-patient or community treatment orders. If that does not happen in practice, we will relook at that

Chair: What worries me is whether, if we go ahead as the Bill is drafted, we then need further primary legislation in order to abolish them. That would create a huge delay

Maria Caulfield: We have not set that out firmly at this stage. We want to implement the recommendations from the review and see how they work in practice. We are optimistic that, by changing the criteria, making sure it is just used for therapeutic benefit and for patients at serious risk of harm, and with the additional safeguards of the tribunal and the nominated person, there will be oversight of that process. If patients and clinicians feel that that is not working in practice, we will have to look at that. It is important to put those measures in place first and then evaluate how they work.



Chair: I am thinking about whether there could be a way within this legislation to ensure that abolishment would not require further primary legislation. I turn to Lady Barker, who knows a lot about this.

Q192 **Baroness Barker:** I sat here in 2005 and listened to a predecessor Minister saying very much the same things as you have about CTOs—how they would be used very sparingly and only for the small number of people for whom they could be identified as beneficial. At the time parliamentarians said, “We don’t believe that”, and, lo and behold, we were right. Here we are, all these years on, and it is the same story, with an additional proposal to bring in supervised discharge orders and the same fears from the same people.

My point is this. I am willing to accept that there may be a case for community treatment orders, but it has not been made, not by the profession and not by the Government. You are, yet again, asking Parliament to pass a law that we already know has had a seriously disproportionately disadvantageous effect on a certain proportion of the population. If you do not at the very least commit very soon to a thorough and detailed review, which needs to pick up many of the points put by Dr Spencer, you will put us in an impossible position. We cannot, in all conscience, continue with this without an evidence base that can be relied on.

Maria Caulfield: I do not think we are dismissing the concerns that there are about community treatment orders. We are very much concerned about their use and their disproportionate use in certain populations. We are taking evidence from the independent review in terms of how we put the safeguards in place. As Dr Spencer says, there are clinicians who are very supportive of CTOs. The guidance given in the review is that these safeguards that would be put in the Bill would make a difference. Obviously, we will continue to monitor that to make sure that that is the case.

There are clinicians who support the use of CTOs and feel they have a valuable role in the management of patients. At the moment, we find that they are being used often in ways that are not appropriate for patients and often for patients from certain backgrounds. It goes back to Baroness Berridge’s point. Why is it that certain groups are disproportionately finding themselves are subject to CTOs? Is it because they have a very poor relationship with health services and do not engage until they absolutely are at crisis point?

We aim to do work across mental health, so outside of this legislation, to make it much more accessible in the community to all communities at a much earlier stage. Will we see a natural fall in the number of CTOs because we are getting in with early intervention and we are in the community, rather than expecting patients to come to us? It is not just what is happening in the legislation that will make a difference to this. It is the whole sphere of change in mental health services.

Baroness Barker: Yes, indeed, which is why my key point is that, after more than 10 years, we ought to have an evidence base for the legislation as it is being proposed. You are telling us that you might do it at some point.

Maria Caulfield: Our evidence is guided by the independent review that made these recommendations, which we are following.



Dr Dan Poulter: I have a suggestion. Taking aside whatever the view may be of the independent review, of individual clinicians or, indeed, of us here, the Minister may be aware that there have been randomised control trials looking at the effectiveness of CTOs. Would the Minister like to explain to us perhaps whether they have shown any benefit to CTOs?

Maria Caulfield: There is a lack of research as well in the mental health sphere.

Dr Dan Poulter: What about the randomised control trials on CTOs?

Maria Caulfield: I have not seen the randomised control trial.

Caroline Allnutt: We are aware of the randomised control trial—the one that absolutely suggests that CTOs are not effective in reducing readmissions.

Dr Dan Poulter: That is the general view, yes.

Caroline Allnutt: I am not defending the use of CTOs at all. The evidence base can be a little mixed. There are other international studies as well. There was a recent CQC report, I think. It did some work with trusts in London and found that certainly parents and carers saw some benefit in terms of people carrying on taking their medication and, therefore, not being recalled to hospital.

Dr Dan Poulter: If I am allowed to say this for the benefit of the panel, the randomised control trials on CTOs show that there is no benefit for a patient being on a CTO as opposed to not being on a CTO, in terms of reducing admissions. The only benefit shown in those trials, I understand, was that there is a slight reduction in the patient coming to harm from others. I believe that that was the only benefit. The evidence does not support CTOs as being an effective intervention, we know. That may be worth discussing.

There is one thing I wondered, and I would be interested in Minister Hinds's view on this. If the committee were to come to a view that, for reasons of lack of evidence and the concerns that Baroness Barker and Baroness Berridge quite eloquently raised earlier, we did not feel that CTOs were effective, would there be a case perhaps to get rid of the use of CTOs in Part II of the Act, but have them specifically for forensic purposes in Part III? I do not know Minister Hinds's view of the use of CTOs for forensic patients. Do you feel that there is a specific benefit for some patients?

Damian Hinds: In the criminal justice system, we have community orders in general. In terms of this legislation, I imagine supervised discharge is where the question would turn. With supervised discharge—I can feel Baroness Barker's reaction in advance, and understandably—there is quite a small number of people to whom it would apply. We are trying to stop that small number of people being stuck in confinement in hospital for very long periods, and to enable them, as an alternative, to come into the community, but with quite significant restrictions on their liberty.

It is different from CTOs in a number of substantial ways. In terms of who can make it happen, only the tribunal or the Secretary of State can effect a discharge in this way. People would have access to the independent mental health advocates and there is more access to the tribunal in this new system, the supervised discharge, than there is in other conditional discharges as they exist today. It is a different kind of set-up. As I say, I think it would be genuinely quite a small number of people, but a small number for whom the alternative—this is the key part—is not coming out of the secure hospital setting.

Dr Dan Poulter: What we are saying is that there is, in fact, quite a clear differentiation for those particular groups of people who are on a CTO under Part III rather than Part II. That is something that you think that the committee should be very cognisant of when making our recommendations.

Chair: Could you perhaps take that one away, in terms of thinking about the differentiation between those two settings?

Damian Hinds: We will, indeed.

Chair: I think we have more questions, but we have to move on.

Q193 **Baroness Hollins:** I should declare an interest as an independent consultant to the Department of Health and Social Care around people with learning disability and autistic people who are detained in long-term segregation, which is a related issue. We know that there are too many people with learning disabilities and autism who are detained for too long in hospital.

We have been hearing concerns from some witnesses that the provisions in the Bill might make things worse—for example that people might be kept in hospital under the Mental Capacity Act, that there would be fewer safeguards for them, that they would not have access to Section 117 funding and so on. It would be helpful if you could explain to the committee why the Government decided to remove people with learning disability and autism from Part II Section 3 when the independent review cautioned against it.

Maria Caulfield: We want to be clear that, if there is a mental health need for people with learning disabilities or autistic people, detention under the Mental Health Act could still be used. Like with mental health, we are trying to change the way people with learning disabilities and autistic people are cared for and not have them in in-patient settings across the board, whether that is learning disability or autism in-patient settings or within a mental health setting. We have a target of reducing that by about 50% by 2024, compared to 2015 levels, and we are making good progress on that. We believe that being an in-patient per se is not risk free and has certain disadvantages for people.

Absolutely, if someone has a mental health condition that warrants them being detained under the Mental Health Act, that will continue. We are investing across the board over £90 million into community services, not just in the services but in the capital estate, to make sure that we have the provision to support people with learning disabilities and autistic people in the community. Outside of the legislation, that is the direction of travel that we are moving in.

Baroness Hollins: One of the issues is that, if the Mental Capacity Act is used instead, it might make matters worse. One question being asked is whether there are any alternative funding routes, for example. I do not know, but would the community discharge fund work? Would the discharge funding available for acute hospitals to support adult social care be made available in mental health hospitals? There is a real worry that the funding will just not be there and that the long stays will continue. I wondered whether you have thought about alternative funding routes.

Maria Caulfield: A part of the requirements in the Bill will put a requirement on local commissioners to have the details of patients who would be at risk with learning disabilities and autism, and then to commission the services that those patients need. At the moment, that does not happen. We need local commissioners to be commissioning services for their local population. There will be a requirement in the Bill to make sure that that happens, that they have the responsibility then to make sure that the services are available at a local level to care for people in that situation.

Baroness Hollins: That is great in terms of trying to avoid admission, but there is the worry about discharge and funding that might support that, I think. That is something to really think about.

Maria Caulfield: The Government are making funding available right now for social care, because this is a factor across all health services: patients who are in-patients and who ideally should be either discharged or not admitted in the first place. That funding will be available to patients whether they have physical healthcare needs or learning disabilities. We want to make sure that in-patient services are there for the people who absolutely need them and are clinically appropriate. The change of culture is to make sure that, if someone does not need to be an in-patient, we facilitate the support in the community to enable them either not to be admitted or to be discharged.

Baroness Hollins: That would be excellent news if parity actually holds with respect to this new fund. Could I ask a slightly different question? This is about what the Government are intending to do, aside from the commitments to community care, to reduce the risk of individuals with learning disabilities or autistic people in crisis being detained through the criminal justice system. Have the Government learned from similar legislation that was introduced and then replaced in New Zealand? What lessons have we learned? Minister Hinds might like to come in here.

Damian Hinds: Anna, do you want to say anything about the international aspects and what we have learned?

Anna Lacey: It is obviously a much wider question than the Mental Health Act reform Bill itself. I am sure you are already aware, Baroness Hollins, of the recent call for evidence that our previous Secretary of State commissioned in terms of neurodiversity across the criminal justice system. As part of that, we are engaging widely, including understanding, as you say, the international evidence base. We have committed by the end of the year to come back with an update on how we are progressing the recommendations made through that call for evidence.

As part of that, and this goes much wider than the Ministry of Justice, we are working with the National Police Chiefs' Council to understand how we can better support neurodivergent individuals right from the point of immediate contact with the criminal justice system. In terms of what we are doing within our purview, per se, we have introduced neurodiversity support managers in prisons. We are also working towards an autism accreditation across the prison estate and are in various talks about improving the training offer for all the different staff who are in contact with our individuals.

David Nuttall: Could I just add a couple of points? One is on the New Zealand example specifically. It is difficult to draw a direct parallel with what goes on in another country with a different policy context, et cetera. I understand that, in 1992, there was a removal of learning disability, or intellectual disability as it was framed there, from the mental health legislation completely. Then, in 2003, new legislation was introduced that, essentially, brought back into scope intellectual disability and the ability to detain people with a learning disability who had been charged or convicted. That was then passed in 2004.

The parallel, if we can draw one, with what we have proposed is in the difference between treatment of people with a learning disability and autistic people under Part II and retaining the ability to detain people without a co-occurring mental health condition under Part III. That is the parallel I would draw for New Zealand.

If I may, on Section 117 funding, the Minister talked about the duties on commissioners. We have put a provision in the draft Bill that would allow, by way of regulations, recommendations from what would become statutory CTRs to feed through to the dynamic support registers that would be required, so that commissioners would have to commission with regard to those requirements from the recommendations as well, which is akin to the Section 117 requirements.

Q194 **Lord Bradley:** I just want to press a little bit on the concerns that have been expressed to us quite strongly over the route, if they are taken out of the Mental Health Act, into the criminal justice system. Anna talked about awareness training in prison, for example, but it is really the upstream work. What investment will go in, besides laudable community services, that can identify, assess and ensure that those people who have not committed an offence but are hitting against the criminal justice system do not flow into the criminal justice system because that is considered the appropriate route, for what I may consider the wrong reasons?

Damian Hinds: Lord Bradley, you make a very good point. We do not, of course, cover the whole of the range of people who would come into contact with the individuals you mentioned, which could include children's services and social workers in general. To be fair, throughout the public sector, there is a greater awareness than there was in the past of the support needed for people with learning difficulties and disabilities, and for people with autism. I do not think that we are really qualified to speak, as I say, on behalf of that whole range. As Anna set out, we are doing work with people in prisons but also with the police. For example, how people are treated in custody is very important.

I just wanted to be crystal clear about one of thing when we talk about who is in and who is out of the Act. For Part II, patients would not be detainable in future, unless they also had a mental health condition, but we are not making that change in Part III, because there is a fundamental difference for the patients we talk about in Part II and in Part III. For Part II

patients, the alternative to being detained in hospital is likely community treatment. For those in the criminal justice system—in other words, for Part III patients—the alternative to being in a secure hospital is, generally, prison. It is a question of how you move to the provision that is more in line with the principles of therapeutic benefit and of least restriction. In the criminal justice system, we retain that facility for people with learning difficulties and for people with autism.

Dr Ben Spencer: The concern we have heard about the provisions under Part II of the Act is that it is not going to lead to people who are currently detained under Section 3 of the Act not being detained. Even with greater community supervision, what will happen is one of two things instead. They will be detained in hospital under the liberty protection safeguards in the future, or currently under the DoLS, or there will be another psychiatric diagnosis given, which will lead to liability to detention. One can see how that would be quite straightforward to do in a lot of situations, such as social anxiety or what have you, where there are overlaps.

We have had evidence and concerns over both those possibilities: first, that the LPS will not give equal safeguards to those currently in the Mental Health Act in terms of the right to appeal; and secondly that, if you use other, perhaps spurious mental disorders to justify detention under Part II of the Act, you are putting someone on a different care pathway that might not be the most appropriate one. If you focus on a psychotic symptom that one may think is a disorder, that may deviate from focusing on the primary diagnosis, which might be a learning disability or autistic spectrum disorders. Personality disorder would be another that one might be concerned about.

The reason why I mention this now, following your contribution, Minister Hinds, is not that it will not be the case that, under Part II of the Act, it will be liability to detention or community. Concerns about liability to detention will continue, but with drawbacks under the current proposals as they stand and, in fact, worse. To justify ongoing detention, if one wants to do that under the Mental Health Act, the only route available will be pursuing a criminal justice route.

This would mean that, where clinicians, who have a duty of care and want to act in the best interests of the patients, feel they need to remain detained and having treatment, there will be an increased push to go down the criminal justice route, to prosecute and to criminalise patients in order for them to get treatment. This is concerningly similar to what the situation is in other jurisdictions like America, where, effectively, you have to offend and be prosecuted to get treatment for your mental disorder.

These are the underlying concerns about what the knock-on and very much unintended consequence of the proposals are, because we all agree that we want fewer people detained. We want fewer people with learning disabilities and autism detained. We want better safeguards. We want to stop abusive practices. The concern is that the knock-on effects would be to have more people with LD or ASD criminalised, detained in hospital without the safeguards that the Mental Health Act currently provides under the LPS, or detained for disorders not linked to their primary disorder and on a perverse treatment path.

The Chair: Dr Ben Spencer is articulating what a lot of us are really perplexed about. This area has taken up much of our time and our thinking. We are still not decided on what our thinking is, in a sense, and so it is so helpful to have this session today. We have even heard those working at the coalface, if I can call it that, in a mental health setting being surprised by this huge change in the Bill. “Where did it come from?” We have had hardly anyone support this, with the exception, possibly, of Professor Tim Kendall earlier in this session.

We all feel that, in an ideal world, this is the right direction of travel, but the unintended consequences are so real, unless there is the most extraordinary ongoing injection of funds into the system, because we cannot pretend that care in the community is going to be anything other than very expensive. I just put that point.

Baroness Berridge: As you or your officials may have seen, we have suggested a third way here. We have a small group of people who do not have genuine comorbidity that requires use of the Mental Health Act, and who are not and should not be in touch with the criminal justice system, or should be de-escalated, if their behaviours can be framed in that way. What happens in practice now is that charges are dropped at an early stage and they go under Part II.

Until we get to our ideal world of this community provision, they will still need to be detained, but because they are not mentally ill they should not really be under the Mental Health Act anyway. They have learning disabilities and autism, yet they are needing, for therapeutic reasons and for their own safety, to be detained. We potentially need a third way here, to say that we do need a power to detain, but that we hope this group, over time, decreases and the community resources stand up.

I was wondering whether you have any view on that. Do we perhaps need a different power to detain, in order to avoid all the unintended consequences, which could have the protections of the tribunal—the Section 117 aftercare—that you do not get if they then tip out and fall into the Mental Capacity Act bucket?

The Chair: Can I also interject? I am sorry, but I have just been corrected, quite rightly, in that the learning disability and autism charities were also in favour of this removal.

Baroness Barker: So are NHS Providers, the CQC, NHS England and a few others. It was mainly the clinicians and the lawyers who are against it.

David Nuttall: If I may respond, it was consulted upon and broadly supported, acknowledging that there was risk, which we absolutely accept. A lot of the discussions about learning disability and autism, and how they are dealt with in the scope of the Mental Health Act, have considered it a binary “in or out” decision. We have tried to find that third way and to say that we are not taking learning disability and autism out of scope of the Mental Health Act entirely. We have talked about it being within Part III.

We have also retained the ability to detain someone under Section 2, recognising that, at a point of crisis, it is very difficult to ascertain whether that is on a mental health basis, whether

someone has been diagnosed as autistic, or whether something else is going on for that person.

In removing learning disability and autism specifically from the scope of Section 3, we wanted to balance that out by saying that we need those duties on commissioners and we need those risk registers, so that we can identify who has a particular set of needs that, if we do not intervene early enough, could escalate towards admission or a crisis, which might put them in touch with the criminal justice system.

We just wanted to set out that that is our thinking about how the pieces of the reform fit together to try to make sure that we get the early intervention, do not allow needs to escalate, and prevent people from coming into contact with Section 3.

Baroness Berridge: We agree with that, but that is not the reality out there at the moment. What is the situation for somebody who does not have a comorbidity, who bumps into the criminal justice system and who, therefore, is detained under Section 2 for 28 days? Where do they go? The clinician is convinced that, for their own safety and for therapeutic benefit, they still need to be detained. Are you happy to rely on the Mental Capacity Act with the lack of tribunal and the lack of well-understood Section 117 aftercare? Is it your position that MCA is fine for this group of learning disabilities and autism in the interim, until we get to where we all want to get?

Maria Caulfield: The rollout of the Act, once it is passed in law, is over time, so these measures would not come into force immediately the Act was passed. That would be part of the planning process. If the committee has had strong evidence to suggest that there is a third way, as Dr Ben Spencer has indicated, we will certainly look at that, because we do not want to create a loophole where patients are missing out on therapeutic benefits, which may not be under the Mental Health Act but may be required elsewhere. I am very happy to look at the evidence, if the committee is concerned about that particular point.

Baroness Barker: We cannot agree legislation on the grounds that it might not be implemented.

Maria Caulfield: I am not saying that it will not be implemented, but there will not be an immediacy. We have been pretty clear this afternoon that some parts of the Act will be very easy to implement pretty quickly, such as having a nominated person in place. There will be other parts of the Act where we do need those resources to be in place before we can then enact them in full. We have been pretty clear about that. Caroline indicated that there will be a period of time before we are able to step up some of the services that will be needed to fulfil the Act.

Q195 **Baroness McIntosh of Hudnall:** I wanted to get your observations about something that we have had evidence about—and other people in this room are much more expert in this than I—which is the prevailing underdiagnosis of autism particularly and of learning disabilities. In order for the series of linked interventions that David was talking about to happen, it would require diagnoses of the kinds of need that people had, because they were identified as being autistic or having other developmental disorders, for example, to be made early enough, and for there to be

enough people who knew what they were looking at.

Most of the people who, it would be fair to say, have come towards us very much in favour of the way that the Bill is now drafted have been people who do know what they are looking at. Therefore, it is clear to them what needs to happen in order to protect those people from finding themselves in an inappropriate care pathway, for example, in the way that Dr Spencer described, or pushed into the criminal justice system or simply not treated at all.

Does anybody have any reassurance for us about that upstream bit of the process, which, frankly, if it is not there, will not serve the principles that you are rightly trying to embed about the inappropriateness of using the Mental Health Act to treat people who do not have mental illness but do have a developmental disorder of some kind?

Maria Caulfield: That is why we are creating the new duties on commissioners to look at their local population and then identify what services are needed for those individuals. That will vary from place to place, because it will be done on an individual basis, not just saying, “Here are our learning disabilities community services”. It will look at, patient by patient, what services they need. They will have a duty to commission those services and to make sure, on an ongoing basis, that they are the services that someone needs.

Baroness McIntosh of Hudnall: I am so sorry to interrupt you, Minister, but it is not so much a problem of commissioning services but of identifying a problem. You cannot commission services if you do not know what you have in the way of potential service users. I am not telling you, because I do not know, but I am asking you what assessment you have made of the ability of the health service as a whole, and the criminal justice system, to identify these particular kinds of disorder when they encounter them and not to misdiagnose them.

Anna Lacey: I can come in on the criminal justice side. I mentioned the neurodiversity call for evidence and the action plan subsequently, and that very strongly identified the absence of a consistent screening process at every stage of the criminal justice system, so that is a top priority for us.

We are not necessarily going to guarantee that there will be the exact same screening process at every stage, because often there are different needs at different times, and what a police officer can do may well be very different from what a judiciary member could do, but that is certainly a top priority for us within the criminal justice system.

Part of that is about promoting best practice, because some areas are already well ahead in terms of their screening practices, and taking a proportionate approach. Clearly, a police officer and a member of the judiciary are not clinicians, so they are never going to be able to diagnose, but it might be that there are certain behaviours that could help identify a potential neurodiversity, which would help to inform how best to support that individual at every stage of the criminal justice system. I point again to that action plan, which is a top priority for us.

Lord Bradley: You are siloing different parts of the criminal justice system. What really should happen is a flow of information from the first point of contact, so that

an assessment can take place that informs the next stage, and maybe additional information is added at that point.

Anna Lacey: I completely agree. There are two parts to this. One is making sure that we have proportionate screening at every stage, which might need to be nuanced; the other is, when that screening has taken place, sharing that information in a right and confidential manner. It is a two-pronged approach.

Dr Dan Poulter: Mr Nuttall, you talked about the ability, under the proposals in the draft Bill, for Section 2 to still apply to someone for a period of assessment as to whether the primary issue was a mental disorder, autism or learning disability. I just wonder what analysis has been done, also perhaps by the Ministry of Justice, of the displacement to the criminal justice system.

I am struck, in this area, by an analogy with, say, Huntington's, which is a really pretty awful neurodegenerative disorder. We sometimes see Huntington's patients who would not be detained, for various reasons, under the Mental Health Act, not least because of failing on the treatment criteria under Section 3, ending up in prison, because of some of the behavioural consequences of what is a really awful condition, and the personality changes and degenerations.

If we are seeing some of those people ending up in the criminal justice system and in prison, what analysis has been done of the likelihood of somebody who may have fairly complex behavioural changes or disturbances linked to autism or learning disability ending up in prison as a result of the inability to detain and treat appropriately, where that may be appropriate, under the Mental Health Act?

Baroness Hollins: Can I just ask mine now, because it links to yours, Dan? It might make it easier for you to answer. It is just that a lot of clinicians have said that 28 days is not enough to make a proper assessment, especially taking into account complex presentations, where there may be a behavioural challenge that is the perceived reason for admission, but also sensory and communication difficulties. Is there scope for allowing a longer period of assessment of these patients? This might also help with this point that you are making, Dr Poulter.

David Nuttall: We have been trying to balance exactly that view—that 28 days may not be long enough to form an assessment, particularly if you do not have skills or capability in diagnosing autism, for example—versus a counterargument that 28 days is a very long time if you have sensory needs and are put into an environment that may lead to a deterioration of the condition. That is what we are trying to weigh up and why we came out with preserving Section 2 as it is, but it is a very valid argument that longer may be helpful in forming a fuller opinion.

On the point about assessing risk of diversion to the criminal justice system, that is very difficult to do when we have a system with provisions to allow people to be admitted to hospital under civil sections. Trying to understand the counterfactual is really problematic. It is equally problematic to predict what that would look like when you have a system of support in place there. The straight answer is that that is a very difficult thing to form a judgment on in terms of what the numbers might be.



The Chair: We have had a good airing on this subject and, as you all gather, it is proving difficult for us and a real challenge, which I hope we will overcome in our report.

Q196 **Dr Dan Poulter:** Minister Hinds, we have heard during the inquiry that a Part III patient is not necessarily a higher risk than someone detained under Part II. Why did the Government decide not to make the same changes to detention criteria for forensic patients as civil patients?

Damian Hinds: Thank you for that important question. Of course, there is a lot of alignment between the treatment of Part II and Part III patients. In particular, something that is not universally picked up—and I do not mean by this committee but more generally—is that, after the White Paper, we got significant feedback about the principle of therapeutic benefit and that it should apply to Part III patients. That is a change that we have made, so therapeutic benefit would apply to both.

Ultimately, what we are doing in the criminal justice system is somewhat different from the purely medical world. There is an established system for assessing risk. We think it is right that it continues to be possible to assess the risk of an individual on an individual basis from the point of view of public protection.

Dr Dan Poulter: How will the Government respond to services that continue to be unable to make the 28-day time limit for transfers?

Damian Hinds: For somebody who is incarcerated in prison and needs to be transported to hospital for it to be a more appropriate setting, we are going to put in place a 28-day statutory limit. I should say that the 28-day limit is not a new thing. It is the statutory nature of it that is new. We have had this guidance since June 2021, working with colleagues in DHSC and NHS England. The transfer and remission guidance already says that it should happen within 28 days.

Making it a statutory right, effectively, is a new thing. That is something that we will have to monitor, and we are going to put that monitoring in place. We are looking at how to have an independent role to oversee it. Ultimately, of course, it relies on there being capacity available in the healthcare system. There is investment going into mental health provision, of course. As that is allocated and so on, having a statutory requirement for transfers to be made within 28 days is quite a powerful lever. All individuals coming into contact with mental health care services are in need, but there are particularly sensitive cohorts.

Then there will be the facility for parliamentarians, the Select Committees that various colleagues sit on and others to hold the system to account on that.

Lord Bradley: On the 28 days, there is an exception for exceptional circumstances. Will you be defining what those are?

Damian Hinds: We are talking about that at the moment. There is a very legitimate question about when clinical need—or perhaps I should say clinical appropriateness—comes into play. Is it ever right to say that, because the right bed or the right setting outside of prison is not immediately available, the statutory requirement is eased, or is that not right, because we are

trying to make sure that that bed becomes available? We are discussing that with colleagues in the healthcare system.

Lord Bradley: Will you be sharing the outcome of those discussions with us?

Anna Lacey: As I am sure you know already, Lord Bradley, in the current phase of the Bill, we have set out what do not count as exceptional circumstances, and we are currently actively consulting with key stakeholders to understand all the different scenarios and whether there is anything else that we should be adding, both positive and negative. In advance of the introduction of the Bill, we will continue to keep you sighted on any new developments. Fundamentally, we are having some really positive engagement with key stakeholders across the health sector to understand what those very limited circumstances would be, because a lack of bed availability in and of itself should not be an exceptional circumstance.

The Chair: What happens to those services that do not meet the targets once they are introduced?

Damian Hinds: We could probably both speak to that. We want the target to be met. There are targets that, in the public sector, do not get met, sadly.

The Chair: But it is in primary legislation.

Damian Hinds: Exactly, it is a right that people will have and, therefore, the providers of said services—us—will be held to account for its delivery.

The Chair: Somewhere in the system, is there a huge push to increase the number of beds, which we have, over years, been reducing? Is this all about to change?

Damian Hinds: I will let Maria speak about mental health provision in general and how that fits with this. The whole point of making it a statutory requirement is to ensure that, as we develop our systems across healthcare—beds as well as everything else in the chain—we can fulfil the statutory right of a patient to be transferred from prison to hospital within 28 days.

Maria Caulfield: With the overall aim of the legislation and the ethos around changes in mental health services across the board, and in trying to make sure that patients are detained as in-patients only when there is a risk of serious harm and there is therapeutic effect, we anticipate that fewer patients will be admitted into hospital. There will be patients on a voluntary basis as well.

With the significant investment that is going into community services, for not just staff but physical provision of facilities, we anticipate that there will then be the capacity to take patients, whether from police cells or from the prison estate.

An area that someone has touched on already this afternoon is the data. What we do not have at the moment—and NHSE and NHS Digital are working on this with colleagues in the Ministry of Justice—are those figures, so that we can accurately plan or best forecast the numbers and the type of patients that we are expecting to see.

At the moment, our data is not as robust as it needs to be, but there is considerable work going into that, so that we can plan and adequately resource the facilities we need. We



anticipate that, by reducing the number of in-patients and those being detained under the Mental Health Act, there will then be the capacity for those who have been detained in prison.

Baroness Berridge: On this 28-day time limit, with the exceptional circumstances, are we, in a positive way, achieving what I was putting to the Minister before about empowerment? If somebody is ill in prison and needs to be transferred, and is not transferred and then harms themselves or dies in the prison, have we not then enabled a whole raft of further legal remedies for the family? The prisoner should have been moved within 28 days for treatment but was not, so it is an empowerment of people in terms of their rights and remedies against the state, basically.

Damian Hinds: The short answer to that is yes. Ultimately, putting in place the statutory requirements leaves decisions open to judicial review. It is increasing the rights of the individual.

Baroness Berridge: There could be damages claims.

Damian Hinds: Yes.

Chair: Those would be paid, not by the hospital, but by the taxpayer.

Q197 **Dr Ben Spencer:** I have a couple of questions on supervised discharges. It is really helpful that you were the previous Security Minister, Minister Hinds, given where my question is going. This is trying to fix a legal problem, as we all know, following the Supreme Court MM case about being discharged, while still under a restriction order, into a setting of a deprivation of liberty. We have the powers to do so when someone lacks decision-making capacity under DoLS, but not when someone has decision-making capacity.

I have a few concerns about this. In all the history of our Mental Health Acts that we have had in various shapes or forms over the past couple of hundred years, we have never crossed the Rubicon of detention in the community. This is something in the Bill that would do that. My understanding is that, in UK law, the only other circumstance where we can detain people in the community who have decision-making capacity is the treatment of terrorists.

Damian Hinds: We detain people in different ways in the community—a lot of them through tagging or through curfew orders.

Dr Ben Spencer: But this is a locked door that they cannot come out of.

Damian Hinds: It is not necessarily. There are different ways that this provision could be made. It could be, for example, moving into a care home or having constant supervision when you are leaving a setting. I say again, by the way, that we are talking about a really small number of new cases each year. The critical thing is that, for this group, the alternative is that they do not get discharged but remain in secure hospital.

Dr Ben Spencer: The concern with CTOs is that the argument, when they were brought in, was that they would apply to only a very few people, but that has now

expanded. Effectively, in statute, we are going to create a new halfway house discharge measure, because it will then allow, under certain circumstances and safeguards, for detention in the community for a new range of people with a mental disorder.

Have you given any thought to another measure, which would be to ensure that these placements are badged as being registered hospitals under the CQC, whereby they can have a responsible clinician and can authorise detention in the community under the existing mental health powers? That would give more rights and support. It would ensure that they are of a high quality and that they have better scrutiny of what is going on in their settings.

Damian Hinds: There is a grey scale here, but, ultimately, the individual can be kept in a secure hospital. Those secure hospitals could be of different types, with different physical manifestations and different care plans for the individual. This gives an additional option that says that, to stop that individual having to stay in a secure hospital for a very long time, there is an option for it to be tailored for that small number of individuals. Again, when I say small numbers, I really do mean small numbers. They could be in the community but with the appropriate level of close supervision for public protection.

Dr Ben Spencer: I appreciate that, if it really is a small number of people who are currently in this situation, you do not want to disclose the exact figure, but is it in the tens, in the twenties or in the fifties?

Damian Hinds: In terms of new cases that we will be dealing with each year, it is in that order of magnitude.

Anna Lacey: Building on what the Minister said there, what we are looking to do here is to discharge the individual. We have had recent examples of those who are currently having the same experience, but under long-term Section 17 leave. There are some visible differences in terms of their own wellbeing from knowing that they have been discharged. We can provide some examples of that, if helpful.

The numbers are really low at the moment. Because it is an operational workaround, we have not been publishing those figures. There is no neat way to cut the figures, but we are committing, under the power of supervised discharge, to provide transparency on the numbers through our annual statistical bulletin, so that you can keep a very close eye on how it is being used. There are concerns from the CTO angle around ethnicity and the overuse. As it stands, that has not been the case under Section 17 leave, and we hope that the numbers will be so low that we cannot even provide that breakdown by ethnicity, but we will keep that under review.

Q198 **Baroness McIntosh of Hudnall:** I hope that this will allow you to give a very quick and clear answer. Recommendation 131 in the Wessely review recommended, “A new statutory, independent role should be created to manage transfers from prisons and immigration removal centres”, so we are going back towards this issue about the management of transfer. The Government appeared to agree that this was a good idea initially, and then they did not. We would very much like to know where it is at the moment.

Damian Hinds: It is in discussion between the Ministry of Justice, colleagues from NHS England, the Prison and Probation Service and the Home Office about how best to do this oversight role. It is fair to say that there is no consensus among stakeholders about exactly where it should sit, and having a non-statutory body gives some more flexibility in that.

The most important thing is that there is oversight, that there is transparency, that it is open to Parliament and others to question, and that the role can intervene and make things better. That is the ultimate purpose of it. As I say, we are still in discussion about how best to do that. We will, of course, come forward with detail about what that means before the Bill is considered by Parliament.

Baroness McIntosh of Hudnall: Okay, but we should understand that, at the moment, the question of who would have responsibility for this role is still in discussion.

Damian Hinds: That is absolutely correct. That is, at this moment, an open question, but one actively being considered.

Baroness McIntosh of Hudnall: It is actively being considered but no resolution is currently in prospect. Would that be fair?

Damian Hinds: I would not say “in prospect”.

Baroness McIntosh of Hudnall: It is not immediately likely.

Damian Hinds: It requires further work.

The Chair: Minister, who leads that discussion?

Damian Hinds: The MoJ leads, but with colleagues from the agencies and departments.

The Chair: Thank you so far. We are almost towards the end. We have just two more questions for you, which are so important to us, as they all are. In fact, we had so many more questions. We cut them down, but it is still a lot.

Q199 **Baroness Berridge:** We have heard that extending the right of nominated persons to those under 18 is a positive step, but that those provisions may lead to safeguarding concerns and conflicts with other children’s legislation. How do the Government intend to make the provision workable in light of these issues?

Maria Caulfield: We recognise the safeguard concerns for those under 18. A number of measures are proposed in the Bill to address that. The child must have capacity to do that. Healthcare professionals will witness the process of nominating that person. The responsible clinician can overrule that decision, if they feel that the nominated person is not appropriate. If parents are not the nominated person, they will still retain their legal rights. The independent advocates will also be involved in that process.

We are proposing a number of safeguarding measures but, if this Committee has heard evidence that that is not enough or additional measures should be put in place, I am very

happy to look at that. We do want to retain the right for children to nominate the person who advocates on their behalf, who is not automatically a parent.¹

Baroness Berridge: It was made clear to us by Dr Parker that the nominated person is not an advocate. They do not advocate. They have certain decision-making powers that they do not even have to consult the child over. One of the specific issues we have is that they can apply to discharge a young person under 16 without the parent being involved.

We have a conflict here. As Dr Spencer has often said, the child might nominate a teacher as the nominated person. The nominated person applies to discharge the child from the secure mental health, but the parents want them detained. Where is the child going to live? It is these gaps that you have currently in the legislation, and we are just wondering. This was the evidence about how the Government are going to propose to bring this in line, because you currently conflict with the Children Act.

Maria Caulfield: My understanding is that the parents will still retain their legal rights.

Baroness Berridge: They would still have parental responsibility, but, in the 72 hours while the child might be being discharged, there is no obligation in statute, according to Dr Parker, for the parents to be notified that the child is coming home. The parents may not want the child at home. The child may pose a risk to siblings. That is what has been exposed to us. You might not have all the answers now, but we have very clearly had evidence that certain aspects of the Children Act have not been taken into account with regard to the operation of the Mental Health Act.

Maria Caulfield: We are very happy to look at that if there are witnesses who come forward to expose any loopholes, but the responsible clinician has the ability to terminate the nominated person as well. It is not just a case of the responsible clinician overriding the decision; they can terminate that appointment. If witnesses have come forward with loopholes or concerns, I am very happy to look at that, because we want to make sure, in enabling those under-18s to nominate a person, that the safeguards are as robust as they can be.

Baroness Berridge: It was explained to the committee by Dr Parker that, by allowing the AMHP to appoint the nominated person for an under-16, they might not be aware that there is a special guardianship order in operation from the court, so the parents do not have parental responsibility. Those are the types of loopholes. There are very serious issues to do with the Mental Health Act and its interplay with the Children Act that we hope you will look at or that we will help you look at with our report.

Maria Caulfield: Yes, absolutely. I would be very happy to look at that.

¹ Following the oral evidence session, the Minister wrote to correct the record regarding the introduction of the Nominated Person to represent patients' interests. The responsible clinician would be able to overrule the Nominated Person on a case-by-case basis, but they would not in fact be able to terminate the Nominated Person's appointment.



Dr Ben Spencer: Thank you very much for looking into it further. The example that I have used in several sessions now is a teacher. It is no slight on teachers, but it is just a good example of someone who probably has quite a strong “parental” relationship with a child, whom a child may nominate as a nominated person.

The main power of the nominated person, as you know, is to request a discharge of a patient who is under Section 3. Our understanding was that, once that power has been granted to the nominated person through this process, the parent would lose that power, if, indeed, they had it in the first place. The parent would not be able, under the powers of the nominated person in the Act, to request a discharge of the child, to exert those powers or to push the tribunal. The nominated person would.

It is this potential conflict of a child being discharged, by definition against advice, because the clinicians would not keep them under Section 3, if they did not think that they needed to be in hospital, but then the parents being in this limbo of dealing with the parental responsibility fallout of it. That also conflicts with Article 8 rights of the parent and the child. It would just emphasise that it is really helpful that you will be going away and looking at this.

Caroline Allnutt: It is also worth emphasising that, in addition to being able to terminate the nominated person’s appointment, the clinician can overrule, on a case-by-case basis. I would imagine that, if the parents were strongly raising objections, the responsible clinician would look at that very closely. Anybody who has an interest in the welfare of the child can apply for the termination as well, which I know is an absolute last resort, but there are those conditions in place already.

Dr Ben Spencer: It is worth reflecting that, if the system is anything like the current one for nearest relatives, that system is very unwieldy and quite difficult. I have been a responsible clinician on an in-patient ward. When these conflicts arise, it is awful. It is always a very difficult and fraught situation, from what I have seen in my own practice. Barring and then displacing in the current system is a very difficult process, with a very high bar. More generally, if this is going to be the approach to deal with these conflicts, there needs to be an accessible access to this, not necessarily just a theoretical access, if that makes sense.

Baroness Barker: Minister Caulfield, you have said once or twice this afternoon that the nominated person is going to be very easy to introduce, but it is going to be very difficult in practice, according to the patients and practitioners we have spoken to in mental health settings.

Caroline Allnutt: Just to clarify what we mean by that, in terms of additional clinical resource time—and I am not saying that there is none, but compared to some of the other reforms—we might be able to bring it in more quickly. Again, in terms of implementation, we are not just going to switch on the powers overnight. There needs to be a lead-in time. We need to revise the code of practice. We need to allow for practitioners to understand and assimilate what is new before that comes into effect.

The Chair: It is also fair to say that, listening to some witnesses, the idea of a nominated person is proving popular, particularly with young people, but it is very



important, as we have learned through the learning curve that we have been through with this process, that young people understand the role of that person. In other words, they are not a buddy. It is something a bit more distant. The role is as important as the position itself in terms of the young person's understanding.

Q200 Sir Charles Walker: Minister Caulfield, since I have been in Parliament, which is now 17 years, all sides of the House, recognising that there are more than two parties, have raised their concerns about children and adolescents not just being put on adult mental health wards but also being transferred 200 or 300-plus miles from home to find a bed. We have heard from witnesses that the Bill does not really go far enough in addressing these concerns.

I have led numerous debates on the Floor of the House. I believe Lord Bradley has led debates at his end of the House in the other place. Many other colleagues have raised their concerns about this. Are we going to get to grips with it? Can the Bill be strengthened to help mental health trusts get to grips with this and not have to make those terrible decisions that no clinician wants to make?

Maria Caulfield: There are some provisions that will strengthen the reporting of children who are placed in adult wards, as well as a requirement to report that and for the CQC to be notified when that happens, so that we keep an eye on the number of cases. The long-term solution to this is not really legislative. It is around the organisation of mental health services.

I talked about the capital investment going into mental health services to increase provision. As we know from the tragic cases we have heard about in recent weeks around a number of mental health in-patient facilities, particularly for young people, if they are placed out of area the risk of having a poor experience in those services is increased. It is much more difficult for a young person to raise concerns, or for family members or, as we will have in the future, nominated persons to maintain contact with that young person.

Our priority is that children and young people are not placed, where possible, on an adult in-patient facility, but also that the out-of-area issue is dealt with. As Mr Hinds touched on, it is about weighing up risks at the time. At the moment, if there is not a children's bed available, or one in the local area, what is the risk to that young person of not being admitted? Is an adult placement slightly further away the safer option?

It is about balancing those risks, but I just want to reassure the committee here that, outside of this legislation, we are investing in our estates programme, so that we have that capacity to reduce those numbers, as well as the data—and I talked about a data gap earlier—to be able to follow those patients, so that bodies such as the CQC are notified within the timelines. We are stipulating that local authorities are notified as well, so that, if an appropriate placement is made, that is rectified as soon as possible.

Sir Charles Walker: Thank you for that, because numerous Ministers and successive Governments have wrestled with this and have recognised that it is a capacity issue. We have to increase and find that capacity. It would not be acceptable, and I know that you would not want to see this, for us to end up in three years' time, at the start of the next Parliament—let us say there is a general election in two years—having the same debates. Words have to now translate into beds, if that does not sound glib and simplistic.

Maria Caulfield: No, absolutely. We had an urgent question on a tragic case a few weeks ago of three young women who died in an in-patient facility. I and the Secretary of State are currently looking at a national review of all in-patient mental health facilities, but specifically having in mind the high-risk population who find it difficult in an in-patient facility, who are more at risk and are not necessarily able to raise concerns, or for whom being out of area makes it riskier to be an in-patient. We are taking this very seriously. There are some provisions in the Bill that will reduce that risk, but, outside of the Bill, it is an absolute priority.

Sir Charles Walker: I do not want to be presumptuous, but that national review sounds really interesting. Would it be possible for one of your officials to put it in a letter, for you to sign, to the chair of our committee, so that it could be contained as part of our report?

Maria Caulfield: We are looking at the options at the moment. We committed to the House of Commons during the urgent question that we would update parliamentarians as soon as we have made that decision. We should be in a place to announce that within the coming days and weeks, so we can update the committee on that.

The Chair: That is incredibly encouraging. Thank you, Minister.

Q201 **Baroness Berridge:** I have a question in relation to capital and resources. As the Bill is in force, it has to go alongside the upscaling of resource. I was at the Department for Education and, from the moment the spending review gives you the capital money, if you are building a new primary or secondary school, you can give an average time and an average cost. From you getting your money in capital from the spending review, what is the average time to build new in-patient facilities? What are we talking about here in terms of implementation?

Maria Caulfield: Some of the in-patient mental health facilities are part of the work being done around the new hospitals programme. The Secretary of State has been really clear that, if we are talking about parity of esteem, some of the funding has to be going to mental health provision. The timescale for that is around 2030, which is when we expect all those projects to be completed. I do know that some of the mental health bids for new facilities are, if not signed off, almost ready to be signed off. A number of new builds will be announced fairly soon.

Baroness Berridge: So you are talking eight years.

Maria Caulfield: That is the maximum. Some are being developed already. We are looking at modern methods of construction, which is a new way of fast tracking, so that, when a build starts, it is as short a lead-in time as possible. We are also very conscious at the moment of inflation and construction costs. The longer we leave it, the higher the costs are. Our priority is investing in the facilities, but we are absolutely mindful of the timescale.

Baroness Berridge: So it is all done by 2030. What is the earliest that is going to come on stream in terms of building from your capital pot of money?

Maria Caulfield: I would have to look at the specific projects.

Baroness Berridge: If you could, that would be good.

Maria Caulfield: We can update the committee on the timescales for those. Some projects have submitted business cases already. We can definitely give that information to the committee.

The Chair: That would be very helpful. Thank you very much.

Q202 **Baroness Hollins:** Going back to the use of inappropriate settings for children and young people, one of the issues we hear about is that not only are they admitted perhaps to an inappropriate setting, such as an adult ward or an out-of-area ward, but they keep being moved. Of course, this also applies to young people with learning disability and autism. Some of the stories that I have heard relate particularly to children or young people with autism. It is that moving as well, which is partly the capacity issue and partly the lack of skill in particular settings. It just needs to be taken into account when you are thinking about this. Again, is there anything that can be done in legislation?

Maria Caulfield: I am not sure about the legislation aspect, but we are looking with local commissioners—because, as Mr Hinds said, it is not always large numbers—at identifying those high-risk young people who are likely to need multiple admissions throughout a number of years and what their likely needs are, to make sure that, if they do reach a crisis point, the provision is available to them.

We are also doing some work around trying to prevent admissions in the first place and getting an intervention in at an earlier stage. For example, for eating disorders, if we can get an intervention in at an earlier stage, we may be able to avoid admissions in the first place. It is about changing that whole culture around mental health, so that the in-patient stays important.

The reason why we did the Wessely review in the first place was that we were worried that admissions are often higher than they need to be. What can we do in legislation, but also outside it, to reduce those numbers to the absolute minimum of people who need to be admitted in the first place? That is particularly important for children and young people.

Baroness Hollins: When those admissions do happen, not only must they be in the right place, but there must be the possibility of therapeutic benefit, based on the skills provided in that setting. It comes back to a capacity and workforce issue. There has to be consistency of staffing, so that the relationships that the young people need in order to get better will be available to them. It is quite a big job, is it not?

Maria Caulfield: It absolutely is. That is why we want to look at the system as a whole at the moment, because we know from some tragic experiences that it is not where we want it to be. The CQC, for example, is revising how it does its inspections of in-patient mental health facilities, because it had a concern that it was missing some of the elements that would flag concerns to commissioners and to Ministers. There is an acknowledgement that change needs

to happen, and we are not afraid to say where it is not working and to shine a light on that, so that we can improve the experience.

Ultimately, it is about therapeutic benefit. Where young people are in for months, if not longer, it has an effect on their education and on their life opportunities. We need to make sure that we are not admitting people unless it is absolutely necessary, and that, when they are admitted, it is the safest possible place for them. We all acknowledge that there are currently examples of where that is not happening.

The Chair: It is all about the quality of care. Thank you, Ministers, so much, and to all of you who have come and answered our questions today. This has been an invaluable session, our last one prior to drafting a report to respond to the draft Bill. Thank you all very much indeed.