



# Joint Committee on Human Rights

## Uncorrected oral evidence: Mental Health Bill (HC 601)

Wednesday 29 January 2025

2.15 pm

Watch the meeting

Members present: Lord Alton of Liverpool (Chair); Lord Dholakia; Baroness Kennedy of The Shaws; Afzal Khan; Lord Murray of Blidworth; Baroness Lawrence of Clarendon; Alex Sobel; Sir Desmond Swayne.

Questions 1 - 16

### Witnesses

**I:** Ulele Burnham, Barrister at Doughty Street Chambers; Dr Lucy Series, Associate Professor in Social Care Law and Policy at Bristol University; Andy Bell, CEO, Centre for Mental Health; Alice Livermore, Senior Lawyer, Mind.

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## Examination of witnesses

Ulele Burnham, Dr Lucy Series, Andy Bell, and Alice Livermore.

**Q1 Chair:** Welcome to the seventh meeting of the Joint Committee on Human Rights. This committee was established by Parliament. It consists of six Members of the House of Commons and a commensurate number from the House of Lords. Its duty is to look at the compatibility of legislation running through Parliament with our human rights obligations and to hold thematic inquiries. Last week, we held part of our thematic inquiry into supply-chain transparency and modern-day slavery. We will be initiating a new inquiry into transnational repression.

Today, we are looking at the Mental Health Bill. We have four outstanding witnesses who will help us to understand the legislation better. Plainly, any deprivation of liberty and any imposition of medical treatment without consent raises serious human rights concerns.

We have looked at the Bill and think that it is wide-ranging. It is complex. It has just been in Committee in the House of Lords, where it received a great deal of scrutiny. Many of its provisions seem to improve the current law, enhancing human rights, so we take note of that. They are provisions that we welcome, but we still would like clarity on some areas.

We have four witnesses today. Ulele Burnham is a barrister at Doughty Street Chambers. Dr Lucy Series is the associate professor in social care law and policy at the University of Bristol. Mr Andy Bell is the CEO of the Centre for Mental Health. Alice Livermore is head of legal at the well-known and wonderful charity Mind. We welcome them to our proceedings today, some online and some here physically.

Can you talk us through the legislation that we already have on the statute book and the legislation that is now laid before us, in how it seeks to amend the current law—the Mental Health Act and particularly the Mental Capacity Act.

**Ulele Burnham:** We agreed between ourselves that Dr Series would give a general overview on this question, and I would come in with practical and practitioner-based experience of the two regimes that we are looking at. Would it be possible for us to do it that way?

**Chair:** Yes, it would. We are always glad when witnesses decide among themselves how to share out the questions and the issues; it means that we are not otiose or have irrelevance or repetition. By all means suggest if you would rather have a colleague answer the question.

**Dr Lucy Series:** Thank you, and thank you very much for holding this session on this really important topic. I am honoured to be asked to contribute.

My research expertise is mental capacity law and human rights, but I have a strong interest in its interface with the Mental Health Act, so I would like to give an overview of how they relate. I think of them as being like siblings with a difficult relationship. The Mental Health Act is

older. It is often described as a compulsory power because it authorises compulsory hospital admission, detention and involuntary treatment. It also increasingly extends into the community, once patients are discharged. Mental health law is quite tightly focused on issues around assessment, treatment and management of mental disorder—when a person is assessed to present a risk to themselves or to others and they are not consenting or are considered unable to consent.

The Mental Capacity Act is younger. It is often described as empowering, and it is much broader than mental health law. It allows people to make decisions in the best interests of someone who is assessed as lacking the mental capacity to make decisions for themselves. It covers a huge range of matters. On the one hand, it is about managing someone's property and affairs on their behalf, but it extends into care and treatment issues.

One of the points that I would like to convey to this committee is that although the Mental Capacity Act is often viewed as empowering—and indeed it really can be in some situations—it really depends on what it is being used for and the situation. The Mental Capacity Act can also be used to authorise very coercive interventions. It has a framework for detention: the deprivation of liberty safeguards. These safeguards apply in hospitals and care homes and can be used to deliver treatment without consent and to detain people, including potentially against their wishes.

We talk about the two statutes as having an interface. These are situations which could arise in hospitals or in the community, where professionals have to choose which statute to use to authorise involuntary admission to hospital, regimes of deprivation of liberty or other kinds of involuntary care or treatment. There are rules governing which law the professionals should use in these situations. Incredibly, in some situations, people can end up being subject to both at the same time.

It is not a leap to say that this interface is an absolute muddle. There is lots of empirical research to show that professionals are often quite confused about which law they should be using. They disagree and fall out about it, and they not infrequently interpret the law wrongly. That is not surprising, as the rules are really complicated. I took a quick look before this session at the schedule that says when you should use the Mental Capacity Act's deprivation of liberty safeguards and when you should use the Mental Health Act. It is five pages long. There is additional guidance, different codes of practice and streams of case law on this. Senior judges who have had to make decisions in these types of cases have described this interface as like sticking your head inside a washing machine and spin dryer.

There are three parts of the interface that I would like to explain to the committee, because this has important implications for the Mental Health Bill. What I am about to say is just for situations concerning the person being admitted to hospital for treatment for mental disorder.

The first rule is that if you could potentially use the Mental Health Act to authorise their detention, and the patient is objecting, then you should use the Mental Health Act, not the Mental Capacity Act. That is because the Mental Health Act is seen as having more rigorous safeguards than the Mental Capacity Act. It is seen as more important to have rigorous safeguards if someone is objecting than if they are compliant. However, if the patient is not objecting, clinicians have a choice. They could use the Mental Health Act or the Mental Capacity Act. There is all kinds of debate between professionals, judges and lawyers about which they should use.

The third part of the rule is important to understand. If you cannot use the Mental Health Act to authorise detention, then the Mental Capacity Act becomes potentially available even if someone is objecting. If that all sounds really confusing, that is because it is. This is a vast oversimplification. This interface is so complicated that it does not satisfy the basic requirements of the rule of law in the sense meant in the *Sunday Times v UK* case. The interface is not formulated with sufficient precision for professionals to know what they should do and for patients to understand what their rights are.

**Chair:** Dr Series, thank you.

**Dr Lucy Series:** Another reason why this interface is bad for patients and policymakers is that it can end up subverting mental health law policy. The Mental Capacity Act effectively acts as an overflow container. If you take somebody out of scope of the Mental Health Act, they become more eligible for detention under the Mental Capacity Act, even if they are objecting.

If we think about all the changes in this Mental Health Bill to make it harder to detain people under the Mental Health Act, that could be raising thresholds or removing some groups, such as learning disabled or autistic people, from parts of the Mental Health Act altogether. However, you are not making it impossible to detain them. You are making them more detainable under mental capacity law. You would end up with the same patients potentially being detained in the same places, subject to the same restrictive regimes, the same treatments, but under mental capacity law their rights would be weaker. They would lose valuable safeguards such as easy access to tribunals. They would lose the new measures around reviews of treatment and care, and they would lose free aftercare under Section 117.

One of the main points to convey to the committee is that unless we address the interface between the two statutes, mental capacity law will become progressively more distorted and coercive and mental health law policy will end up being subverted.

I will pass over to Ulele now, to explain some of the challenges in practice.

**Ulele Burnham:** I thank Lucy very much for that and I thank the committee for inviting me to give evidence.

I will deal very briefly with one of the issues that Lucy raised, which is the difficult problem that occurs when, for example, under Schedule A1 of the Mental Capacity Act, a person is objecting to treatment or detention for mental disorder and is accommodated within a hospital. I want to talk about what happens in practice in that situation and how the present law creates difficulties, some of the kind that Lucy described and some even more complex and nuanced problems.

As Lucy says, what we describe in legal circles as the interface between the Mental Health Act and the Mental Capacity Act stems from the provisions specific to two important schedules to the Mental Capacity Act, Schedule A1 and Schedule 1A. When one tries to read those labyrinthine provisions and make sense of them, they prescribe or proscribe the circumstances in which treatment interventions, whether detention or other forms of care or treatment, can or should take place under the aegis of one or other of the statutory frameworks. That is the interface. As Lucy says, where a person is objecting to treatment in hospital for mental disorder, a principle runs through these schedules, if you can get through their complicatedness, suggesting that this sort of situation requires the deployment of the Mental Health Act because it has safeguards, and the consent to treatment provisions apply. As Lucy said, there has been lots of case law about that.

Even in the discrete area that I am going to talk about, which is “case E” cases, a person could still be detained, according to the schedule to the Mental Health Act, although none of the mental health regimes under the Act applies to them.

I assume that the committee is aware that the grounds for civil detention under the Mental Health Act include three criteria: the diagnostic criteria, the risk criteria, and the availability of appropriate medical treatment criteria. Schedule A1 of the Mental Capacity Act indicates that a person—we call them P in the context of the Mental Capacity Act—could be detained under that section of the Mental Health Act if those grounds are made out.

Schedule 1A of the Mental Capacity Act provides that in general circumstances, that person is not eligible to be detained under the Act. When you are in hospital for treatment for a mental disorder and you object to that treatment, you are entitled to the safeguards that arise under the Mental Health Act.

The difficulties that are presented in practice by this are as follows. This particularly affects those persons with behavioural disorders such as autism and ADHD. I start with one bit of information about the present state of the law. The Mental Health Act code of practice suggests at paragraph 20.20 that: “Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism”. In this kind of case, a person with autism accommodated in hospital is objecting to the treatment for mental disorder and is not yet subject to detention under the Mental Health Act. However, they are accommodated in conditions which amount to detention or a deprivation of liberty. The steer of the

Mental Health Act code of practice is that compulsory treatment in hospital is rarely likely to be helpful for such a person.

The first problem that emerges regards clinicians, who are responsible for making medical recommendations for detention based on satisfying the diagnostic criteria and the risk criteria for mental health detention. Those clinicians are, anecdotally and in cases that I have been involved in, reluctant to detain under the Mental Health Act persons with autism and such behavioural disorders. Therefore, you immediately get into a situation in which the Mental Capacity Act and the interpretation of those provisions by the courts suggest that detention under the Mental Health Act is appropriate in those circumstances, unlike some of the codes of practice and the approach of the professionals. As Lucy says, different professionals apply different rules. Clinicians can determine in those circumstances, but it is not going to be helpful for a person with autism to be subject to compulsory admission.

Where there is a strain on resources, as there is now and as the courts have said on several occasions, and there are not sufficient places in the community to support people with autistic spectrum conditions and behavioural disorders and to give them the amount of care and support that they need in community settings, you often find that such persons end up in hospital. It could be an acute hospital, a paediatric hospital, where their risk behaviours are such that they are kept in hospital to preserve their physical and relational safety. Yet the mental health clinicians do not regard them as properly detainable under the Mental Health Act.

Therefore, there is a situation where that person is in objective conditions of detention in a hospital, but the law suggests that they cannot be deprived of their liberty under the Mental Capacity Act. What is happening to them cannot be rendered lawful by the Mental Capacity Act and those who are responsible for securing lawful detention under the Mental Health Act are reluctant to do so. There ends up being no proper authorisation for the detention and treatment in hospital of such persons and there is nowhere else for them to go. In such circumstances, the Court of Protection can find itself in a situation where it does not wish to be. It is bound not to authorise the deprivation of liberty because the case law suggests that in such circumstances those persons are ineligible for detention. That is a practical problem on the ground.

The other problem that is associated with this is an increasing indication from Strasbourg and the case law under Article 5, specifically relevant to the deprivation of liberty of movement—

**Q2 Chair:** Sorry, Ms Burnham, I do not want you to pre-empt some of my colleagues' questions as we delve deeper into the contradictions and the requirements, especially under the ECHR and so on. The clock is ticking away and I want to get everybody in. Mr Bell, do you want to add anything on this point? The interface is a muddle. We heard from Dr Series that it is so complicated that it does not satisfy the demands of the law. We will all take away her illustration of sticking your head inside a

washing machine in trying to understand it. If you could be brief, then we will go to Ms Livermore, then to my colleague, Sir Desmond Swayne, then to Mr Khan.

**Andy Bell:** Thank you. I work at the Centre for Mental Health, an independent charity with a focus on reducing inequalities in mental health, predominantly through research. Our work has not looked specifically at the interface with the Mental Capacity Act, but we did support the independent review of the Mental Health Act in 2018. Our perspective comes from looking at the Mental Health Act as a piece of mental health legislation affecting people with mental illness. Our concern is that the current Act is outdated. It has a legislative framework that does not reflect how we want mental health services to be functioning in the 21st century. We broadly see the Bill as being a way of bringing it up to date, at least in some ways.

The use of the Mental Health Act since 2007, which was the last time that there were significant changes made to it, has increased very considerably. I am sure that the committee will want to come to the huge disparities in the use of it. As well as the very significant concerns that fellow panellists have shared around the interface with the Mental Capacity Act, it is important to say that we really do need Mental Health Act reform as well.

**Chair:** Thank you very much indeed. I turn to Ms Livermore, then we will go to Sir Desmond Swayne.

**Alice Livermore:** Thank you for inviting me and for holding this evidence session. I have a very brief point to make.

Mind thinks that people in similar circumstances—in this case, detention, deprivation of liberty in mental health hospitals—should have equivalent safeguards. As Andy said, we are moving towards this process of reform of the Mental Health Act. It is far from perfect, but the direction of travel is to greater rights and greater safeguards. On the other side, with the deprivation of liberty safeguards and whether the liberty protection safeguards should ever come into force, you are moving towards far lesser safeguards. You have the same people having the same experiences next to one another in rooms but who could have completely different safeguards in mind. On a very fundamental level, Mind thinks that is wrong. That is all I have to say.

**Chair:** Thank you very much indeed. That is extremely helpful. Sir Desmond, the floor is yours, and then we will hear from Mr Khan.

Q3 **Sir Desmond Swayne:** Let us come to Article 5. What is the problem with the existing Mental Health Act? Do we have any handle on how many people have been deprived of their liberty in defiance of the demands of the article? How egregious are those examples? Do not all speak at once. Shall we do it in reverse order?

**Alice Livermore:** Absolutely. On your first point, around data on the number of people who are detained, we can write to the committee with that.

**Sir Desmond Swayne:** I am after the number of people who are detained in defiance of the demands of Article 5. How big a problem is this?

**Alice Livermore:** If possible, I would be grateful if I could write to the committee about this.

**Chair:** That is perfectly fine. It would help us. I think Ms Burnham was going to come to this point. Would you like to have a crack at answering Sir Desmond's question?

**Ulele Burnham:** I am not across the numbers of those detained in defiance of the provisions of Article 5. However, there have been a number of cases of the deprivation of liberty for children, within the Family Division of the High Court. In these cases, the courts have been unable to authorise deprivations of liberty for children in inappropriate settings—for example, paediatric hospitals and acute hospitals, where no other placements exist for them. Everybody knows that it is not necessarily in their best interests to be in a paediatric hospital. There they would not receive treatment that meets the definition of therapeutic benefit under the Mental Health Act. Instead, they would just be contained there.

Three or four times in the Family Division of the High Court judges have refused to authorise a deprivation of liberty in hospital, even when there was nowhere else for the child to go. That is because, in those circumstances, the court found that the child's presence in that hospital was inimical to its best interests. There is case-law evidence of the circumstances in which the court has refused to authorise a deprivation of liberty, and for a court to refuse it says something about what the court thinks of the circumstances in which the person, or in this case the child—

**Sir Desmond Swayne:** It is telling us that there are not enough resources. The problem is hospitals and places, not the law, surely.

**Ulele Burnham:** That is true, but I was trying to address the question that you asked: what evidence is there of people being deprived of their liberty in defiance of Article 5?

**Sir Desmond Swayne:** Yes, but your answer is about those who are not being deprived of their liberty.

**Ulele Burnham:** No. They are being deprived of their liberty. Their circumstances amount to a deprivation of liberty within the conventional meaning of that term. It amounts to detention, but it is not authorised by a court or any other relevant body, which is even worse, if you like.



**Chair:** I see—no court has been involved. Mr Bell, I know you wanted to come in, and then we will go straight to Mr Khan.

**Andy Bell:** Thank you. Again, on the overall use of the Mental Health Act, we have seen rates rise. The uses of the Act have pretty much doubled since the 2007 Act was passed. It is very important that we are clear on what we mean by the numbers. There are around 50,000 uses of the Act per year now. That is considerably more than it was when the last piece of legislation was completed. Those uses of the Act include detentions in hospital and the use of community treatment orders subsequently.

There is no evidence that mental illness or severity of mental illness has increased at that rate during that period. It has stabilised in the last few years, which is very welcome.

However, we also see—and this is incredibly important—that people from black and minoritised communities have very much higher rates of detention, far in excess of what you would expect in the population as a whole. This is particularly the case in the use of community treatment orders. People from black and black-British communities in England face a seven times greater risk of being placed on a community treatment order than a white person. We see inflated rates among some other minoritised communities as well. There is no good reason for that. There is no acceptable reason apart from racism. I do not necessarily mean that it is a direct form of racism, but none the less it is a form of racial injustice that we see those higher rates because they cannot be explained with any objective reasons.

**Chair:** Thank you, Mr Bell. That is very helpful. We will come back to that later on. Mr Khan will come in now, and then can Ms Livermore reply in the first instance to him? After that, we will go to Mr Sobel.

Q4 **Afzal Khan:** Thank you. The Mental Health Bill raises the threshold for detention. Will the change proposed reduce unjustified detention and improve compliance with Article 5 of the European Convention on Human Rights? Would a reduction in the number of people detained under the Mental Health Act result in any risk to the public, whose protection from harm also raises a human rights issue?

**Alice Livermore:** In answering this question, I want to talk about a group of people who will not be affected by this change because they are already outside the ambit of Article 5 protections: children and young people who are admitted informally.

NHS England does not publish data on them, so it is quite hard to track how many there are. However, a few years ago, the Children's Commissioner found that about a third of children and young people who are admitted to in-patient wards are there informally. They have told Mind that although they are admitted informally, they often report feeling coerced into complying with treatment and confinement because they are worried that if they do not they will be sectioned.

Within this category of young people, there is a subcategory: children under 16 who are admitted informally on the basis of parental consent. They have not consented to the admission. Their parent has consented on their behalf. Yet despite not being there on the basis of consent, they will have access to none of the safeguards that a detained young person would have. As the Act currently stands, they will not have access to independent mental health advocates, nearest relatives or tribunals. They will also miss out on elements of the reform, including statutory care and treatment plans and opt-out advocacy.

Children who have experienced admission on the basis of parental consent have told Mind that they feel completely disempowered and bypassed in their own care and treatment. We know that in some cases parental consent is being relied on for confinement but also for very significant invasive treatment. Last year, there was a case in which a 12 year-old was confined in hospital for treatment for anorexia, subject to nasogastric feeding—an incredibly invasive process—and was subject to very high levels of restraint, with sometimes four or five adults for one 12 year-old.

Confusingly, she was confined in a mental health ward that was not registered to use the Mental Health Act. However, the court found that where a child lacked Gillick competence and their parents and their clinical team were in agreement about their best interests, they could be confined and treated based on parental consent. There are significant human rights issues there. I wanted to bring that to the attention of the committee.

To answer your question more directly, there is an issue with how you operationalise the changes that are being proposed in raising the threshold. The independent review recommended that, when the approved mental health professional is preparing the paperwork using these new criteria, they must clearly state on the application form the specific harm that they have identified and how detention will reduce it, including what alternatives are not available or suitable. That has not made its way into the Bill. I have concerns. While the criteria may change on the statute book, how will that end up working in practice? How will it drive down detention? How will it ensure greater compliance with Article 5.1(e)? Mind thinks that these recommendations of the independent review should be in the Bill.

On your point about public protection and human rights aspects, we cannot have this conversation without talking about whether there are services in the community for the people that are no longer meeting the threshold for detention under the Mental Health Act. We heard throughout our engagement with the Mental Health Act review that people struggle to get help. They cannot get the help that they need. They cannot get it when they are crying out for it. They are not taken seriously. The options are not there. We have heard from people who are clearly suicidal and engaged in serious self-harm but only receive treatment for physical injuries. We know that people from racialised

communities are particularly affected. We can go into that in more detail in the forthcoming questions.

We also know that for people who are denied help, their mental health deteriorates, and they end up being detained. Even if the thresholds are raised, if the support is not there in the community and people get more and more ill, they will eventually meet those thresholds, even if they are increased.

It is also important to think about a person's journey through the system. They get more and more unwell in the community, reach the new threshold and then are discharged. We have also heard that people are discharged and then left to struggle. When we asked young people about this specifically, they described going from this incredibly intense environment in hospital, where they were receiving constant support, to being discharged virtually to nothing in the community, going back to their families and their families having to pick it up. Some were promised community support that never happened. Some told us that they left hospital with no plan at all.

That conversation about public protection is simply one side of it. We need a conversation about the resourcing, the extent to which the Bill looks at one part of the system.

**Chair:** Thank you. That also helps to answer the point that Sir Desmond was making earlier in his question about resourcing. You will be glad to know that some of the committee tomorrow will be meeting the Children's Commissioner, Dame Rachel de Souza, and I give an undertaking now that we will put your point about the protection of children on the agenda for that discussion.

I turn now to my colleague Mr Sobel, and after that we will be hearing from Lord Murray.

Q5 **Alex Sobel:** Over the last 30 years, I have known a range of people who have been sectioned under this Act personally, as an employer and now where they are constituents. I understand the complexities, the multitude of reasons why this happens and the difficulties around individuals' human rights. One area that concerns me is people with neurodiversity, particularly autistic people. The Bill will largely remove the power for autistic people and others with neurodiverse conditions and learning disabilities to be detained as civil patients under Section 3 of the Act, but not if they are involved in criminal proceedings under, slightly confusingly, Part 3 of the Act. Does this difference in treatment raise any human rights concerns for you? Maybe, Ms Burnham, we can start with you.

**Chair:** Indeed, you did touch on autism earlier, so it would be good to hear what you have to say.

**Ulele Burnham:** I did. This is also an area that Dr Series was going to cover, but I will say two things swiftly. I welcome that people with learning disabilities and autism will now not be detained under civil

sections, except in very specific circumstances. They can be detained under an admission for assessment under Section 2 once the revised statutory criteria are met. Everyone knows that there is a higher threshold for the risk of harm that has to be satisfied now. That is in one sense a good thing.

However, the fact that Part 3 of the Bill continues to permit that demographic of persons to be detained under what we know as forensic sections, by virtue of their subjection to the criminal justice process, may mean that they are more likely to be shunted into the criminal justice system in this way. That is certainly a risk. There is a real problem there regarding what happens to those persons or the unintended consequences of this change.

Is it better for learning disabled persons and persons with autism to be dealt with under the criminal justice system rather than the mental health system, however inadequate that mental health system might be? There is a real issue there.

**Chair:** Through the law of unintended consequences, people may be shunted into the criminal justice system unintentionally. Dr Series, can you add to the reply to Mr Sobel?

**Dr Lucy Series:** When this was discussed in previous hearings by this committee and the Joint Committee on the Draft Mental Health Bill, lots of experts raised concerns that this could happen, including psychiatrists and autistic self-advocates, some of whom felt that this would be worse. In discussing this, lots of people have pointed to findings in New Zealand that when you took people with intellectual disabilities out of mental health law, some of them did end up in the forensic system as well. This has also happened in Australia. I can share some written sources on that.

**Chair:** Would you? That would be very helpful.

**Dr Lucy Series:** Of course.

Obviously, this would be terrible. There are other ways in which neurodiverse people might still end up in hospital. The other route is the Mental Capacity Act, for the reasons that I explained earlier.

Another concern that has been raised is that people would end up being detained on the basis of a different diagnosis, a depressive disorder or some other condition that is running in parallel to their autism. That does not mean that being in a mental health environment is any better for them. It still might be incredibly harmful to them.

Underlying all this is the issue that Andy and Alice have raised, that people do not end up at this point when services in the community are serving them. They end up at this point because either their social care is non-existent or has broken down, or because they are not able to access appropriate mental health or autism services at the point of need. It is regrettable that this Bill does not address that. It does not create strong

rights to access services at the point where people need them to prevent people escalating to the point that they end—

**Chair:** We will have a supplementary on that.

**Alex Sobel:** I think you are coming to the point so I will try to get you to be a little more pointed. At the moment this seems to be a slightly Kafkaesque, Catch-22 situation for people in the system, caught between either a mental health unit or the criminal justice system. We will have to try to make a recommendation in relation to the Bill here. What recommendation would you make? You indicate that there should be a right to community services. Do you want to expand on that? It would help us in writing the recommendation.

**Dr Lucy Series:** Andy had some thoughts on that which he might be willing to share. Certainly, I would like to see stronger rights for social care services. Also, paper-based rights, as we have seen with the Care Act, only get you so far. You need the money to make it possible for authorities to provide them.

**Chair:** Thank you. Mr Bell, do you want to come in? Then we must go to Lord Murray.

**Andy Bell:** There is a provision currently in Wales, the Mental Health (Wales) Measure, which was introduced after the 2007 Act. It gave citizens in Wales the right to seek a mental health assessment. It came alongside the changes. There is good evidence that a very high proportion of people who seek an assessment for that are accepted as needing some kind of support, so it is used wisely.

There is a really strong case for having an equivalent here in England. It would not deal with all the discrepancies that we talked about. There is not a single easy, ready solution here, but there is a strong case for a right to assessment provision in this Bill.

**Chair:** Thank you. On the Welsh evidence that you just referred to, we would be very grateful if you could share that with us so that we can include that in the report. Thank you. Lord Murray?

Q6 **Lord Murray of Blidworth:** My question relates to Clause 33 of the Bill and related clauses. This is the conditional discharge subject to deprivation of liberty conditions. Obviously, the Bill permits conditions amounting to a deprivation of liberty to be applied as part of a conditional discharge from detention or from being placed under a restriction order. The provisions in Clause 33 refer to conditions amounting to a deprivation of a patient's liberty, and therefore appear to accept that the Article 5 tests would apply to them. Are the panellists satisfied that they are compatible with Article 5? Perhaps Dr Series could answer first.

**Dr Lucy Series:** Thank you for asking me, but I was very much hoping that I would not be picked. I am afraid I am not an expert on—

**Chair:** Who of your colleagues would you like to come in on this?

**Dr Lucy Series:** I nominate Ulele or Alice.

**Ulele Burnham:** I will say something about this briefly, but this was something that Ms Livermore was intending to address when we agreed on the split. Perhaps Alice can answer, and I will respond very briefly on it afterwards.

**Alice Livermore:** Mind would say that this new power would allow people who are currently detained in hospital to be discharged into less restrictive community placements, subject to conditions which amount to a deprivation of liberty. We think in theory that it could also help to address a situation where a person might currently be subject to the Mental Health Act's current conditional discharge regime, but DoLS—deprivation of liberty safeguards—at the same time. That can become extremely complicated when an individual wants to challenge anything about it, because there are effectively two regimes running slightly independently.

However, Mind is very concerned about this new power and the implications of it. Those concerns are largely informed by what happened after the introduction of community treatment orders, although obviously the powers in the clause that you mentioned would apply to a much smaller group of people.

Andy has talked about the last time that the Mental Health Act was updated. The idea was that there would be perhaps 500 people on CTOs. That figure now stands at around 5,000 and there is huge racial disproportionality, which Andy has already referred to, in the use of CTOs. People have told us that CTOs are better than being in hospital, but only a little better, because it is still based on threat and coercion in the community. The CQC has highlighted, in respect of CTOs, that it is very unclear to people what they have to do to progress towards discharge. That is very likely to apply to conditionally discharged patients who are subject to deprivation of liberty conditions.

Regarding the current safeguards, the current arrangements for tribunals would allow someone with capacity to apply within the first six months, then every two years after that. That is far too long. It probably should be annual instead. There needs to be associated guidance but also duties regarding the use of this power and the ways in which it may or may not be legitimate to deprive a person of their liberty.

Information given to the person subject to these new powers is key. They need to be given information on why the deprivation of liberty conditions are considered necessary. The new care and treatment planning provisions need to be updated when someone is conditionally discharged subject to these conditions. That should also include the steps that someone needs to take to progress towards discharge from those conditions.

Because of our extreme concern that there will be racial disproportionality in the use of these orders, we would suggest a number of amendments to the Bill addressing that, but that would be more appropriate—

**Chair:** A little later on, we have a question on that.

**Lord Murray of Blidworth:** Also, in the provisions to Clause 33 and related provisions, there is a power to exercise the imposition of deprivation of liberty conditions retrospectively. Theoretically, someone who has been discharged on the basis that depriving them of their liberty was not necessary might now have their liberty at least fractionally taken away. Does that raise any additional Article 5 concerns for you, Ms Livermore, or for any of the other panellists?

**Alice Livermore:** Yes, absolutely it does. It raises significant concerns about someone being taken backwards. Also, in the Bill as drafted, it is very unclear when a retrospective power would be applied. You are leaving a cohort of people in extreme uncertainty with no idea of when these conditions of deprivation of liberty could be applied and, if they will be applied, at what point they might be applied. So yes, it does raise huge concerns for Mind if the power is applied retrospectively.

**Chair:** Thank you. Do any of your colleagues on the panel want to add to that? If not, I would like to move on because Lord Dholakia wants to take us back to the apparent incompatibilities in the legislation.

**Ulele Burnham:** I want to say something very briefly that might be positive about this. The current case law means that persons who lack capacity in relation to treatment provisions in the community which would amount to deprivation of liberty can move out of hospitals and into the community, subject to those conditions. They can be deprived of their liberty in the community, which may be a less restrictive regime than if they were in hospital. On the other hand, persons who have capacity and are discharged from mental health treatment cannot be subject to conditions which amount to a deprivation of liberty in the community. Therefore, there is a difference in treatment between those two groups.

This provision makes it possible for persons who have capacity to live in the community, albeit in circumstances where, possibly because of the risks that they present, the conditions to which they are subject in the community would be a deprivation of liberty. This is how it would be articulated. This might be seen to be less restrictive than keeping such persons in hospital, because they cannot be discharged into conditions which amount to a deprivation of liberty.

**Chair:** Thank you very much indeed. I now turn to Lord Dholakia, and after that we will be hearing from Baroness Lawrence.

Q7 **Lord Dholakia:** My question relates to the interaction between the Mental Health Act 1983 and the Mental Capacity Act 2005. To what extent does this address existing concern? Could it do more?

***Dr Lucy Series:*** The Bill essentially replicates the existing and quite complicated interface with the Mental Capacity Act. There is a history to that. There has been a lot of debate about this interface, but there has not been a consensus. The Law Commission did a big piece of work a few years ago about reform of the deprivation of liberty safeguards. It proposed a new framework, the liberty protection safeguards, which would be more light touch in protecting human rights.

As a result of that, the Law Commission recommended that only the Mental Health Act should be used for detention in hospital for treatment for mental disorder, because it had stronger safeguards. This would leave quite a simple interface—is the person being detained in hospital for treatment of mental health problems? If so, only the Mental Health Act can be used. However, the following year, the independent review of the Mental Health Act came to the opposite conclusion, partly because its focus was on bringing down detention rates under the Mental Health Act. Also, some of the chairs believed that the Mental Capacity Act was somehow less coercive, even if it was doing fundamentally the same thing.

The review recommended instead that we should tighten up this discretion for professionals regarding which Act they use. The dividing line would essentially be that if the person is objecting, you would have to use the Mental Health Act, and if the person was not objecting you would have to use the Mental Capacity Act. The problem is that what counts as an objection in these situations is not always straightforward. People's views fluctuate. They can be quite unclear. Some neurodiverse patients and patients with cognitive impairments such as dementia may not communicate verbally, or it may be difficult to understand their meaning at times.

Another thing from the empirical research is that behaviours that look like an objection and which could even be someone saying, "I want to go home" are sometimes dismissed by clinicians who conclude that the person lacks the capacity to object. Therefore, there is a real danger with objections being the dividing line, as it is very subjective and might leave people without protection.

When the Government consulted on this proposal it was not well supported. Nor was there a clear consensus on what should be done. Therefore, the Bill does not really change the situation. The current Government has not said yet whether this will happen or when, but the DoLS might be replaced by the liberty protection safeguards, which would offer potentially even weaker protections in certain situations. The questions about this interface will become even more pressing and concerning.

However, although the interface rules remain the same, the changes in the Bill will impact on the interface. As I was explaining earlier, if you take groups out of scope of the Mental Health Act—an obvious example is removing the Section 3 power to detain people with learning disabilities or autism—they become more eligible for detention under the Mental



Capacity Act. They could then end up under the DoLS or these liberty protection safeguards. The tighter that you draw the boundaries of mental health law, the more people you potentially divert into mental capacity law, and their rights are then weaker. They would lose easy access to tribunals, statutory care, treatment reviews and aftercare, which could be very important for getting people out. The issue is well understood. The solution is a real point of controversy.

**Chair:** If you think further on this and want to make written representations to us, feel free. You have raised some very serious questions and we are grateful for that.

Let me turn now to Baroness Lawrence. As we proceed, if others want to pick up on points, feel free to add to your remarks.

**Q8 Baroness Lawrence of Clarendon:** Mr Bell, you talked about the disproportionate number of people from the black community who are detained under the Act and placed in a community treatment order. What is the extent of that order? What does it mean?

**Andy Bell:** Community treatment orders were introduced in the 2007 Act. The euphemism that was used at the time was “supervised community treatment”. On discharge from hospital under section, rather than simply being discharged from the Mental Health Act, someone would continue to be subject to the Act. They would have to meet all the conditions of the Act, but rather than being in hospital they are at home. Effectively, it would be simpler for someone to be returned to hospital if, for example, they were not continuing to take treatment. There are powers within community treatment orders to make restrictions on, for example, where they live and aspects of what they do with their life, which again have some troubling aspects.

It is a coercive power. It allows someone to be at home and means that for some people, rather than being in hospital waiting to go home they can leave hospital knowing that they will have more structure and that there will be more support—or maybe, which is a very troubling thing. There are equivalents in other jurisdictions. They often look quite different in other parts of the world, but a lot of countries now have something like CTOs.

**Baroness Lawrence of Clarendon:** One thing that has not been discussed, the elephant in the room, is the drugs. If people move from hospital out into the community, are they on medication? Who supervises that? In all the discussions so far, nobody has mentioned the drugs that people leaving hospital may be under.

**Andy Bell:** Nobody can be forced to take medication when they are outside hospital. People are required to take medication in whatever form they receive it. Sometimes that can mean going back to hospital to receive a depot injection, for example. Although you cannot force the use of that, the circumstances may be that if someone did not receive their medication, they would be regarded as not complying with treatment.

That would be the signal for them to be returned to hospital under the Mental Health Act.

**Baroness Lawrence of Clarendon:** What is the depot injection?

**Andy Bell:** When you get your antipsychotic medication in a very large dose, you go back to hospital to receive it as an injection. There are different forms in which medication is delivered. That is not my area of expertise. A clinician would be better able to answer detailed questions on that. CTOs mostly are used to ensure that somebody who receives medication continues to receive it when they have left hospital.

**Baroness Lawrence of Clarendon:** Can Dr Lucy Series say a little more about that?

**Dr Lucy Series:** I am afraid not. My research specialism is more on the social care side of things than the medical treatments. Perhaps Alice or Ulele can.

**Chair:** If the panel can point the committee to someone who can answer this important question, I would be grateful.

**Baroness Lawrence of Clarendon:** Does Ms Livermore have anything to say?

**Alice Livermore:** I am afraid that I cannot speak to the point around medication, but I will discuss it with my colleagues and write to the committee if we can find someone who can provide the evidence.

I want to raise a point which is not given the weight that it should be given in this discussion. The same disproportionality that Andy has talked about is happening in in-patient settings to under-18s as well, but there is very poor data about what is happening. There is not a lot of published data, but a few years ago the Children's Commissioner published a report which found that black and mixed-race young people make up a third of in-patient admissions despite representing 11% of that population. They are much less likely to be admitted informally. I have already flagged my concerns about informal admission, but none the less, they are far less likely.

One in 10 black children is admitted informally, compared with one in three white children. However, because data on the number of informal admissions is not published by NHS England, it is exceptionally hard to track exactly what is happening to these children. That needs to have the lid lifted on it, to see what is happening to children and young people.

**Chair:** That is very helpful; the publication of more data would certainly help. While we are on this question of data and disproportionality in how it affects people from ethnic minorities, the independent review in 2017-18 found that black people were four times more likely to be detained under the Mental Health Act than white people and eight times more likely to be on a community order. The picture did not improve. In 2022, during the draft Mental Health Bill arrangements, they noted that in

2021-22, people from the black community were still four times more likely to be detained than white people and were now over 11 times more likely to be given a CTO. Does that data stand up? In addressing this, what should we be doing? After this, I will turn to Lady Kennedy.

**Alice Livermore:** There have been some minor changes. I am sure that Andy can correct me if I have not got this quite right but black people are three and a half times more likely to be detained under the Mental Health Act and over seven times more likely to be placed on a community treatment order. There has been a bit of variation. It also just worth noting that our experiences and outcomes are worse as well. Black or black British people are more likely to be detained for longer, to experience repeated admission, to be subject to police powers and to experience higher levels of restraint compared with white people.

**Chair:** Thank you very much indeed. We will turn to Baroness Kennedy, then hear again from Mr Khan.

Q9 **Baroness Kennedy of The Shaws:** I declare that Ms Ulele Burnham is a colleague of mine in chambers. We are very well acquainted.

A question arose from the debate on the Mental Health Bill in the House a couple of nights ago. I heard concern being expressed by a Peer and reinforced by Baroness Butler-Sloss, who was President of the Family Division and is very concerned about the welfare of children. It was about the circumstances in which, if you are having mental health issues, you can nominate someone to make decisions for you. Most often young people, even when they are 16 and 17 and approaching adulthood, choose their parents. The concern was about young people who are somewhat estranged from their parents or have complicated relationships with them nominating persons who exercise a certain amount of coercive control over them. Sometimes it is an emotional partner, sometimes it is a friend whom they are keeping company with. I wondered about the issue of nominating and how carefully it is scrutinised.

**Alice Livermore:** There are a few issues here. The nominated person replaces the nearest relative. It is a really important safeguard. Under the Bill, you can appoint someone if you have capacity or competence to do so. Despite the Bill referring to competence regarding under 16 year-olds, it does not define it. There is no statutory test for assessing competence. There is case law and Gillick competence. If you are Gillick competent and under 16, you can consent to an intervention, but the independent review identified that there was no clarity or consistency in how that assessment was done. The immediate point is that under-16s are at a disadvantage when appointing a nominated person because there is no test for determining whether they are competent.

Then there is the point around what happens if they lack competence or capacity. As the Bill is structured, an approved mental health professional has to appoint someone on their behalf. Currently, we have a statutory list for who is the nearest relative. If a child is care-experienced and is subject to various care orders, then there is a very clear order for who

will be their nearest relative. However, under the Bill there is no clear list. While an approved mental health professional will not have to guess, as there is a little bit of guidance, if someone is 16 or above they are effectively treated as an adult. There is no requirement to appoint someone who has parental responsibility or to appoint a member of the local authority if they are subject to a care order. Therefore, it is quite problematic for 16 and 17 year-olds.

For under-16s, there is a little more guidance, but it does not align fully with what the Children Act says about special guardianship orders and local authority care orders. To your point, Mind's position would be to bear in mind the centrality of allowing children and young people to make their own choices about appointing a nominated person where they are competent or have the capacity but ensure that there are very clear safeguards to remove that person if they pose a risk to the child or act against the best interests of the child. If someone who is exercising coercive control applies to discharge a child against the wishes of the parents with whom the child lives, there needs to be, at the very least, very clear guidance about what should happen in those situations. Perhaps elements of the Bill need to be looked at to ensure that there are safeguards to stop a nominated person whom a child or young person has appointed from taking steps that would pose a risk to the welfare of that child.

**Baroness Kennedy of The Shaws:** That is very interesting. It was exactly that area: how one would deal with that and whether there could be guidance in the new Bill dealing with that and giving more guidance to those who are making these decisions.

In the independent review, there was a recommendation that patients should have an opportunity, guaranteed by statute, to set out in advance choices relating to their care and treatment if they are detained. It was in the interests of respecting individual autonomy. Interestingly, that was not taken up in the Bill. Should it have been included? I would like some of the others to put their minds to that, too.

You gave the example of a young person who has eating disorders, and the business of tubal feeding. Could somebody indicate in advance, "I do not in any circumstances want to have force-feeding?" Do you feel that this is missing from this Bill, that it should be possible for someone to say in advance certain things about how their care and treatment should be delivered?

**Chair:** Can we start with Ms Livermore and then go round the panel? Two colleagues have caught my eye who want to ask supplementary questions on this. We will take those together before we go to Mr Khan.

**Alice Livermore:** Under the Mental Capacity Act, you can make an advance decision to refuse treatment. These do not currently have any weight under the Mental Health Act, with a few limited exceptions. The Mental Health Bill would give legal weight to advance decisions to refuse treatment under the Mental Health Act. This would enable someone who

has made an advance decision to refuse treatment, to access enhanced safeguards before the treatment that they have refused has been given.

Something came up in respect of the independent review around advance consent to admission, not just treatment. I wonder whether it would be helpful to elaborate on that, or whether you would prefer to focus purely on treatment.

**Baroness Kennedy of The Shaws:** I was largely looking at the nature of the care, which can sometimes be incredibly invasive, but it would be useful if you covered someone saying whether they would wish to be detained at all or not.

**Alice Livermore:** Absolutely. Under the current Act, nasogastric feeding can be provided as medical treatment without any of the safeguards that you would expect with other similarly invasive treatments such as electroconvulsive therapy. This is something that the Bill does not amend. As things are going, nasogastric feeding will not have enhanced safeguards. However, if you make an advance decision to refuse treatment, potentially you can access enhanced safeguards before that treatment can be given. These perhaps do not go as far as they could. The independent review suggested that the end point of those enhanced safeguards should be an appeal to the tribunal, but that has not been taken up in the Bill. It is more about responsible clinicians saying that there are no alternatives and that being approved by a SOAD.

Advance consent to admission was in the independent review and was something that Mind was always very concerned about, because it would reduce rather than enhance a person in their care and treatment, as they would be agreeing to be detained without the safeguards of the Mental Health Act or the Mental Capacity Act. While you might understand a treatment and be very clear on your experiences of that treatment, admissions vary so significantly that even if you have been admitted previously, a subsequent admission might be nothing like the first one. You could have been on a single-sex ward where restraint is rarely used, and the hospital was next to a bus stop—so you were taken straight to your support network.

Going back to the resourcing point, we know that people are sent far away from their homes. They are on a ward that perhaps has mixed-sex accommodation where restraint is used that is not particularly therapeutic for them. Dr Series has already alluded to an issue around objection. If you consented in advance but began objecting to the admission because it was not like a previous admission, how will that objection be identified by staff? Also, there is a distinction between clearly consenting and actively objecting. In-patient wards are very coercive places. You might not feel that you can object to the admission, and your advance consent continues to take you outside of Article 5 safeguards for extended periods.

Q10 **Chair:** Very helpful, thank you. Can Dr Series come in on that, then Mr Bell?

**Dr Lucy Series:** I echo Alice's concerns about advance consent. When you refuse something in advance, it makes it harder for people to do things to you against your will. However, if you consent in advance but then the experience is not what you anticipated and is more distressing, it is unclear what the safeguards would be.

The Bill does not legislate for advance consent, but there were worrying remarks in the White Paper that the previous Government produced to prepare earlier versions of this Bill, and in a draft code for the liberty protection safeguards. It suggested that the Government believed that there were already provisions for advance consent in common law. They expressed plans to implement this within the patient journey.

Even though this is not in the Bill, there is a danger that it might suddenly turn up in the code of practice and be implemented on the ground without proper regard to what safeguards patients will have. How revocable is that consent which was given in the past, and what safeguards are there around that? A big change like that needs to be brought in through proper scrutiny processes like this, where we can answer questions about what the safeguards would be.

**Andy Bell:** I was going to put the advance consent thing to one side because I agree entirely with what colleagues have said. In terms of advance choice documents, they were a very positive suggestion, and it is very important that they have legal status. We were disappointed that the draft Bill produced by the previous Government did not talk about advance choice documents at all. The current Bill is an improvement upon that as it stipulates that there is a requirement on services to inform people of a right that they already have to make these advance choices. That is a step forward, but it is not quite the same as having them in the Bill. We would have been happier with that.

There is good evidence around the importance of advance choice documents and safety planning generally in terms of keeping people safer and giving people more dignity and autonomy, so that even when you are very unwell you can advance choices about how you are treated. That may reduce the traumatic nature of treatment, albeit that being in hospital under the Mental Health Act, in the environments that people face often right now, is a traumatic experience in itself.

**Ulele Burnham:** I have nothing to add. I agree with all that has been said by the fellow panellists. I underscore what Dr Series said about the difference between advance consent and advance refusal and how that changes matters if the person seeks to object, having consented.

**Chair:** Now, your interesting replies have given rise to two supplementary questions. We will take them together—Lord Murray, then Mr Sobel.

**Lord Murray of Blidworth:** My very short question follows on from what Lady Kennedy was asking about nominated persons. In new paragraph 2 in Schedule 2 to the Bill, there is a power for a court to terminate the

appointment of a nominated person. The Bill says that the county court may do that. In the last Committee day on the Bill, an amendment tabled by Baroness Butler-Sloss, the former President of the Family Division, and Lord Meston, a former county court judge, proposed changing this to the Court of Protection. That seems to be quite a sensible decision. Does the panel have any views on that?

**Alex Sobel:** Although these children are not under the care of the local authority and so the local authority cannot act as corporate parent, it still has a duty of safeguarding and for the well-being of these children. In terms of a nominated person, there could be a role for a local authority. At the moment this seems very legalistic. We need to think about this in the round in terms of the young person.

**Chair:** Before we go to Mr Khan, let us have a response to those two questions. Can Dr Series come in first?

**Dr Lucy Series:** I know a good deal about the Court of Protection, but less about how the county court exercises this power to displace the nearest relatives—the precursor of the nominated person. There is very little data or research on it.

When the Court of Protection decides to turn its attention to something it can do so very thoroughly and would certainly dig into concerns about coercive control, undue influence or somebody's capacity. However, it may be much more costly and take longer to get that hearing than in the county court, so you would have a trade-off. If anyone from the Court of Protection were here, I suspect that they would point out how overworked the court already is.

**Ulele Burnham:** It is an interesting suggestion because the displacement power resides in the Mental Health Act and the framework goes to the county court in that connection. I echo what Dr Series says about the overload on the Court of Protection and that the county court is now quite used to dealing swiftly with displacement applications. Many county court judges are Family Court judges as well, so they understand the law in relation to children. I am not inclined to suggest that the right route is the Court of Protection in this situation, but that is an immediate response as it is a discrete framework which operates from provisions in the Mental Health Act.

**Chair:** I sensed that you were going to promise us that you would give it further thought and perhaps write to us about that as well, because that is a very interesting—

**Ulele Burnham:** I will happily do so.

**Andy Bell:** I do not think that I have anything to add to that.

**Alice Livermore:** A very quick point: the power to displace a nominated person would apply to the displacement selected by a patient of any age. I am not sure that the Court of Protection can make decisions about under-16s. Therefore, I do not know how this would work in practice if

that power was transferred. It would effectively mean that under-16s' nominated persons would be displaced.

**Chair:** I see from the screen that Ms Burnham affirming is.

Q11 **Afzal Khan:** The committee recently met with the head of the UK National Preventive Mechanism, which oversees the monitoring of places of detention in the UK. He raised concerns about delays in the transfer of prisoners suffering from mental disorders to secure hospitals, and about the lack of available data on this process. Does the Mental Health Bill do anything to meet such concerns? If not, could it be amended to deal with them?

**Andy Bell:** I can probably give you some information on that and others may bring in more legal knowledge. The Centre for Mental Health has looked at mental health in the prison system, and the criminal justice system more broadly, for the last 20 years. The introduction of a 28-day limit for transfers to hospital is a very important new provision. While a good proportion of people are transferred within that time, a significant minority are not, and many spend a very long time in prison, in unacceptable circumstances, waiting for a hospital bed. There are a number of reasons for that which we can go into.

It is really important, and has come up in debates, that there is clear accountability for achieving a hospital placement, and that the process is as simple as possible. Many people in prison will be subject to multiple assessments. They may be assessed by the prison mental health team as needing to be transferred to hospital. Clinicians from the receiving hospital will meet the person and decide whether they will accept them. If they do not, they may contact another hospital to try again. That is a messy, bureaucratic and deeply distressing process for the individual. The introduction of a time limit, while it is quite a blunt instrument for that purpose, should at least create better accountability for achieving that.

It will be terribly important that the code provides a very clear picture of whose responsibility it is to affect those transfers and that a named person is responsible for ensuring them. Good data always helps to improve accountability. If you cannot find the data, it is very hard to hold systems to account for achieving improvements. People are staying in prison very unwell and in unacceptable conditions. A trip to hospital if you are in the community would take a matter of hours but in prison is taking months in some circumstances. This is predominantly affecting people from minoritised communities and needs urgent attention.

**Chair:** Thank you for underlining what Mr Khan said. The National Preventive Mechanism did raise this question with us. It would be very helpful if Ms Burnham could say what we could do in the Bill to insist that more data is collected so that we become aware of these delays that have been described by Mr Bell so powerfully.

**Ulele Burnham:** I am going to have to answer this question rather tangentially, referencing some work that I was involved with on the Bar



Council's response to the consultation paper produced after the Wessely report.

One of the problems with this Bill is that the whole reform process was driven by a concern that Theresa May had in 2017, that there was disproportionality and a need to change the mental health system. She cited racism as an issue. The Wessely review spoke very candidly about its recommendations in that regard. The Bill that we see now does not reflect those kinds of concerns or provide the support mechanisms, funding streams and data production requirements that might help with the kind of issue that you are mentioning.

I do not see this Bill being able to address the data problem. The data problem is there and is central to the issue that Mr Bell raises in relation to the people who are foundering in prison when they ought to be in a different therapeutic environment, and regarding the communities that this committee has recognised are differentially, disparately and more deleteriously affected by regimes under the Mental Health Act, such as black and ethnic-minority persons.

I do not know whether that assists but, for me, this Bill cannot produce the necessary results in terms of data production.

**Chair:** Thank you, that is helpful. Dr Series, do you want to add to that?

**Dr Lucy Series:** Only to say that I know very little about the issues around prisoner transfer. I have a colleague who is an expert in this, whom I have put in touch with your committee's clerk.

**Chair:** Thank you.

**Alice Livermore:** I have nothing to add.

Q12 **Alex Sobel:** Many patients detained under the Mental Health Act have the capacity to refuse or consent to medical treatment but are given medical treatment against their will. Is that compatible with their human rights, particularly under Article 8 of the ECHR, which includes the right to respect physical integrity and personal autonomy? Ms Burnham, do you want to start us on that?

**Ulele Burnham:** Again, this is a matter that Ms Livermore was intended to lead on.

**Alice Livermore:** Because, as you identified, providing medication against someone's will represents a serious interference with their physical integrity, the law permitting it needs to ensure proper safeguards. In Mind's view, the Bill seeks to give greater weight to individual choice about treatment and provides enhanced safeguards against arbitrariness. In that sense, it moves towards compatibility with Article 8.

To give a few examples, there is a duty on approved clinicians to consider certain things, including the past or present wishes and feelings of

individuals when making a decision about treatment. There are the enhanced safeguards around refusal of treatment that I have already mentioned, and there are advance decisions which have been given legal weight under the Bill, for over-18s at least, in terms of advance decisions to refuse treatment.

There are still lots of issues, particularly around nasogastric feeding. That is such an invasive treatment and such an interference with Article 8 rights. The safeguards around providing it, in Mind's view, simply are not good.

**Alex Sobel:** That is one example. Our committee is interested in compatibility with Article 8. What other areas would make it compatible? If it is too many, you can write to us.

**Alice Livermore:** Unsurprising, one area where greater compatibility is required which the Bill does not provide for is in relation to under-18s. When we have spoken to children and young people, 69% of them have had negative experiences of in-patient admission. Only one in 10 felt listened to, and they did not feel that they had any control over the choice of treatment that they were given.

I am repeating myself to some extent. For under-16s, there is not a decision-making test in the statute, despite the way that the Bill couches many of the reforms as dependent on whether you have capacity or competence. Under-16s are at this immediate disadvantage. It means that the enhanced safeguards around treatment will not apply as effectively for them.

Advance decisions do not apply to under-18s, so a child or young person cannot make them. Mind thinks—

**Alex Sobel:** Just coming back to the under-16s or under-18s, nobody addressed my earlier question. All these children should have social workers provided by the local authority, considering the circumstance. What role do you think a local authority could have in this?

**Alice Livermore:** Where children are subject to care orders and lack the competence or capacity to appoint a nominated person, the local authority should automatically be the nominated person. There should be enhanced safeguards around notifying local authorities where children are placed in adult wards, where they are placed in out-of-area placements and where their placements are going to last for extended periods of time. There was a recommendation within the independent review that the Children Act was amended so that it was clear that any young person admitted or detained—I cannot remember which it was—met the criteria for a child in need under Section 17 of the Children Act. I am not a family law expert, but I do not think that would automatically mean that they would get a social worker, though I stand to be corrected.

**Baroness Kennedy of The Shaws:** I do not think so.

**Alice Livermore:** There are lots of ways in the Bill in which the roles of local authorities could be enhanced. However, we also need to think about the care and treatment of a young person while they are in hospital. That is the responsibility of the hospital, but we also need to think about what happens before they go into hospital and what happens when they are discharged. That is the point that we all have made: what is the resourcing in the community, from community mental health services or local authorities?

**Chair:** Mr Bell, would you like to come in on this?

**Andy Bell:** No, I do not have anything to add. Thank you.

**Chair:** Okay. There will be an opportunity on the last question for people to fill in any gaps if you do not feel that you have made your point. My colleague Lord Murray will ask the penultimate question.

Q13 **Lord Murray of Blidworth:** This is a question about private settings. In circumstances where care is provided in private settings, is there any risk of people receiving treatment, or being detained under the Mental Health Act, which fall outside the human rights protection arrangements? Is there anything that the Bill should be doing to prevent that from happening?

**Chair:** Dr Series, this is one for you, is it not?

**Dr Lucy Series:** I am very grateful to the committee for asking about this. I know that the committee has a long-standing history of drawing attention to it.

I would like to tell you about the case of a Mr Sammut, which came before the High Court last year. He had schizophrenia. He was a patient detained under the Mental Health Act but was then discharged from hospital into a privately run nursing home. His aftercare was funded under Section 117 of the Mental Health Act, which is a funding stream available to help get people out of hospital.

In the nursing home, he was deprived of his liberty. The nursing home did what it was supposed to do. It applied to the council for that to be authorised under the deprivation of liberty safeguards. However, as for many tens if not hundreds of thousands of people in similar situations, the council never got around to completing the requisite assessments. In legal terms, he was deprived of his liberty but without any authorisation. In other words, he was unlawfully detained.

In this care home, in circumstances that the coroner would later describe as neglect, Mr Sammut died of constipation. Constipation is a known side-effect of lots of antipsychotics. However, it was not addressed or treated, and so he ended up dying an agonising and preventable death from a very treatable condition. His family brought a human rights claim against the nursing home. They argued that the nursing home had violated their relative's right to life and his right to liberty, and that he

had endured inhuman and degrading treatment. The case came before the High Court last year.

Most of us assumed that this was quite straightforward, but a judge ruled that, because his care was being delivered by a private company, the Human Rights Act did not apply, so the claim was unsuccessful. The reasons why the judge ruled in this way are quite technical. I provided a written submission on this, but to summarise, there are older decisions. A decision known as *YL v Birmingham City Council* said that if a private care provider is delivering care that has been commissioned and paid for by a public body, then these are not functions of a public nature. That meant that the Human Rights Act did not apply. In that judgment, the court put a lot of emphasis on, for example, how these private companies are there to make a profit and are not there for charity.

The view of most human rights lawyers at the time was that this had really misunderstood how the Human Rights Act was meant to work, so Parliament legislated to try closing this gap. The most recent iteration of that legislation was in the Care Act. It essentially says that where a public body or a local authority commissions social care under specific statutes, the Human Rights Act applies to the private provider.

Mr Sammut's case shows us that if public bodies outsource using different statutes, that gap is still there. The courts are willing to find that the Human Rights Act will not apply. This is a big problem for anybody whose care is commissioned under Section 117 of the Mental Health Act, but it is actually a much bigger problem than it first looks. It looks like the courts might make similar rulings for all kinds of outsourced health and social care. It could potentially be the case that the Human Rights Act does not apply when the NHS outsources private healthcare or outsources to social care companies under continuing healthcare funding.

For patients who are sectioned under the Mental Health Act, it is likely that the courts would find that the Human Rights Act applies. However, there are many patients in mental health settings who are there informally or under the deprivation of liberty safeguards. They would not be protected.

In the Sammut judgment, there was a very strange Catch-22. The court agreed that Mr Sammut was deprived of his liberty, but because that detention was unlawful, it said that the care home had no power to detain him and therefore it was not exercising a coercive power, so the Human Rights Act did not apply. You end up in this bizarre Catch-22 situation where the remedy that you need to challenge an unlawful deprivation of liberty is unavailable to you because you are unlawfully detained.

Other groups of people who might be affected by this judgment include children in private social care settings, of which there are a growing number. It might also apply to NHS-funded hospice care, because that is often provided by charities. It could potentially apply in school settings. Free schools, academies and private specialist residential schools where lots of disabled people are placed may no longer have the protection of

the Human Rights Act, or at least it might be in doubt. This is an enormous problem, and none of us understood this until Mr Sammut's case.

Unfortunately, because the Bill is focused squarely on mental health, it cannot remedy the scale of this problem. It cannot solve it for children's social care, NHS continuing care, schools and so on. However, an amendment has been tabled by Baroness Barker and Baroness Keeley, trying to solve the problem for mental health patients. It would say that the Human Rights Act applies to any private provider of health or social care, if somebody is there under Section 117 aftercare, if they are a mental health patient—in a private mental health setting, perhaps informally—or has been deprived of their liberty in connection with a mental disorder. That is probably as far as we could push it. That amendment has not been debated yet in Committee, but we hope that the House of Lords will look kindly on it and that the Government will adopt it.

I also hope that this committee might raise this issue in other settings—for example, around children and other aspects of NHS care. I think that it is a serious problem.

**Chair:** Thank you very much indeed, Dr Series, that is very helpful to us. Ms Burnham, would you like to comment on this? In the case of Mr Sammut, some of the issues raised are still live, so could members refrain from talking about that specific case, as it may be covered by sub judice proceedings?

Stopping people from falling through the gap is the point that was being raised. Ms Burnham, could you deal with that? What more could the Bill do? We have been given one example and have been told about some of the issues and problems that might be faced in trying to amend the Bill, but is there anything other than the amendment that has been placed before the House of Lords in Committee? What more could be done to amend the Bill to stop people from falling through that gap?

**Ulele Burnham:** Perhaps it would be best if I responded to this by way of written submission. I agree with what Dr Series says about the gap and am aware of the case law that she is referring to with Sammut and YL. To take the point beyond what she has said would require some further thought on my part. That is probably the best way to deal with that issue.

Q14 **Chair:** Do Ms Livermore or Mr Bell want to add to that? No? Then thank you very much indeed for your answers.

The last question is about filling any gaps that we may have failed to address in the course of the proceedings so far. Also, because of our responsibility in looking at the commitments that the United Kingdom has entered into with international obligations, can you point us to any infringements that might raise concerns that bind the UK—such as the UN Convention on the Rights of the Child, which has been referred to quite a

lot already, and the Convention on the Rights of Persons with Disabilities. Are there gaps in that regard? We will start with Ms Burnham and go round. This is also your last chance to raise any points with us that we have not covered so far.

***Ulele Burnham:*** The thing that springs to mind immediately about international instruments is the Convention on the Rights of Persons with Disabilities. There are two pieces because there is an interface, of which Dr Series and I spoke earlier, between the Mental Health Act and the Mental Capacity Act. Looking at these two provisions from the point of view of the Convention on the Rights of Persons with Disabilities, I suspect that many CRPD experts would say that these two pieces of legislation are anathema to how things are framed by the committee, because the committee's work focuses on, for example, persons not being detained by reason of a disability. The Mental Health Act arguably does precisely that, certainly as far as the diagnostic criteria is concerned. That is a problem.

Another problem is raised by the CRPD. Some of the nicest views that were raised were about what will happen to people with learning disabilities and autism if they are shunted into the forensic branch of the mental health detention provisions. This could raise issues about discriminatory treatment of those with learning disabilities and autism, compared with the other cohort of persons to whom the Mental Health Act might apply.

There is a residual concern about Article 5. From the things that I looked at discreetly for today's evidence, there is a concern about its compliance with the Mental Health Act as it stands. The committee will be aware that there is a change to the definition of "appropriate medical treatment" in the Bill. Appropriate medical treatment was seen as being to alleviate symptoms or treat the core disorder, and there was no need to demonstrate a likelihood of the resolution of those manifestations or symptoms. Therefore, you could be detained under the Mental Health Act even though there was no likelihood that the disorder from which you suffered, or its symptoms or manifestations, would benefit from the treatment that was being given.

Now, the Bill says something a little different—that there must be a reasonable prospect of therapeutic benefit. In that sense, this brings the Bill more in line with Strasbourg case law, which indicates that detaining someone and providing them with basic care, such as nursing, or just care that stops them from injuring themselves, is not regarded by Strasbourg as therapeutic treatment that would meet the criteria for Article 5. That is one positive thing about the Bill.

In more general terms, there are problems with reforming a very old piece of legislation based to some extent on antiquated views of how those with intellectual and psychosocial impairments should be treated. There is a problem with piecemeal reform of that.

I make one final point about the disproportionality issue. I want to underscore what the committee knows and what was mentioned by Ms Livermore and Mr Bell. Given that this procedure for reform of the Mental Health Act was driven by concerns about the disproportionate application of the interventions under the Mental Health Act and their effect on persons in black and ethnic-minority communities, it is disappointing that the Bill does not contain anything which would do something about that.

This Bill might not be able to do so. At the point of detention or at the point of decisions of consent to treatment, for example, it is hard to bring into focus structural racism on a societal level. However, the raft of provisions which the consultation paper in 2021 referred to as needing to be put in place, and the money that was required to be spent to deal with this problem, cannot be found anywhere in the discussions around this Bill. The very thing that generated this reform has fallen by the wayside.

**Chair:** Thank you very much indeed. Certainly we will give further thought to the disproportionality issue that you have rightly reminded us of and which you have underlined from the questions that were asked earlier on. Even though this Bill does not solve institutionalised racism, if it does something about this specific aspect of it, we would love to hear from you further on that.

**Ulele Burnham:** It shifts the dial slightly in moving from carceral solutions to social problems. The problem that it leaves us with is that without funding and the social structures, then, as all panellists have said, it is difficult to be very optimistic about the impact of this Bill.

**Andy Bell:** Just on that point, one of the most important recommendations from the independent review was to set up the patient and carer race equality framework. This is by far the strongest attempt ever made to tackle racial injustice in our mental health system. It has a very clear theory of change. There is resource going into it at the moment. There is a requirement on the NHS from the last planning guidance to implement the patient and carer race equality framework. It is not a job of five minutes. It will need time, commitment and resource. The people who are leading it will need all our support to ensure that it really does lead to change within the mental health system and the systems around it.

In terms of how the Bill might affect disproportionality, what gives me hope is that many of the changes are aiming to reduce subjective decision-making. For example, if someone is placed on a CTO, it will require two clinicians rather than one to make that decision. That may help to reduce the huge variability that we have seen between different psychiatrists. Some use CTOs a lot, some never use them. Again, there is no good reason for that. Having two people to make that decision is important. We would like to see the Bill amended so that renewals are made more frequently and by two people, rather than just on the opinion of one practitioner.

In terms of other things to mention which may be relevant to the committee, there was a recommendation in the independent review for the Act to ensure that if people are in hospital they can continue religious observances and practices. We heard lots of evidence from individuals that this was a major issue. This would also help to tackle a particular type of inequity in terms of reducing disparities. Clearly, data is incredibly important. It is not always the best tool to shape behaviours but there will be opportunities within the Bill or the code to ensure that we are much tighter in the type of data that we expect to be collected, particularly regarding the disproportionate use of the Act with particular groups of people. That would apply to those being transferred from prison to hospital.

I did not respond as well on that question as I could. In terms of changes to the Bill, the first would be around data. The second would be about being very clear on where responsibility lies in England and Wales. It may be different for affecting those transfers within the time limit. That could be very clear. Again, it could be in the code, but it would be better in the Bill.

Q15 Finally, we know that many people end up in hospital under the Mental Health Act because of a crisis in their life to do with housing, money or other things. It is not necessarily a mental health crisis. It is often a crisis in life. Therefore, it is important that people have a statutory right to support with housing and money. Unfortunately, some people go into hospital and lose their housing, or their financial situation deteriorates. That is an iatrogenic harm from the use of state powers. We would like to see something in the Bill to ensure that people are given the right help and support as part of care and treatment plans for their money and housing rights.

**Chair:** On that last point, again it would be helpful, Mr Bell, if you could point us in writing to where in the Bill that should be addressed. On the inequities point, which nobody had raised with us before, with such things as spiritual and religious needs, which you just touched on, again if you think that this should be in the guidance or the Bill, it would be appreciated if you could give that a little further thought and write to us. Thank you.

Let me turn to Dr Series; then we will give the last word to Ms Livermore.

**Dr Lucy Series:** You were asking about perspectives from the CRPD. I will leave the rights of children to Ms Livermore. The committee will be aware that the Convention on the Rights of Persons with Disabilities interprets human rights in a radically different way, particularly around mental health, to the European convention. Very crudely, the European Convention on Human Rights says that it is not only permissible but in some cases necessary for a person to be detained and treated against their will—for example, to keep them safe.

On the other hand, the Convention on the Rights of Persons with Disabilities says that in no case should you detain somebody on grounds



linked to disability. This does not just mean only on grounds of disability. It means that disability in connection with risk would be prohibited. That would be seen as discriminatory. They would say, "We do not preventatively detain other risky populations, so why are we singling out this group?" The UN committee has been very clear that it regards mental health laws such as ours and mental capacity laws like ours to violate the convention.

The Law Commission and the Wessely review looked at this. The Wessely review sought a wide range of views from service users, which were quite mixed, interestingly. Some service users who had experienced detention agree with this perspective and some do not. Therefore, neither review moved us in that direction.

Human rights norms continue to evolve and change. One of the things that is very powerful which has come out of this quite radical view of the UN committee is a deep exploration of alternatives to detention. How do we create environments where people do not need to be detained because their care and support needs are being met in other ways? Partly that is around things such as better social care rights and independent living for some groups, and rights to health.

I liked a phrase from the manifesto of the National Survivor User Network in the UK, that people should have the right to the right support from the right person at the right time. The belief was that if they could access the right support from the right person at the right time, you could, by and large, avoid situations of crisis, or at least significantly reduce them, and bring people out of crisis quicker.

There is something very powerful in the UN convention around the positive rights. I hope that future iterations of mental health law emphasise those positive rights more and, instead of focusing more narrowly on when we can detain, ask how we can avoid it altogether.

**Chair:** You have just mentioned alternatives to detention. The same obligations apply in other jurisdictions. Can you share any examples of best practice from overseas, where perhaps they get those alternatives better than we have we have done hitherto in the United Kingdom? That would be of help to us as well.

**Dr Lucy Series:** I can send some things in writing, some pieces of research that have been carried out in connection with the convention.

Q16 **Chair:** Thank you. The last word I promised to Ms Livermore.

**Alice Livermore:** I want to pick up on something that Dr Series has just said around the right support, the right person and the right time, and something that Mr Bell raised earlier around the individual right to assessment and treatment. There is an opportunity for this Bill to create a positive duty. If there was a positive right, it could go some way to addressing some of the issues around disproportionality. You could draft a right in such a way that it respects an equality and cultural appropriateness of community services.

There probably are a few things that the Bill could do. As Mr Bell has mentioned, advance choice documents are one of the positive things in the Bill that will help to address some of the racial disproportionalities, but it could go so much further. There are a number of things that it could do. The Secretary of State will need to have regard to the guiding principles that informed the review when drafting the code of practice. We think that they should be at the heart of all decision-making when it comes to the Bill. They should be right at the beginning so that any decision made under the Act would consider them. We think that an additional principle is needed, an equity principle, so that all decisions made under the powers of the Act consider the equity implications.

From what happened with Seni's law, we recommend a responsible person at local level oversees race equity in the operation of the Act and how it is being implemented. There would be someone working there at a local level to ensure that the changes are having an effect in practice.

Then, as Andy mentioned, there is something about data and reporting. There are probably some easy points within the Bill, given the increased emphasis given to care and treatment planning, to ensure that when that care and treatment planning is being done, the clinicians—the decision-makers—have regard to culture and protected characteristics.

I will come to the UNCRC now. I will try and keep it brief because I have made many of the points already, but I want to raise a few concerns about where the Bill probably is in contravention of elements of the UNCRC. First, Article 37(c) requires children deprived of their liberty to be separated from adults unless it is considered not to be in their best interests. The CQC has reports on the number of young people who are admitted to adult wards. There has been a slight decrease after a peak in 2020-21, but there are still significant numbers of children being placed in adult wards. In many cases, the reason given is that there is no alternative mental health in-patient or outreach service available for young people. It is not because the adult wards are the best place for them, but because there are simply no other alternatives.

When children are admitted to adult wards, they are denied the opportunity for peer support. They have limited and often virtually no access to educational opportunities. They are around staff who are trained to deal with adults, and around people who could be 60 years old, whereas they are 17 or 16.

I also have some concerns about Article 12, which requires state parties to give children the right to express their views and decisions about them. I have already mentioned statutory decision-making tests. I will not repeat that. However, because of the higher proportion of children and young people who are admitted informally, there is a need to look again at some of the safeguards in the Bill and whether they should be extended to informal patients who are under the age of 18. Specifically, I am thinking about statutory care and treatment plans, and having those in the Bill for under-18s, and opt-out advocacy extension to informal patients. The Bill does extend advocacy to informal patients, but on an

opt-in basis, and we know that children and young people often struggle to access advocacy.

Particularly in respect of the statutory decision-making test, the failure to include that test in the Bill puts under-16s at a disadvantage in being able to access the reforms and safeguards effectively that is so significant that it could constitute discrimination under Article 14, read with Article 8 of the ECHR and Article 2 of the UNCRC.

Finally, Lord Meston has tabled an amendment to the Bill which would insert a test for decision-making for under-16s. It is based on the functional test in the Mental Capacity Act. There has been some discussion and debate about whether the functional test is appropriate or indeed compatible with the UNCRC. Mind very respectfully disagrees: the functional test is compatible, not least because the functional test in the Mental Capacity Act already applies to 16 and 17 year-olds—who are children for the purposes of the UNCRC.

**Chair:** Thank you very much indeed for that very comprehensive and helpful reply. Although this Bill is before the House of Lords at the moment, it is almost back to front. It will go to the House of Commons much later. Therefore, everything that has been said today will be fed into that process and we will have a chance to write to the Ministers involved and to colleagues in both Houses, to pursue some of the points that have been raised.

Ms Livermore, everything that you have said about children and young people we will raise tomorrow during our meeting with the Children's Commissioner, who will be very seized of some of the points that you have expressed.

All that remains is for me, on behalf of the committee, to thank our four witnesses today. You have given us two hours of your time. We have explored some very difficult, complex, challenging issues. We have gone into deep waters around the nature of this Bill. Ms Burnham, Dr Series, Mr Bell and Ms Livermore, on behalf of the whole committee I thank you for sharing your expertise and being willing to continue engaging with us as we go forward with the evidence that you have provided today. With that, I close the formal proceedings.