



House of Commons  
Health Committee

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# Post-legislative scrutiny of the Mental Health Act 2007

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**First Report of Session 2013–14**

*Report, together with formal minutes, oral and  
written evidence*

*Ordered by the House of Commons  
to be printed 10 July 2013*

**HC 584**  
**Incorporating HC 997-i-ii, Session 2012–13**  
Published on 14 August 2013  
by authority of the House of Commons  
London: The Stationery Office Limited  
£14.50

## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Additional written evidence may be published on the internet only.

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<sup>1</sup> Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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## Summary

The Mental Health Act 2007 (the 2007 Act) amended and updated the Mental Health Act 1983 (the 1983 Act), which remains the cornerstone of mental health legislation in England. The measures in the 2007 Act were proposed to reflect the changing way in which patients with mental health problems can be treated and cared for. Its provisions more accurately reflect the range of professions that work with patients and the desire to provide as much care as possible within communities, rather than in hospital. A single definition of mental disorder was included in the 2007 legislation in order to incorporate conditions which the original legislation did not properly account for.

A new ‘appropriate treatment test’ was established by the 2007 Act with the purpose of ensuring that patients are only detained if treatment appropriate to their condition is available. It is striking that the implementation of the test coincided with a substantial increase in the detained patient population, but there is insufficient evidence to identify a causal relationship between the test and detention. The Department of Health does not appear to have clear understanding of the factors driving increased detention, particularly in relation to failures in community treatment and the readmission of patients.

Over the course of this inquiry the Committee learnt of severe pressure on beds, with some wards running at over 100% occupancy. It is now acknowledged that there appears to be an inverse relationship between the number of available beds and rates of detention. The most worrying consequence of this was the suggestion that voluntary admissions to psychiatric wards are now so difficult to access that patients are being sectioned to secure treatment in hospital. The Committee is very concerned that clinicians would resort to a practice which represents a major infringement of a patient’s civil liberties. In the Committee’s view, the Department of Health should urgently investigate whether patients have been sectioned in order to access psychiatric units and report to Parliament on the prevalence of this practice.

Coupled with this, the Committee also heard reports that patients who manage to access treatment voluntarily are subject to ‘de facto detention’, whereby they are detained under section if they seek to leave hospital. It appears that this practice is not extensive within the mental health system; nonetheless, the Committee regards it as completely unacceptable. We believe that the professional regulators should review their advice to clinicians regarding the use of sectioning powers. This review should make it absolutely clear that sectioning in place of voluntary admission is never acceptable, that patients must be made aware that they have the right to discharge themselves unless they are detained under a properly authorised section, and that all clinicians have a duty to highlight concerns if they believe these principles are being breached.

The Department of Health has emphasised the importance of ‘parity of esteem’ in the commissioning and delivery of services for mental health patients. In practice this means that the care needs of mental health patients should have equal priority to the needs of patients who require physical healthcare. This is a welcome principle, but evidence we received suggested that the behaviour of commissioners is not consistent with it. The Committee heard that community mental health services are vulnerable to cuts and that commissioners find it easier to cut mainstream mental health services because of the way

in which they are commissioned through block contracts. For 'parity of esteem' to be meaningful the Department of Health must encourage the development of commissioning and payment systems which reflect this objective and do not make mental health services vulnerable to cuts by local commissioners.

Under the 2007 Act, detained patients and those subject to community treatment have the right to be supported by an Independent Mental Health Advocate (IMHA). An independent advocate who helps patients make best use of their rights is an important provision, and the Committee believes that this aspect of the legislation has improved the safeguards available to patients. Nevertheless, it is clear that there is substantial variation in access to IMHAs across the country. Similarly, research suggests that the more a patient needs an independent advocate the less likely they are to find one that can meet their requirements. The Committee therefore recommends that rather than being an opt-in service, patients should be allocated an IMHA unless they decide to opt-out. Local authorities are responsible for commissioning advocacy services and therefore ensuring equity of access and quality. The Committee believes that Health and Wellbeing Boards should ensure that high quality advocacy services are being delivered.

The Committee was told that the presence of IMHAs had resulted in clinicians retreating from their duty to inform patients of their rights and to help patients take advantage of them. Whilst the Committee regards IMHAs as a valuable supplement to support patients, clinicians should lead in helping patients to understand and make best use of their rights.

Section 136 of the 1983 Act gives police officers the right to remove from a public place to a place of safety a person who they believe to be suffering from mental disorder. The 2007 Act amended this power so that patients taken into police custody can be conveyed to a hospital which, evidently, is a more appropriate place of safety. The Committee found no cause for concern with the power to convey, but the extent to which it has been used and its impact on patients is unclear. An independent assessment of the power should be commissioned by the Department of Health to ensure that the legislation is working as intended.

In examining this aspect of the legislation the Committee found that detentions under section 136 of the Mental Health Act have grown considerably. The number of patients taken directly to hospital by the police has increased steadily but a significant minority are still detained in police custody. The Committee heard that only one in five of those people held by the police under section 136 were subsequently detained by clinicians for further assessment. Police custody should be used as a place of safety only in exceptional circumstances. Health Ministers should work with their counterparts in the Home Office to refine the application of section 136.

Supervised Community Treatment (SCT) was introduced as part of the 2007 Act to enable some patients with mental disorder to live and be treated in the community whilst still being subject to recall to detention in hospital. The conditions imposed are dependent on the circumstances of each case and they form part of the Community Treatment Order (CTO) which is made by the clinician responsible. The number of patients subject to compulsion under the Mental Health Act has increased as a result of SCT. In 2007 the Department claimed that CTOs would help to reduce the detained population but this has not been borne out. The Committee heard criticism that CTOs are simply a mechanism for

medicating patients in the community and that patients find there is a stigma attached to being subject to a CTO.

It was argued in evidence that CTOs should only be applied to those ‘revolving door’ patients who repeatedly disengage from treatment when discharged from hospital and not for patients who have always been compliant with their treatment. This, however, was not the intention of the legislation and a history of non-compliance is not required to justify a CTO under the terms of the 2007 Act. The Committee believes that the intention should be kept under review, as compulsory treatment must always be supported by evidence of need and effectiveness.

Further questions remain regarding the application of CTOs. There is substantial variation in the use of CTOs across the country and research has suggested that CTOs have not managed to reduce hospital admissions. The results of the Oxford Community Treatment Order Evaluation Trial concluded that CTOs perform no better than previous measures and the patient benefits do not justify curtailing a patient’s liberty. It is clear, therefore, that in light of these findings Minister should review the current operation of CTOs.

Deprivation of Liberty Safeguards (DOLS) were included in the 2007 Act as an addition to the 2005 Mental Capacity Act (MCA). They provide a statutory framework to protect the rights of patients detained under the MCA. These are usually patients in care homes with dementia, or in some cases, severe learning difficulties. The committee found that application of the safeguards is variable and on many occasions those responsible for ensuring patients are protected by them have failed to do so. There is considerable confusion around the scope of the safeguards and how and when to apply them in practice.

The evidence the Committee heard regarding the application of DOLS revealed a profoundly depressing and complacent approach to the matter. There is extreme variation in their use and we are concerned that some of the most vulnerable members of society may be exposed to abuse because the legislation has failed to implement controls to properly protect them. An urgent review of the implementation of DOLS should be undertaken by the Department of Health and presented to Parliament, together with an action plan for improvement, within 12 months.

The Committee examined the application of the 2007 Act in relation to the representation of patients from minority ethnic groups subject to the Mental Health Act. We did not find that the 2007 Act had inherently disadvantaged these groups, but it is notable that the number of Black and Black British patients subject to CTOs is even more disproportionate than the number detained in psychiatric hospitals. The Committee believes that in order to support minority ethnic patients local authorities should ensure they commission culturally sensitive and effective advocacy services. Helping minority ethnic patients, especially Black patients, understand and make best use of their rights would be an important step in addressing the disproportionate number of Black patients subject to the provisions of the Mental Health Act.

# 1 Introduction

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## Post-legislative scrutiny

1. We report on the Committee's post-legislative assessment of the Mental Health Act 2007. The purpose of post legislative assessment is not to repeat policy debates from the original passage of an Act but to assess the implementation and operation of the legislation.<sup>2</sup> We took evidence from Dr Hugh Griffiths, National Clinical Director for Mental Health, Bruce Calderwood, Director of Mental Health and Anne McDonald, Deputy Director of Mental Health and Disability, Department of Health, Alison Cobb, Senior Policy and Campaigns Officer, Mind and Chair of the Mental Health Alliance, Simon Lawton-Smith, Head of Policy, Mental Health Foundation, Dr Julie Chalmers, Royal College of Psychiatrists lead on the Mental Health Act and Naomi James, National Survivor User Network.

## Background to the 2007 Act

2. The Mental Health Bill (Lords) was introduced in the 2006–07 session with the intention of amending and updating the Mental Health Act 1983 which is the cornerstone of mental health legislation in England and Wales. The Mental Health Act 2007 (the 2007 Act) received Royal Assent on 19 July 2007. The majority of the provisions of the 2007 Act came into force in November 2008.

## Terminology used in the report

3. Where the term 'Mental Health Act' is used this refers to the Mental Health Act 1983 as amended by the provisions of the Mental Health Act 2007. Where specific reference is intended to be made in relation to either the 1983 legislation or the 2007 legislation the report uses the terms '1983 Act' or '2007 Act'.

## Mental Health Act 1983

4. The 1983 Act is "primarily about detention in hospital"<sup>3</sup> and "few provisions in the act relate to patients in the community".<sup>4</sup> The 1983 Act established the criteria around sectioning and who could apply for someone to be detained under the 1983 Act. It focused on compulsory detention as opposed to voluntary hospital admissions. The 1983 Act established a "treatability" test which, theoretically, would only permit detention if effective treatment was available to improve a patient's condition.

5. The 1983 Act sought to tighten the definitions around mental health but it did not define mental illness:

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2 Office of the Leader of the House of Commons, *Post-legislative Scrutiny—The Government's Approach*, March 2008, p 8

3 *The Mental Health Bill*, Research Paper 07/33, House of Commons Library, March 2007, p 8

4 Ibid



Section 1 of the Act defines mental disorder as “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. [...] The section explicitly rules out “promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs” as, on their own, constituting a mental disorder.<sup>5</sup>

6. The 2007 Act established a single definition of mental disorder as it was felt that some mental disorders were not obviously covered by the 1983 Act. The new definition determined that “‘mental disorder’ means any disorder or disability of the mind”.<sup>6</sup> In drafting the new definition the then Government sought to ensure that the single definition would “not result in people being detained solely on the basis of learning disability.”<sup>7</sup> Therefore:

section 2 of the 2007 Act provides that (for certain provisions of the 1983 Act) a person cannot be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is “associated with abnormally aggressive or seriously irresponsible conduct” on the part of the person concerned.<sup>8</sup>

7. References to alcohol or substance abuse were not included and references to promiscuity and immoral conduct were regarded as redundant; the exclusion relating to sexual deviancy was also removed.

8. The 1983 Act established the routes into detention and types of detention to which patients can be subject:

The 1983 Act provides for two broad routes into hospital: one through the criminal justice system (on remand, at the time of sentencing or by transfer from prison) and the other through civil procedures, often referred to as “sectioning”. “Sectioning” involves a decision made by professionals that does not require a court order or confirmation by a Tribunal. The civil route accounts for over 90% of formal admissions.

Key provisions on “sectioning” are contained in sections 2, 3, and 4 of the Act, which are often referred to by name. They relate to people with a mental disorder and cover respectively short term admission for assessment (generally for not more than 28 days), admission for treatment (initially for six months, renewable for another six months, then yearly, but potentially indefinite) and emergency admissions.<sup>9</sup>

9. Patients detained under section 3 of the Mental Health Act are subject to the safeguards within the Act. The key safeguard is the right of the patient to request an assessment of their case at a tribunal if they decide they wish to challenge their detention. Patients have the right to do this over each statutory period for which they are detained (i.e. six months

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5 Ibid, p 9

6 Mental Health Act 2007, Section 1

7 Department of Health, *Post-legislative assessment of the Mental Health Act 2007*, July 2012, p 4

8 Ibid

9 House of Commons Library, March 2007, p 9

in the first instance). Patients detained for assessment under section 2 have 14 days from the start of their detention to appeal to a tribunal.

### *Purpose of amending the 1983 Act*

10. The intention of the 2007 Act was to reform the existing law dealing with compulsory detention and treatment. The Bill was introduced in the House of Lords in November 2006 but reform to the legislation had been planned for at least eight years.<sup>10</sup>

11. The proposal went through numerous phases, including:

a blue paper, Green Paper, a White Paper, a draft Bill published in 2002, another Draft Bill published in September 2004, on which a Joint Committee of both Houses reported in March 2005, the Government's response to it, and the Bill, introduced in the House of Lords in November 2006.<sup>11</sup>

12. Due in part to the lengthy process associated with preparing new legislation the Government decided to abandon plans to introduce a wholly new bill. Instead the 2006 Bill sought to amend, rather than replace, the 1983 Act. In their memorandum to the Committee the Department of Health said that "the main purpose of the act was to amend the 1983 Act in a number of areas where it was generally agreed that reform was needed."<sup>12</sup>

13. In explaining the rationale for amending the 1983 Act, the then Health Minister, Rt Hon Rosie Winterton MP, said:

We want to ensure that people with serious mental health problems receive the treatment that they need to protect themselves and others from harm. We need to recognise that the world has moved on since 1983. Many more people can now be treated in the community, rather than in hospitals, so the use of compulsory powers should reflect that. Professional demarcation lines have changed since 1983, and functions are now being carried out by people with the right skills and experience, rather than individuals from particular professions. Again, our legislation should change to reflect that fact. We also want to strengthen patient safeguards, which includes tackling human rights incompatibilities.<sup>13</sup>

14. The 2007 Act introduced a large number of changes and amendments to the existing legislation. In undertaking this inquiry the Committee focussed its attention on those provisions which have been identified by the Department of Health and the Mental Health Alliance (MHA), in their submissions to the Committee, as being of most significance.

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10 Ibid, p 7

11 Ibid

12 Department of Health, July 2012, p 2

13 HC Deb, 19 January 2007, column 1335

## 2 The Appropriate Treatment Test, Community Treatment Orders and detention

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### Impact of the 2007 Act

15. The 2007 Act introduced a new test which assesses whether appropriate treatment is available for a patient which would enable them to be detained for treatment. The Department of Health said that this was implemented to “support services which would pre-empt and help to manage behaviour rather than react to behavioural breakdown.”<sup>14</sup> They also believed that it would help avoid preventative detention that does not provide any treatment that serves a clinical purpose. Explaining the rationale for introducing the new test, the then Health Minister Lord Warner told the House of Lords:

The appropriate treatment test is designed to ensure that no one will be brought or kept under compulsion unless suitable treatment is available for them. It will not be enough for treatment to exist in theory, which in itself is a considerable patient safeguard. The treatment must be not only available and appropriate to the medical condition but appropriate to the circumstances. For instance, factors such as how far the services are from the patient’s home or whether those services are culturally appropriate will need to be considered.<sup>15</sup>

16. In evidence to the Committee Dr Julie Chalmers, the Royal College of Psychiatrists lead on the Mental Health Act, told us that that the reform had not had a significant impact on the diagnosis and treatment of patients. She said that at the time of the Bill passing through Parliament the reform caused a lot of debate within the profession but added:

I think that it has had very little impact on the practice of psychiatrists, perhaps because the approach to personality disorder is going to be shaped not particularly by legislation but by new initiatives and other treatment methods.<sup>16</sup>

17. Alison Cobb, Chair of the MHA, told the Committee that the policy intention behind the appropriate treatment test had been to create more flexibility over the definition in order to allow the detention of people who need to be treated but could not be held under the existing legislation.<sup>17</sup> However, Dr Hugh Griffiths, National Clinical Director for Mental Health at the Department of Health, reported that this reform had not changed the way in which clinicians practise and argued that this is because “it is enabling legislation; it is just to make it clearer and more helpful”.<sup>18</sup>

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14 Ibid

15 HL Deb, 28 November 2006, col 658

16 Q 2

17 Q 3

18 Q 69

### **Growth in detention**

18. Although the Committee was told that the introduction of the appropriate treatment test had not resulted in a change of clinical practice, it is striking that the development of the test has coincided with a substantial increase in the total population of patients detained under section. The Care Quality Commission (CQC) has found that detentions under the Act rose by 5% in 2011–12 compared with the previous year with 48,631 detentions in hospital for assessment or treatment.<sup>19</sup>

19. Dr Chalmers noted that there had been no growth in the number of patients detained from court under the Mental Health Act and a moderate reduction in the number of people detained for treatment, but that these developments had then offset by an increase in the numbers detained for assessment.<sup>20</sup> The MHA does not, however, attribute the growth in detentions to the introduction of the appropriate treatment test and Alison Cobb concluded that rising detentions were not the result of “a particular change in the reasoning or clinical decision making”<sup>21</sup>

20. We were presented with no convincing evidence that there was an increased cohort of people in England suffering from psychotic illnesses. A growing population of detained patients is not a phenomenon peculiar to England. Bruce Calderwood, Director of Mental Health at the Department of Health, told us that

[...] the trend in detentions applies not just in this country but also in other European countries. Even in Scotland, where after their Act there was a slight reduction in the number of detentions, in recent years it has gone up again. There seems to be something broader there than just the application of the legislation in terms of what is going on.<sup>22</sup>

### **Impact of Community Treatment Orders on detention**

21. The Department of Health’s impact assessment for the 2007 Act indicated that the introduction of Community Treatment Orders (CTO) would save the NHS approximately £34 million per year by 2014–15. This figure was reached on the assumption that 10% of people admitted under section 3 would, instead, be placed under supervised community treatment.<sup>23</sup> CTOs are examined elsewhere within this report, but it is relevant to note here that the Department of Health judged that the provisions of the Act would help to provide increased bed capacity and reduce detention.

22. The 2007 impact assessment implied that the availability of CTOs would help to raise the threshold for hospital treatment and detention. Evidence to this inquiry from the Department highlights an 8.4% decline in the number of section 3 detentions since 2007–08 but concedes that section 2 detentions have increased over the same period.<sup>24</sup> Simon

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19 Care Quality Commission, *Monitoring the Mental Health Act in 2011/12*, January 2013, p 12

20 Q 4

21 Ibid

22 Q 71

23 Department of Health, *Mental Health Bill 2007, Regulatory Impact Assessment Revised Version*, June, 2007, p 10

24 Ev 41

Lawton-Smith, Head of Policy at the Mental Health Foundation, told the Committee that “CTOs do not seem to be reducing the number of people in hospital, as there are now more people in hospital under the Act than there were five years ago.”<sup>25</sup> In 2008–09, when the CTO provisions came in to force, there were 42,208 detentions under sections 2 and 3 of the Mental Health Act. By 2011–12 this figure had reached 44,894.<sup>26</sup>

23. The Committee has received little compelling evidence to support the contention that the threshold for admission to hospital under the Mental Health Act has risen as a result of CTOs enabling patients with less severe conditions to be treated in the community. Evidence presented by, among others, the Mental Health Foundation supports the view that the threshold for admission has risen because of growing pressure on the availability of bed places in psychiatric units.<sup>27</sup>

**24. It is of concern to the Committee that the Department of Health does not have a clear picture as to the factors which are driving increased rates of detention. In particular, a lack of data on readmissions means that there is no information to illustrate whether pressure on beds is detrimentally affecting the treatment of those patients eventually detained under section.**

### Availability of beds in psychiatric wards

25. Although the factors that contribute to a growth in the detained population are poorly understood, the Committee heard evidence that a link had been established between a lack of bed capacity in psychiatric units and increases in detention. Dr Chalmers cautioned that she was not arguing in favour of a causal link, but she acknowledged that a relationship had been established between the two factors. Dr Griffiths accepted that:

there is some research evidence that there appears to be an inverse relationship between the number of beds apparently available and the number of people being detained.<sup>28</sup>

26. Dr Griffiths and Dr Chalmers both highlighted the CQC’s finding that in over 50% of wards there was 90% occupancy and in 15% of wards there was in excess of 100% occupancy.<sup>29</sup> Department of Health officials described the system as running “too hot”<sup>30</sup> and the Committee is concerned that this degree of occupancy gives clinicians little leeway to be flexible in the way in which they may treat patients.

### Detention in place of voluntary admissions

27. A disturbing element of the evidence the Committee took was the suggestion that pressure on bed places had made it difficult for patients to be admitted to psychiatric units

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25 Q 34

26 CQC, January 2013, p 13

27 Q 8 (Mr Lawton-Smith)

28 Q 72

29 Q 4

30 Q 72

on a voluntary basis. Dr Chalmers repeated reports from the CQC that in some areas “being detained is the ticket to getting a bed.”<sup>31</sup> Mr Lawton-Smith accepted that it was possible that a clinician might section a patient who in the past would not have been sectioned in order to access a psychiatric unit.<sup>32</sup>

28. The Committee is very concerned by the suggestion that some clinicians may resort to use of sectioning powers to secure hospital access for some patients who would otherwise have been voluntary patients. Such behaviour would represent a serious violation of the civil rights of the patient — as well as an abuse of the professional obligation of the clinician.

**29. We recommend that the Department of Health urgently investigates whether patients have been sectioned in order to access psychiatric units and reports to Parliament on the prevalence of this practice within the mental health system.**

30. The Committee also heard from Naomi James that those patients who are admitted voluntarily often feel that they are under de-facto detention and, and are “being told by staff on the ward, ‘If you try to leave, we will put you under section.’”<sup>33</sup> Dr Chalmers acknowledged that this could be a problem and said:

The college is well aware of this issue of de facto detention, which is picked up repeatedly with the CQC. We are trying to make it clear that we have to champion people’s rights. If we think that they are in that situation, and that the patient is the only person who does not know they will be detained if they try to leave, that is not okay.<sup>34</sup>

31. Dr Griffiths described threatening voluntary patients with formal detention as an “utterly unacceptable practice”.<sup>35</sup> He said that he believed this practice was not as prevalent a feature of the system as it once had been, but he could provide no figures to detail the extent to which it still happened.

**32. We are concerned about reports of practices such as de-facto detention of patients. Although such practices appear less serious than the use of sectioning powers to secure access to hospital, we welcome Dr Chalmers’ clear statement that these practices are “not okay”, and inconsistent with the clinician’s professional obligations to the patient.**

**33. We recommend that the professional regulators should review their advice to clinicians about their obligations in the context of the use of sectioning powers under the Mental Health Act. In particular we recommend that their advice should reflect the following principles:**

- a) **It is never acceptable to use sectioning powers when the action is not justified by the clinical condition of the patient;**

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31 Q 4

32 Q 9

33 Q 11

34 Q 18

35 Q 122

- b) **Patients have the right to discharge themselves from hospital unless they are subject to properly authorised detention under the Mental Health Act;**
- c) **All registered professionals are under a duty to raise concerns if they believe there are grounds for believing these principles are not being respected.**

## Availability of community services

34. Naomi James told us that community support services and peer support services had suffered cuts and she recounted anecdotal evidence that patients were facing long delays in accessing therapy.<sup>36</sup> Bruce Calderwood and Dr Griffiths sought to emphasise substantially increased investment in community mental health services over the last ten years but conceded that:

The latest figure we have for the last year's investment to 2012 shows that, although there was a cash increase of, I think, 1.5% that is actually a real terms reduction of 1%. So some places are reporting reductions, which is something that does disturb me.<sup>37</sup>

35. Reduced availability of community-based treatment is worrying and we are concerned that commissioners find it easier to cut mainstream mental health services than other services. Dr Griffiths told us that:

we have had block contracts for mainstream mental health services and not a payment by results tariff system that exists for acute hospitals. It is much easier to cut a block contract budget than it is a payment by results system and we are bringing in payment by results. It is a little harder to do in mental health, but we are bringing in a system and it is evolving as we speak.<sup>38</sup>

## Parity of esteem

36. The Health and Social Care Act 2012<sup>39</sup> and the Department of Health's Mandate to NHS England require that mental health be given 'parity of esteem' – which means that the care needs of mental health patients should have equal priority with the needs of patients who need physical healthcare. The practical test of this desirable principle will be whether local commissioners have the skills and knowledge to "make measurable progress towards achieving 'parity of esteem' by 2015".<sup>40</sup> We note the concern expressed by the All Party Parliamentary Group on Mental Health that Clinical Commissioning Groups will not have the skills or expertise to effectively commission mental health services.<sup>41</sup>

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36 Q 5

37 Q 76

38 Ibid

39 Health and Social Care Act 2012, section 1

40 HC Deb, 26 February 2013, c166

41 All Party Parliamentary Group on Mental Health, *Health and Social Care Reform: Making it work for mental health*, July 2012, p 3



37. Local commissioners and NHS England will be responsible for achieving ‘parity of esteem’ for patients needing mental and physical healthcare. The Department of Health can support these efforts by accelerating the development of commissioning and payment systems which reflect the policy objective. If this is not prioritised, the Committee is concerned that ‘parity of esteem’ will continue to be a meaningless aspiration. Enshrining a concept in legislation is only useful if the tools are available to make it a reality for patients.



### 3 Independent Mental Health Advocates

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38. The 2007 Act gave qualifying patients the right to support and assistance from an independent advocate. The Secretary of State has a duty to make reasonable arrangements to ensure this is available for qualifying patients who include those under detention or subject to a community treatment order. Independent Mental Health Advocates (IMHA) were, until April 2013, commissioned by Primary Care Trusts. From 1 April this year commissioning became the responsibility of local authorities.

39. In oral evidence Alison Cobb described the IMHA role as a key improvement to the legislation and described the service as “a really valuable provision and safeguard for people who are in a very powerless situation”.<sup>42</sup> Dr Chalmers added that clinicians knew that the service could work well.<sup>43</sup>

**40. The Committee agrees that the 2007 Act has improved safeguards for patients by providing a framework for improved patient advocacy.**

#### Access to advocacy

41. Recognition of the success of IMHAs must be accompanied by a number of qualifications. Our inquiry confirms evidence from the CQC that variation in access to IMHAs is a chronic problem within the system. In 2012 the CQC found that in 21% of care plans there was no evidence that patients had been informed of their legal right to an IMHA.<sup>44</sup> Naomi James told the Committee that a quarter of patients were unable to access advocacy, adding that there was “little equity of access and the style of provision is variable”.<sup>45</sup> Dr Chalmers said that providing good quality advocacy for patients with disabilities or communication problems was a challenge<sup>46</sup> and Naomi James said it represented a “broader systematic problem in mental health”<sup>47</sup> whereby services did not recognise a patient’s needs.

42. Naomi James argued that advocacy services were under pressure because “as the rate of detention increases, there are fewer people (IMHAs) to go round”.<sup>48</sup> Bruce Calderwood argued that the problems related to access were not linked to the rise in detentions.<sup>49</sup> He also argued that trends around access showed that “the problems of lack of access are reducing over time”.<sup>50</sup>

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42 Q 12

43 Q 17

44 Care Quality Commission, January 2013, p 5

45 Q 11

46 Q 25

47 Ibid

48 Q 15

49 Q 97

50 Ibid

43. Anne McDonald told us that research undertaken by the University of Central Lancashire found that for patients “the more you needed an advocate, the more difficult it was to access them.”<sup>51</sup> Naomi James reported that patients “are not accessing IMHAs early enough”<sup>52</sup> and “staff are often unaware of the legal duty on wards to inform patients”<sup>53</sup> Both Naomi James and Bruce Calderwood highlighted the CQC’s findings which pointed to considerable variation in the service available.<sup>54</sup>

44. The Department of Health has acknowledged that some patients have struggled to access IMHAs.<sup>55</sup> Dr Griffiths told us that a proposal that patients should automatically be referred to an IMHA was currently under consideration by the Department of Health.<sup>56</sup>

**45. We recommend that the IMHA service becomes an opt-out rather than an opt-in service. This measure would help address the difficulties patients face in accessing advocacy and eliminate some of the practical problems clinicians face in making patients aware of their right to request an IMHA.**

### *Responsibilities of clinicians*

46. The 2007 Act is explicit in its instruction that patients must be informed of their right to advocacy as soon as is practicable.<sup>57</sup> Anne McDonald told us that clinicians should not only explain to patients the rights that they have but that they should also “be facilitating people’s access to advocates”.<sup>58</sup> Naomi James said that in some cases staff made decisions about whether advocacy was required on behalf of patients.<sup>59</sup> Bruce Calderwood said that clinicians:

should not be judging whether it is in someone’s best interests to have an advocate, but it is people’s statutory right to have an advocate and therefore they need to be able to explain the statutory rights if the person does not understand. If the person is in a state of confusion and anguish, which will be quite common when people are first admitted, then they should explain regularly, until the person does understand it. The code of practice is very clear on that.<sup>60</sup>

47. Importantly, the CQC emphasises the point that whilst IMHAs have a statutory role to inform patients of their legal status and rights, this does not diminish the responsibility of nursing staff and doctors to communicate this information to patients. The CQC has warned that the presence of IMHAs should not allow hospital staff to abdicate responsibility for this aspect of patient care and they stressed:

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51 Q 98

52 Q 11

53 Ibid

54 Q 11, 95

55 Department of Health, July 2012, p 11

56 Q 97

57 Mental Health Act 2007, section 130A

58 Q 102

59 Q 11

60 Q 103

in practical terms, nursing staff have much greater contact with detained patients than IMHAs and are best placed to ensure that patients get the best opportunity to understand and exercise their rights.<sup>61</sup>

Naomi James identified a link between the existence of advocacy services and a retreat by clinicians from their responsibilities to inform patients of their rights.<sup>62</sup> Dr Chalmers agreed that this represented a question of good professional practice, explaining that

It is usually the nursing staff's core job to present the rights and to go back to patients. In the first few days of admission, people may be very distressed and may not want to engage in a discussion about rights, so that should be re-presented repeatedly. That is a requirement. If it is not happening, that needs to be picked up by the CQC and the trust board, and those responsible need to feed it back.<sup>63</sup>

48. Although IMHAs have an important supplementary role to play as independent advocates for patients, the Committee is in no doubt that the patient's primary advocates should be their clinicians. **We recommend that the review by the professional regulators of advice issued to clinicians, which we propose in Paragraph 33 of this report, should put this obligation for the clinician to be the advocate for the patient beyond doubt.**

### **Commissioning and funding**

49. Local authorities have been allocated responsibility for commissioning the IMHA service which predominantly supports patients undergoing NHS commissioned treatment. Local authorities already commission Independent Mental Capacity Advocates (IMCA)<sup>64</sup> and Bruce Calderwood explained that as local authorities already commissioned an advocacy service this reform would build on "the ability they already have".<sup>65</sup> Simon Lawton-Smith questioned whether local authorities would have the knowledge and skills to commission services which meet the needs of a range of patients.<sup>66</sup>

50. **The Committee accepts the basic logic of combining commissioning for similar advocacy services and believes that these added responsibilities represent an opportunity for local authorities to broaden and deepen their skills in this field. There is no regulator of independent mental health advocacy, so commissioners play a vital role in ensuring that advocacy services are of the necessary quality. We therefore urge local authorities to work cooperatively to ensure that patients across the country can access effective advocacy services.**

51. The Department of Health told us that £9.2 million had been made available through the local government funding formula to support the commissioning of independent

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61 Care Quality Commission, January 2013, p 25

62 Q 15

63 Q 16

64 IMCAs offer a similar service to IMHAs but support patients who lack capacity rather than those suffering from severe mental illness. These are typically patients in social care who have dementia or severe learning difficulties.

65 Q 99

66 Q 12

advocacy.<sup>67</sup> This funding is not protected by ring-fencing and will not be tracked to ensure that it is used for the intended purpose.<sup>68</sup>

**52. The Committee agrees that local commissioners should manage their own priorities and budgets, but draws their attention to their statutory duties in this respect. It recommends that every Health and Wellbeing Board should seek specific and quantified evidence from their local commissioners to satisfy themselves that these statutory duties are being discharged.**

## The role and function of advocates

53. Simon Lawton-Smith outlined concerns that the right to an IMHA did not extend to patients who voluntarily admitted themselves to hospital. Dr Griffiths explained that at the time of the 2007 Act IMHA services were not extended to voluntary patients as “it was felt that extending the formal IMHA role to all patients could destabilise some already existing good advocacy services.”<sup>69</sup> Both Mr Calderwood and Mr Lawton-Smith acknowledged that policy in Wales had been reformed to include voluntary patients within the Welsh IMHA service.

**54. Patients in hospital voluntarily are often equally as unwell as those detained under section. Voluntary patients enjoy few safeguards, and the Committee believes there is a compelling case to extend advocacy provision to this group of patients. Advocacy for patients with mental health problems is now well established and protecting existing services is not sufficient reason to exclude vulnerable people from a valuable service. IMHAs offer crucial assistance to patients and the Committee recommends that the 2007 Act should be amended to extend entitlement to IMHA support to all patients undergoing treatment on psychiatric wards or subject to CTOs.**

55. There appears to be some uncertainty over the scope of advice and guidance which IMHAs are able to offer to the patients they help. Anne McDonald told the Committee that, other than offering legal advice, IMHAs can provide formal advice to patients regarding the steps they should take and how to make best use of their rights.<sup>70</sup> This, however, is at odds with the Action for Advocacy code of practice which states that the advocacy role should include “gathering and presenting up-to-date and accurate information to help service users make informed choices but NOT [their emphasis] giving advice.”<sup>71</sup> Providers of IMHA services such as the charity SEAP say that advocates cannot “offer advice, opinions or judgements about what is best for you.”<sup>72</sup>

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67 Q 94

68 Qq 100–101

69 Q 122

70 Q 119

71 Action for Advocacy, May 2006, A Code of Practice for Advocates, p 8

72 <http://www.seap.org.uk/services/independent-mental-health-advocacy/about-independent-mental-health-advocacy.html>

56. Alison Cobb told us that it would be “worthwhile”<sup>73</sup> to consider extending the scope of the role and Naomi James concurred that advocates should be able to act as more formal advisers.<sup>74</sup>

**57. Part of the value of an IMHA lies in their ability to provide patients with advice which covers both mental health legislation and the health system. The Committee recommends that the Department should issue new guidance which clarifies both the scope and limitations of the advice and support which IMHAs are able to provide. The Committee also recommends that the Department should ensure that the training and accountability systems for IMHAs are appropriate in the context of the role they are expected to fulfil.**

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73 Q 12

74 Ibid

## 4 Places of safety

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### Background

58. Section 136 of the 1983 Act gives police officers the power to remove from a public place to a place of safety a person who they believe to be suffering from mental disorder. Detention for a maximum of 72 hours is permitted and places of safety include “a hospital, a care home for mentally disordered persons, a police station or any other suitable place whose occupier is willing to receive the patient temporarily.”<sup>75</sup> Police officers must be satisfied that the patient requires immediate care or control and the purpose of removal to a place of safety is to assess the patient’s condition.

59. The key reform of the 2007 Act was to allow patients to be removed from one place of safety to another during the 72 hour assessment period. The Department of Health believes that:

this provision has allowed some people detained under section 136 to be moved from a police station to a more appropriate environment for assessment, leading to better quality care during the section 136 detention and better decisions on their future care.<sup>76</sup>

60. Section 135 of the Mental Health Act allows for the police to remove a person from their own home to a place of safety if they have a magistrates’ order. Of 23,907 place of safety orders made in 2011–12 only 338 were under section 135. No removals to police custody were made under section 135 during this period.<sup>77</sup>

### Hospital-based places of safety

61. Since the implementation of the 2007 Act in November 2008 the use of hospital-based places of safety has increased by 66%.<sup>78</sup> Bruce Calderwood, however, did not attribute this growth to the provisions of the 2007 Act but rather to the capital investment in hospitals “to create more places of safety.”<sup>79</sup> Dr Chalmers also said that she did not believe that the power to convey had influenced the increased use of hospital-based places of safety. On the capital investment programme, Dr Chalmers said that whilst physical capacity had been made available, funding was not always in place to ensure these facilities are fully staffed.<sup>80</sup>

62. Dr Chalmers argued that trends in the application of section 136 detentions should be examined. She quoted statistics collected by The Health and Social Care Information Centre (HSCIC) which found that:

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75 CQC, January 2013, p 17

76 Department of Health, July 2012, p 18

77 The Health & Social Care Information Centre, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2011/12*, October 2012, p 18

78 Ibid, p 18

79 Q 141

80 Q 30

an estimated 8,667 orders were made where the place of safety was a police custody suite; this accounts for at least 37 per cent of the overall total of orders (23,569) made under Section 136.<sup>81</sup>

The HSCIC also reported that “there were 15,240 uses of place of safety orders (Sections 135 and 136) in hospitals; this figure is 6 per cent (841) greater than during 2010–11.”<sup>82</sup> To put this in context, “there has been an overall 26% increase in the use of section 136”<sup>83</sup> since 2005–06 but a 25% reduction in the use of police stations as places of safety. Over the same period the use of hospital based places of safety grew by 152%.

63. Supplementary evidence from the Department of Health stated that:

Figures were not collected on the number of transfers from police stations to health based places of safety... Anecdotally, the Department understands that these transfers are not a high proportion of the total number of uses of Section 136.<sup>84</sup>

**64. The Committee heard no evidence to challenge the Department of Health’s anecdotal view in relation to the power to convey. In the absence of such evidence the Committee does not favour elaborate reporting processes to prove that no problem exists, but recommends that since the Act has now been in force for five years the Department should commission an independent assessment of the impact of the power to convey in order to ensure that the legislation is working as intended.**

### ***Use of police custody***

65. Bruce Calderwood told us that although two-thirds of patients now went to a hospital-based place of safety this was:

still not good enough because it is very clear—and the code of practice makes it very clear—that it is justifiable at times to take people to a police station as a place of safety, but it ought to be exceptional.<sup>85</sup>

Dr Griffiths confirmed that less than 20% of those people held under section 136 were detained by clinicians for further assessment.<sup>86</sup> Dr Griffiths added that there was “very variable use of section 136”,<sup>87</sup> and this is certainly borne out by the statistics.

**66. People detained under section 136 are often distressed and can be very vulnerable, and the proportion who are subsequently detained by clinicians is surprisingly low. The Committee notes that the CQC has now been tasked with mapping access to hospital based places of safety, and welcomes the further trial of street triage whereby nurses**

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81 The Health & Social Care Information Centre, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2011/12*, October 2012, p 5

82 Ibid, p 5

83 Q 30

84 Ev 40

85 Q 142

86 Ibid

87 Q 147



join police officers to deal with incidents involving people with mental health problems. The Committee recommends that Health Ministers should work with their Home Office counterparts and police representatives to improve the operation of the place of safety provisions of mental health legislation. Better application of section 136 would relieve pressure on hospital-based places of safety and allow for a reduction in the use of police custody.

### ***Detention of children under Section 136***

67. In oral evidence Anne McDonald told the Committee that approximately 300 children had been detained under section 136 last year, although this figure was thought to be an underestimate.<sup>88</sup> She noted that there was little information regarding the eventual outcomes for children detained by the police in this manner<sup>89</sup> and this appeared to include a lack of data regarding the number children who end up being held in police custody.

68. Bruce Calderwood said that Ministers had been clear that the practice of holding children in a state of mental distress in police custody was unacceptable.<sup>90</sup> He outlined how the Department was approaching this issue and, referring to children held in police custody under section 136, he said:

That is one of the things that we need to work through with the Home Office around what practice is to see if we can reduce to a minimum the numbers of children in a state of mental distress who end up in a police station. Having said that, there will be circumstances where it is the right thing for an individual to do because it is not clear what is wrong. The crucial thing is that something happens fast and that the child is not left in a police station waiting for an assessment, waiting for help to arrive.<sup>91</sup>

69. The Committee is concerned that there is little information regarding the outcomes of children detained by the police under section 136 of the Mental Health Act. We believe that this form of detention should be regarded as a last resort and that any commonplace use of police custody as a place of safety for children is completely inappropriate. We recognise that circumstances may arise where, for their own safety and the safety of others, police officers may have no option but to hold a child in custody. It is the responsibility of local commissioners to work with providers to ensure that places of safety with suitable child protection and safeguarding arrangements are available to the police when a child is held under section 136.

**70. The Committee recommends that the Department of Health reviews as a matter of urgency the practice of detaining children under section 136 and, that as part of the review, it examines the outcomes for children detained in this way. This review should be undertaken with a view to identifying effective alternative options that can be used by the police and health care professionals.**

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88 Q 151

89 Q 152

90 Q 155

91 Ibid



## 5 Supervised Community Treatment

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71. Supervised Community Treatment (SCT) was introduced as part of the 2007 Act to enable some patients with mental disorder to live and be treated in the community whilst still being subject to recall to detention. SCT is only considered for those patients detained for treatment and must be agreed by an Approved Mental Health Professional (AMHP) for the purpose of delivering “appropriate medical treatment which is necessary for their health or safety or for the protection of others.”<sup>92</sup>

72. The conditions imposed are dependent on the specific circumstances of each case and they form part of the Community Treatment Order which is made by the clinician responsible. CTO conditions “cannot compel treatment or authorise deprivation of liberty”.<sup>93</sup>

### Purpose of the legislation

73. As of 31 March 2012 4,764 people were subject to CTOs in England.<sup>94</sup> As discussed in Chapter 2, evidence presented to the Committee has argued that CTOs have not reduced the number of people detained in psychiatric units. Simon Lawton-Smith argued that there was not the physical capacity to accommodate another 5,000 detained patients and that the provisions had added significantly to the total number of people subject to the Mental Health Act.<sup>95</sup>

74. Nevertheless Simon Lawton-Smith told us that supervised community treatment was in some cases “helping people to stay well in the community”<sup>96</sup> and that AMHPs had found that they were “useful to a degree”.<sup>97</sup> Naomi James argued that there was stigma attached to patients subject to CTOs associated with an emphasis placed on risk rather than development of a care-plan based around a broader concept of recovery.<sup>98</sup> Mr Lawton-Smith and Ms James both said that CTOs had tended to diminish the concept of treatment to involve simply medicating patients within the community.<sup>99</sup>

75. The impact assessment for the 2007 Act indicated that the introduction of CTOs would save the NHS approximately £34 million per year by 2014–15. As outlined in Chapter 2 this figure was calculated on the assumption that 10% of section 3 admissions would instead be placed under supervised community treatment.

76. The Department of Health’s supplementary evidence informs us that:

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92 Department of Health, July 2012, p 11

93 Care Quality Commission, January 2013, p 77

94 Ev 41

95 Q 33

96 Ibid

97 Ibid

98 Q 45

99 Qq 33, 45

at the time of the Act it was expected that the use of community treatment orders (CTOs) would build up gradually over five years, so that by 2013 around 3,000–4,000 people would be on CTOs at any one time. The Health and Social Care Information Centre reported 4,764 patients on CTOs in England on 31 March 2012.<sup>100</sup>

The Department of Health's memorandum explains that "the greater than expected numbers of patients on CTOs will have an impact on the true costs and benefits of CTOs"<sup>101</sup> but officials could not tell us if the projected saving is likely to be met.

**77. Debate continues about the value of CTOs, but no evidence was presented to the Committee which suggested that any short-term revision of the legislation is necessary. The Committee recommends that the Ministers keep this aspect of the legislation under review.**

### 'Revolving door' patients

78. In oral evidence the MHA argued that CTOs were being applied beyond the original intention of the legislation. They said that the purpose of the provisions in the 2007 Act was to address the 'revolving door syndrome' whereby patients left hospital, disengaged from treatment, deteriorated and were eventually readmitted to a psychiatric ward. On this basis, placing patients without a history of disengagement from treatment on CTOs is inappropriate in the view of the MHA. The MHA's written evidence outlines the extent to which CTOs have been used for patients who have no history of refusing to engage with treatment:

Care Quality Commission data (2009/10 Annual Report on the use of the Mental Health Act) suggests some 30% of people placed on a CTO have no history of non-compliance with treatment (so are not 'revolving door' patients).<sup>102</sup>

79. Simon Lawton-Smith outlined the nature of the MHA's concern:

I think there is an issue if someone enters hospital for the first time as a young man with, say, psychosis, and is immediately discharged under a community treatment order, without any evidence that they will necessarily not take their medication, relapse and have to go back into hospital. [...] During the House of Lords Committee stage, Lord Warner stated, 'One thing that has not changed as much as we would like, however, is the continuing number of revolving-door patients,'<sup>103</sup> so he specifically mentioned CTOs in terms of revolving-door patients. We are worried that they are being used perhaps inappropriately [...] for patients who do not have a history of continuing non-compliance.<sup>104</sup>

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100 Ev 41

101 Ibid

102 Ev 36

103 HL Deb, 17 January 2007, c701

104 Q 45

80. The Department of Health contests this interpretation of the legislation and said that the purpose of supervised community treatment had been misunderstood. Anne McDonald told the Committee that:

when the 2007 Act was originally debated there was an amendment that tried to restrict it to people who had been detained more than once. That amendment was not made, so Parliament's intention was not to restrict it to just that group but to put it to the clinical decision about the risk in the community rather than that group of patients.

This builds on the evidence in the Department of Health's memorandum to the Committee which acknowledged the fact that there was some dispute over the interpretation of the 2007 Act. The memorandum noted that:

Some commentators have asked why SCT is being used for people "it was not intended for", for example CQC's 2009/10 annual report questioned the number of SCT patients who do not have a history of non-compliance and this concern has been repeated in the Mental Health Alliance's recent report. These comments may be a misunderstanding of the original intention of the 2007 Act which was that SCT should be available to support "modern provision of mental health services, where treatment is based in the community rather than in hospital".<sup>105</sup>

Dr Griffiths admitted that "clearly the intention was to try and help support people who were in and out of hospital to remain better and more stable for longer."<sup>106</sup> He argued, however, that there are cases where CTOs could be useful for patients who did not meet these criteria, and said that he could envisage such circumstances.

**81. During the passage of the 2007 Act, Parliament considered and rejected the proposal that CTOs should be limited to those with a history of non-compliance. The Committee does not therefore believe that the current application of CTOs is incompatible with the 2007 Act.**

**82. Although the Committee is satisfied that the operation of CTOs does reflect the intention of the legislation, it is right that this intention is kept under review. Compulsory medical treatment, whether in the community or in hospital, raises serious civil rights issues and needs to be supported by evidence of its need and its effectiveness.**

## Effectiveness of community treatment orders

83. The results of the Oxford Community Treatment Order Evaluation Trial (OCTET) undertaken in 2012 and led by Professor Tom Burns at the University of Oxford tell us that CTOs have not succeeded in reducing the readmission to hospital as compared with section 17 leave. Section 17 leave is "a well established rehabilitation practice used for brief

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<sup>105</sup> Department of Health, July 2012, p 12–13

<sup>106</sup> Q 126

periods to assess the stability of a patient's recovery after or during a period of involuntary treatment".<sup>107</sup>

84. The Committee has been advised that this randomised control trial represents the most rigorous analysis yet of CTOs in England. Professor Burns and his team found no "support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty".<sup>108</sup> **In light of the OCTET research findings the Committee recommends that Ministers should review the current operation of CTOs.**

85. **The Committee does not object to the principle of supervised community treatment in defined circumstances and agrees with Dr Griffiths that it is possible to envisage justifying a CTO on grounds other than a previous record of non-compliance with a treatment regime after discharge from hospital. The Committee is, however, struck that the evidence base for this policy remains sparse, with the result that the argument has not developed far since the passage of the legislation. The Committee recommends that the Department should commission a fuller analysis of the value of a CTO in different clinical situations.**

### Variation in the use of CTOs

86. Across England there have also been substantial variations in the use of CTOs. The CQC found that the "lowest reported 'discharge rate' onto a CTO was 4% and the highest 45.5%".<sup>109</sup> These figures are a proportion of the total number of admissions under the Mental Health Act for each health care organisation. The CQC also found that "a number of NHS organisations with considerable rates of detention under the Act provided nil returns for the use of CTO".<sup>110</sup>

87. Dr Griffiths explained to the Committee that variation was to be expected because differing demographics in local areas required diverse service configurations.<sup>111</sup> He also said that although he was not comfortable with the degree of variation, the use of a CTO was a clinical decision.<sup>112</sup>

88. The role of mental health tribunals was called in to question by the Mental Health Alliance. Dr Chalmers told us in oral evidence that:

There was quite a push from the tribunal service for us to consider placing people on CTOs. If we did not, they would adjourn and come back and ask us what our decision making was around that.<sup>113</sup>

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107 Professor Tom Burns, Community Treatment Orders for patients with psychosis (OCTET): a randomised control trial, *The Lancet*, Vol 381(2013), p 3

108 Ibid, p 1

109 CQC, January 2013, p 77

110 Ibid p 80

111 Q 127

112 Ibid

113 Q 43

Dr Griffiths acknowledged concern in this area, but argued that this was more as a result of confusion around the wishes of tribunals than a specific push towards CTOs. Dr Griffiths said that tribunals asked the question:

“Have you considered a CTO?”, because they are anxious that people should consider the least restrictive option at all times. It seems to me that what some clinicians may do is interpret that as meaning the tribunals expect them to be put on a CTO. The tribunals say that is not what they are saying but that they are merely asking whether they have considered it. To what extent that may be driving behaviour is unclear.<sup>114</sup>

### *Clinical debate*

89. The oral evidence presented by the MHA demonstrated that there was division within the psychiatric community regarding the use of CTOs. Simon Lawton-Smith highlighted a survey of over 500 psychiatrists, the results of which had found that 325 respondents thought CTOs were useful and 74 did not.<sup>115</sup> He added that some psychiatrists believed CTOs to be unethical. The MHA acknowledge that some variation would be driven by demographics but Dr Chalmers conceded that:

CTOs split the profession initially. Some felt that they were overly paternalistic [...] Others were quite keen.<sup>116</sup>

90. The CQC has criticised the inclusion of vague conditions within CTOs, highlighting requirements such as ‘not abusing alcohol’ as being meaningless without a definition of what constitutes abuse.<sup>117</sup> Naomi James explained to the Committee that the loss of choice and control had a negative impact on patients and the stigma attached to CTOs existed as a result of being subject to conditions “without choice”.<sup>118</sup>

91. Dr Chalmers said:

This is a good practice issue [...] I certainly do not think we should tell people how to live their lives, but some doctors have felt that they have the power to put in place a lot of unreasonable conditions.[...] It is something about which the college has concerns, and on which we want to issue good practice guidelines.<sup>119</sup>

**92. Although the Committee accepts that use of a CTO in an individual case is a clinical decision, we are surprised by the extent of variation between clinicians. The Committee recommends that the Royal College of Psychiatrists should engage with the evidence review recommended at Paragraph 85 and draw its conclusions to the attention of its members. The Committee does not believe that wide variations of clinical practice should be permitted to continue without serious professional challenge.**

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<sup>114</sup> Q 131

<sup>115</sup> Q 40

<sup>116</sup> Q 43

<sup>117</sup> CQC, January 2013, p 81

<sup>118</sup> Q 45

<sup>119</sup> Q 42

## Effect of financial pressures on clinical decisions

93. Whatever the outcome of the clinical debate, there is no justification for clinical decisions, in particular about the civil rights of vulnerable patients, being distorted by financial pressures. In this context the Committee is concerned that the pressure on beds in psychiatric wards outlined in Chapter 1 may also be driving the inappropriate use of CTOs. Simon Lawton-Smith told the Committee that 25% of all CTOs were revoked with the patient readmitted to hospital. He said:

It is possible that people were discharged from hospital earlier than they should have been, maybe to free up a bed. There is no firm evidence on that, but it is obviously a danger when there is such pressure on beds.<sup>120</sup>

**94. The absence of clear clinical guidelines supported by robust analysis of the evidence increases the risk that individual decisions will be distorted by financial considerations. This consideration reinforces the need for the review of the evidence recommended in Paragraph 85, supported by the engagement of the Royal College of Psychiatrists recommended in Paragraph 92.**

## 6 Interaction with the Mental Capacity Act 2005

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### Deprivation of liberty safeguards

95. The Deprivation of liberty safeguards (DOLS) were included in the 2007 Act as “an addition to the 2005 Mental Capacity Act”.<sup>121</sup> It was determined that existing practice in this area did not comply with the European Convention on Human Rights in respect of detention for their own safety of people who lack capacity. The Department of Health describes the purpose of DOLS as to:

provide a statutory framework for authorising the deprivation of liberty for people who lack the capacity to consent to treatment or care, where in their own best interests, that care can only be provided in circumstances that amount to a deprivation of liberty.<sup>122</sup>

The DOLS came in to effect in April 2009 and apply in hospitals and care homes (but **not** supported living) in relation to adults aged over 18 years of age:

- who suffer from a mental disorder — such as dementia or a learning disability
- who lack the capacity to give informed consent to the arrangements made for their care and / or treatment and
- who are considered to be at risk of harm if they are not deprived of liberty (as per Article 5 of the ECHR)
- where it is in their best interests, according to the Mental Capacity Act 2005, to be deprived of their liberty in a hospital or care home.<sup>123</sup>

96. DOLS apply to people detained under the Mental Capacity Act 2005 (MCA). Patients detained under section via the Mental Health Act are in most cases protected by the safeguards of the Mental Health Act. Specific safeguards established within the DOLS include provisions to:

- provide the person with a representative
- allow a right of challenge to the Court of Protection against the unlawful deprivation of liberty
- provide a right for deprivation of liberty to be reviewed and monitored regularly

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<sup>121</sup> The Mental Health Alliance, May 2012, p 9

<sup>122</sup> Department of Health, July 2012, p 20

<sup>123</sup> The Mental Health Alliance, May 2012, p 11



## Implementation of the safeguards

97. Implementation of DOLS has proved problematic, with wide variation in their use. A key finding of the MHA was the disparity in application and authorisation rates between supervisory bodies and much a lower overall use of DOLS than predicted. The MHA attributed this to differences in training and guidance issued by different supervisory bodies who determine their own policies and interpretation. The MHA's written memorandum noted that:

Some supervisory bodies with very low activity rates have claimed that this reflects their success in persuading care providers in their areas to adopt less restrictive care practices. However, this flies in the face of the evidence from the regulators that their inspectors are frequently coming across instances of potential deprivation of liberty and of staff who are ignorant of the legal requirements in these circumstances.<sup>124</sup>

98. The Department of Health acknowledged the variation in implementation of DOLS but said that an overall growth in the use of the safeguards meant that "the safeguards are becoming better understood and there is increasing awareness."<sup>125</sup> In oral evidence however, Bruce Calderwood was circumspect. He said that the variation in use of DOLS had been "extreme"<sup>126</sup> but as yet there was no understanding why such extreme variation had occurred.<sup>127</sup>

## Clinical responsibility

99. The process for applying to protect a patient with DOLS includes an independent assessment of that patient. The care home or hospital, commonly known as the managing authority, must apply to a supervisory authority (local authorities and PCTs until April 2013 and now solely local authorities) for the independent assessment to be undertaken. The MHA reported in 2012 that 75% of DOLS cases were already dealt with by local authorities: this was likely to be because the majority of patients whose deprivation of liberty was authorised were dementia sufferers in care homes.<sup>128</sup>

100. Assessments must be undertaken by a best interest assessor and a mental health assessor. The Alzheimer's Society guidance explains:

The best interests assessment must be carried out by someone who is not involved in that person's care or in making decisions about it. [...] The best interests assessor must be an approved mental health professional, or a qualified social worker, nurse, occupational therapist or chartered psychologist with the appropriate training and experience.

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<sup>124</sup> Ibid, p 11

<sup>125</sup> Department of Health, July 2012, p 23

<sup>126</sup> Q 179

<sup>127</sup> Q 186

<sup>128</sup> Mental Health Alliance, May 2012, p 9



The mental health assessor must be a doctor who is able to assess whether a person is suffering from a mental disorder.<sup>129</sup>

101. Bruce Calderwood told the Committee that it was the assessors who were best placed to understand how the safeguards should be implemented. He said

the real experts on this are the people doing the assessment. There is less evidence of people feeling confident in about identifying when to make applications to the assessors.<sup>130</sup>

## Urgent need for action

102. One of the complaints of the MHA regarding DOLS concerns a lack of understanding of the original legislation. They said that care providers did not:

know when they were exceeding the powers it gave them and would therefore need to apply for a DOLS authorisation, or how the MCA could be used appropriately, sometimes negating a need for DOLS.<sup>131</sup>

In addition the MHA have found a lack of understanding amongst providers and care staff regarding the “meaning of deprivation of liberty in practice”<sup>132</sup> and a resistance to use DOLS because of the complex processes involved and “widespread anxiety and defensiveness about care standards and practice”.<sup>133</sup> Also recorded are “a high level of legal and procedural errors caused by the complexity of the scheme coupled with inadequate staff training.”<sup>134</sup>

103. The CQC also reports confusion amongst staff as to the legal status of patients, which results in uncertainty regarding deprivation of liberty.<sup>135</sup>

104. The absence of a standard definition of deprivation of liberty has hampered the ability of staff to properly interpret the guidance in relation to DOLS, according to the MHA.<sup>136</sup> In oral evidence Dr Chalmers explained the problems of trying to encapsulate the concept of deprivation of liberty:

Unlike under the Mental Health Act, where detention is seen as being locked up—a locked door in a hospital—the concept of the deprivation of liberty safeguards, the case law and the description of what might constitute a deprivation of liberty are much more holistic. I think it has a value because of that, as it pulls in things that relate not just to article 5, the right to liberty: a lot of the cases have arisen because people are not getting access to their families. There is something quite rich in the

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129 [http://www.alzheimers.org.uk/site/scripts/documents\\_info.php?documentID=1327](http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1327)

130 Q 182

131 Mental Health Alliance, May 2012, p 10

132 Ibid

133 Ibid

134 Ibid

135 CQC, January 2013, p 35

136 Mental Health Alliance, May 2012, p 13

concept, but, given that, there are difficulties of definition. I would think that it needs more debate.<sup>137</sup>

105. Dr Chalmers suggested that stronger guidance and support from the Department of Health was necessary to help clinicians interpret the law. She indicated that the Department of Health had reduced support for clinicians and practitioners in this area. Dr Chalmers said:

It was helpful when there was a sort of DOLS group and the Department of Health published a sort of resume of the case law, to give some kind of interpretation—a kind of practical “What does the law mean?” [...] Experts need to get together and say, “This is what we think. This is the consensus view on what the law at this point means for practitioners”—a very easy-to-read kind of thing. [...] Rather than giving an absolute definition, we need more finessing, understanding and interpretation by the right people of what the case law means for me as a practitioner on the ground.<sup>138</sup>

Dr Chalmers accepted that this was something clinicians could lead the way on in order to drive the process but argued that it required the weight of a more authoritative body to reassure practitioners.<sup>139</sup>

**106. The Committee found the evidence it received about the effective application of deprivation of liberty safeguards (DOLS) for people suffering from mental incapacity profoundly depressing and complacent. The Department itself described the variation as “extreme”. People who suffer from lack of mental capacity are among the most vulnerable members of society and they are entitled to expect that their rights are properly and effectively protected. The fact is that despite fine words in legislation they are currently widely exposed to abuse because the controls which are supposed to protect them are woefully inadequate.**

**107. Against this background, the Committee recommends that the Department should initiate an urgent review of the implementation of DOLS for people suffering from mental incapacity and calls for this review to be presented to Parliament, within twelve months, together with an action plan to deliver early improvement.**

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137 Q 52

138 Q 52

139 Q 54

## 7 Ethnicity and the use of the Mental Health Act

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### Disproportionate representation of minority ethnic groups

108. The CQC found in 2011–12 that there was a “continuing trend in high rates of detention amongst certain black and minority ethnic groups.”<sup>140</sup> The general trend for hospitalisation and detention under the Mental Health Act 1983 is at disproportionately high rates amongst minority ethnic groups. Rates of detention were 2 to 13 times greater than was expected<sup>141</sup> and this particularly applies to the Black and Black British population.<sup>142</sup>

109. We heard evidence about the experiences of minority ethnic groups within the mental health system and the reasons which explained much higher rates of detentions amongst these groups. The MHA have found that Mixed, Black and Black British groups are “40% more likely than people in the White group to be using mental health services, with or without compulsion.”<sup>143</sup> In oral evidence Alison Cobb expanded on this and told the Committee that it might be the case that:

people from black communities may be afraid of services and have fears around being detained, medication or how they might be treated. The impact of that results in damaged trust and people not wanting to engage with services and, perhaps, delaying making contact with services until really late in the piece, when it may be more likely that the Act will be used.<sup>144</sup>

110. The Department of Health accepts that there is:

long-standing concern about the disproportionate numbers of people from minority ethnic groups, particularly Black Caribbean, Black African and other Black groups, using in-patient mental health services and detained under the 1983 Act.<sup>145</sup>

Bruce Calderwood spoke in more detail about this concern, saying that this problem was specific to migrant communities. Specifically discussing detention, he said:

There are higher rates here than there are in either the Caribbean or in Africa, so there is something around the experience of black and Afro Caribbean people in this country as opposed to where they, their parents or grandparents come from, which actually is helping to cause much higher levels of psychosis than in the general population.<sup>146</sup>

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<sup>140</sup> CQC, January 2013, p 16

<sup>141</sup> Ibid, p 17

<sup>142</sup> Q 170

<sup>143</sup> Mental Health Alliance, May 2012, p 18

<sup>144</sup> Q 63

<sup>145</sup> Department of Health, July 2012, p 13

<sup>146</sup> Q 170

Dr Griffiths added that this was not simply a problem which England or the United Kingdom must address and that “It is a phenomenon all over the world that migrant populations have higher rates of mental illness.”<sup>147</sup> Bruce Calderwood told the Committee that there was also a ‘London effect’ whereby:

The pattern of detention due to the Mental Health Act in London is very different from the rest of the country, and that seems to be, again, to do with social isolation, homelessness and people not having anyone to look after them. It is very difficult to disentangle race effects from the London effects.<sup>148</sup>

Anne McDonald told us that social factors attached to living in London along with the city being a major transport hub might be part of this phenomenon. Interestingly, she said that:

if you present for an assessment under the Mental Health Act, the [...] likelihood of actually being detained are very similar between Birmingham and Oxford but much higher in London.<sup>149</sup>

111. Bruce Calderwood and Dr Griffiths argued in their evidence that the disproportionate detention of people from black communities could not be attributed to institutional racism in the system. They accepted that, inevitably, racism would occur and acknowledged that racism in society might be a driver of mental health problems.<sup>150</sup> Overall, however, they concluded that “it looks as if the much higher rate of the use of the Mental Health Act can be explained to a considerable extent by some of these demographic characteristics.”<sup>151</sup>

## Effect of the 2007 Act

112. We did not take any evidence which claimed that the 2007 Act was inherently weighted against certain people or communities or had exacerbated the problems identified within the system. It is telling, however, that 15% of CTOs issued between 2008–2011 were for Black or Black British patients.<sup>152</sup> This group represented approximately 3% of the population in 2009 and it demonstrates that even the most recent innovations in care have not managed to overcome the ethnic imbalance. The extent to which CTOs are issued to Black patients is even more disproportionate than the rates of detention under the Mental Health Act. Bruce Calderwood explained to the Committee that when a patient is detained under the Mental Health Act:

it is not just about diagnosis and whether you have a mental disorder; it is about risk. There are many determinants of risk, some of which are contained in your social circumstances.<sup>153</sup>

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147 Ibid

148 Q 173

149 Q 175

150 Q 170 ff.

151 Ibid

152 CQC, January 2013, p 89

153 Q 170

Naomi James told us that some patients subject to CTOs had reported elements of risk being too heavily weighted in their care plans.<sup>154</sup> The evidence presented to the Committee demonstrated that societal factors which create risk will influence clinical decisions regarding treatment.

113. Alison Cobb emphasised the significance of delivering advocacy services to detained patients and those on CTOs. In Chapter 2 we identified the problem that those most in need of advocacy were least likely to be able to access it. The University of Central Lancashire found that this problem is apparent for minority ethnic groups.<sup>155</sup> This is a failing in the system which we believe can be resolved.

114. Introducing the Bill to Parliament, Lord Warner said that decisions around treatment must consider whether services are “culturally appropriate”.<sup>156</sup> This is a vital consideration and it is right that the legislation should address this point. It is, however, the responsibility of NHS England and clinical commissioners to commission and construct mental health services that make the legislative intent a practical reality.

**115. Effective commissioning of advocacy by local authorities can begin to tackle the failure to provide minority ethnic patients with a robust advocacy service. Anne McDonald said that it is important to commission in a way “which improves quality and access”<sup>157</sup> and this should be a priority in relation to advocacy. Helping Black patients to use and exploit their rights would be a small but important step in begin to address the disproportionate number of Black patients subject to the provisions of the Mental Health Act.**

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154 Q 45

155 Department of Health, July 2012, p 18

156 HL Deb, 28 November 2006, col 658

157 Q 179

## Conclusions and recommendations

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### Impact of Community Treatment Orders on detention

1. It is of concern to the Committee that the Department of Health does not have a clear picture as to the factors which are driving increased rates of detention. In particular, a lack of data on readmissions means that there is no information to illustrate whether pressure on beds is detrimentally affecting the treatment of those patients eventually detained under section. (Paragraph 24)

### Detention in place of voluntary admissions

2. We recommend that the Department of Health urgently investigates whether patients have been sectioned in order to access psychiatric units and reports to Parliament on the prevalence of this practice within the mental health system. (Paragraph 29)
3. We are concerned about reports of practices such as de-facto detention of patients. Although such practices appear less serious than the use of sectioning powers to secure access to hospital, we welcome Dr Chalmers' clear statement that these practices are "not okay", and inconsistent with the clinician's professional obligations to the patient. (Paragraph 32)
4. We recommend that the professional regulators should review their advice to clinicians about their obligations in the context of the use of sectioning powers under the Mental Health Act. In particular we recommend that their advice should reflect the following principles:

It is never acceptable to use sectioning powers when the action is not justified by the clinical condition of the patient;

Patients have the right to discharge themselves from hospital unless they are subject to properly authorised detention under the Mental Health Act;

All registered professionals are under a duty to raise concerns if they believe there are grounds for believing these principles are not being respected. (Paragraph 33)

### Parity of esteem

5. Local commissioners and NHS England will be responsible for achieving 'parity of esteem' for patients needing mental and physical healthcare. The Department of Health can support these efforts by accelerating the development of commissioning and payment systems which reflect the policy objective. If this is not prioritised, the Committee is concerned that 'parity of esteem' will continue to be a meaningless aspiration. Enshrining a concept in legislation is only useful if the tools are available to make it a reality for patients. (Paragraph 37)

## Independent Mental Health Advocates

6. The Committee agrees that the 2007 Act has improved safeguards for patients by providing a framework for improved patient advocacy. (Paragraph 40)

## Access to advocacy

7. We recommend that the IMHA service becomes an opt-out rather than an opt-in service. This measure would help address the difficulties patients face in accessing advocacy and eliminate some of the practical problems clinicians face in making patients aware of their right to request an IMHA. (Paragraph 45)

## Responsibilities of clinicians

8. We recommend that the review by the professional regulators of advice issued to clinicians, which we propose in Paragraph 33 of this report, should put this obligation for the clinician to be the advocate for the patient beyond doubt. (Paragraph 48)

## Commissioning and funding

9. The Committee accepts the basic logic of combining commissioning for similar advocacy services and believes that these added responsibilities represent an opportunity for local authorities to broaden and deepen their skills in this field. There is no regulator of independent mental health advocacy, so commissioners play a vital role in ensuring that advocacy services are of the necessary quality. We therefore urge local authorities to work cooperatively to ensure that patients across the country can access effective advocacy services. (Paragraph 50)
10. The Committee agrees that local commissioners should manage their own priorities and budgets, but draws their attention to their statutory duties in this respect. It recommends that every Health and Wellbeing Board should seek specific and quantified evidence from their local commissioners to satisfy themselves that these statutory duties are being discharged. (Paragraph 52)

## The role and functions of advocates

11. Patients in hospital voluntarily are often equally as unwell as those detained under section. Voluntary patients enjoy few safeguards, and the Committee believes there is a compelling case to extend advocacy provision to this group of patients. Advocacy for patients with mental health problems is now well established and protecting existing services is not sufficient reason to exclude vulnerable people from a valuable service. IMHAs offer crucial assistance to patients and the Committee recommends that the 2007 Act should be amended to extend entitlement to IMHA support to all patients undergoing treatment on psychiatric wards or subject to CTOs. (Paragraph 54)
12. Part of the value of an IMHA lies in their ability to provide patients with advice which covers both mental health legislation and the health system. The Committee



recommends that the Department should issue new guidance which clarifies both the scope and limitations of the advice and support which IMHAs are able to provide. The Committee also recommends that the Department should ensure that the training and accountability systems for IMHAs are appropriate in the context of the role they are expected to fulfil. (Paragraph 57)

### **Hospital-based places of safety**

13. The Committee heard no evidence to challenge the Department of Health's anecdotal view in relation to the power to convey. In the absence of such evidence the Committee does not favour elaborate reporting processes to prove that no problem exists, but recommends that since the Act has now been in force for five years the Department should commission an independent assessment of the impact of the power to convey in order to ensure that the legislation is working as intended. (Paragraph 64)

### **Use of police custody**

14. People detained under section 136 are often distressed and can be very vulnerable, and the proportion who are subsequently detained by clinicians is surprisingly low. The Committee notes that the CQC has now been tasked with mapping access to hospital based places of safety, and welcomes the further trial of street triage whereby nurses join police officers to deal with incidents involving people with mental health problems. The Committee recommends that Health Ministers should work with their Home Office counterparts and police representatives to improve the operation of the place of safety provisions of mental health legislation. Better application of section 136 would relieve pressure on hospital-based places of safety and allow for a reduction in the use of police custody. (Paragraph 66)

### **Detention of children under Section 136**

15. The Committee recommends that the Department of Health reviews as a matter of urgency the practice of detaining children under section 136 and, that as part of the review, it examines the outcomes for children detained in this way. This review should be undertaken with a view to identifying effective alternative options that can be used by the police and health care professionals. (Paragraph 70)

### **Purpose of the legislation**

16. Debate continues about the value of CTOs, but no evidence was presented to the Committee which suggested that any short-term revision of the legislation is necessary. The Committee recommends that the Ministers keep this aspect of the legislation under review. (Paragraph 77)

### **'Revolving door' patients**

17. During the passage of the 2007 Act, Parliament considered and rejected the proposal that CTOs should be limited to those with a history of non-compliance. The



Committee does not therefore believe that the current application of CTOs is incompatible with the 2007 Act. (Paragraph 81)

18. Although the Committee is satisfied that the operation of CTOs does reflect the intention of the legislation, it is right that this intention is kept under review. Compulsory medical treatment, whether in the community or in hospital, raises serious civil rights issues and needs to be supported by evidence of its need and its effectiveness. (Paragraph 82)

### **Effectiveness of community treatment orders**

19. In light of the OCTET research findings the Committee recommends that Ministers should review the current operation of CTOs. (Paragraph 84)
20. The Committee does not object to the principle of supervised community treatment in defined circumstances and agrees with Dr Griffiths that it is possible to envisage justifying a CTO on grounds other than a previous record of non-compliance with a treatment regime after discharge from hospital. The Committee is, however, struck that the evidence base for this policy remains sparse, with the result that the argument has not developed far since the passage of the legislation. The Committee recommends that the Department should commission a fuller analysis of the value of a CTO in different clinical situations. (Paragraph 85)

### **Clinical debate**

21. Although the Committee accepts that use of a CTO in an individual case is a clinical decision, we are surprised by the extent of variation between clinicians. The Committee recommends that the Royal College of Psychiatrists should engage with the evidence review recommended at Paragraph 85 and draw its conclusions to the attention of its members. The Committee does not believe that wide variations of clinical practice should be permitted to continue without serious professional challenge. (Paragraph 92)

### **Effect of financial pressures on clinical decisions**

22. The absence of clear clinical guidelines supported by robust analysis of the evidence increases the risk that individual decisions will be distorted by financial considerations. This consideration reinforces the need for the review of the evidence recommended in Paragraph 85, supported by the engagement of the Royal College of Psychiatrists recommended in Paragraph 92. (Paragraph 94)

### **Urgent need for action**

23. The Committee found the evidence it received about the effective application of deprivation of liberty safeguards (DOLS) for people suffering from mental incapacity profoundly depressing and complacent. The Department itself described the variation as “extreme”. People who suffer from lack of mental capacity are among the most vulnerable members of society and they are entitled to expect that their rights are properly and effectively protected. The fact is that despite fine words in

legislation they are currently widely exposed to abuse because the controls which are supposed to protect them are woefully inadequate. (Paragraph 106)

24. Against this background, the Committee recommends that the Department should initiate an urgent review of the implementation of DOLS for people suffering from mental incapacity and calls for this review to be presented to Parliament, within twelve months, together with an action plan to deliver early improvement. (Paragraph 107)

### **Effect of the 2007 Act**

25. Effective commissioning of advocacy by local authorities can begin to tackle the failure to provide minority ethnic patients with a robust advocacy service. Anne McDonald said that it is important to commission in a way “which improves quality and access” and this should be a priority in relation to advocacy. Helping Black patients to use and exploit their rights would be a small but important step in begin to address the disproportionate number of Black patients subject to the provisions of the Mental Health Act. (Paragraph 115)

# Formal Minutes

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**Wednesday 10 July 2013**

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper  
Grahame M. Morris  
Andrew Percy

Mr Virendra Sharma  
David Tredinnick  
Valerie Vaz

Draft Report (*Post-legislative scrutiny of the Mental Health Act 2007*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 115 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the First Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be printed with the Report.

[Adjourned till Tuesday 16 July at 2.00 pm]

## Witnesses

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### Tuesday 26 February 2013

Page

**Alison Cobb**, Senior Policy and Campaigns Officer, Mind, and Chair, Mental Health Alliance, **Simon Lawton-Smith**, Head of Policy, Mental Health Foundation, **Dr Julie Chalmers**, consultant psychiatrist, lead on Mental Health Act, Royal College of Psychiatrists, and **Naomi James**, National Survivor User Network.

Ev 1

### Tuesday 12 March 2013

**Dr Hugh Griffiths**, National Clinical Director for Mental Health, **Bruce Calderwood**, Director of Mental Health, Disability and Equality, and **Anne McDonald**, Deputy Director of Mental Health, Department of Health.

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## List of printed written evidence

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# List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

## Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584
Second Report	Urgent and emergency services	HC 171

## Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

## Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)

Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)

# Oral evidence

## Taken before the Health Committee

on Tuesday 26 February 2013

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper  
Andrew George  
Barbara Keeley  
Grahame M. Morris

Andrew Percy  
David Tredinnick  
Dr Sarah Wollaston

### Examination of Witnesses

*Witnesses:* **Alison Cobb**, Senior Policy and Campaigns Officer, Mind, and Chair, Mental Health Alliance, **Simon Lawton-Smith**, Head of Policy, Mental Health Foundation, **Dr Julie Chalmers**, consultant psychiatrist, lead on Mental Health Act, Royal College of Psychiatrists, and **Naomi James**, National Survivor User Network, gave evidence.

**Q1 Chair:** Good morning. Thank you for joining us this morning. This is a relatively new form of inquiry by a Select Committee, looking not at what the effect of a piece of legislation is going to be but at what the effect of a piece of legislation has been, five years after it was passed, in order to try to draw out some of the experiences that we should recognise and to inform policy for the future. It is an important part of this Committee's work. Welcome to this session. Can I ask you to begin by introducing yourselves briefly to us?

**Alison Cobb:** Hello; my name is Alison Cobb. I am the senior policy and campaigns officer at Mind, the mental health charity, and I chair the Mental Health Alliance.

**Simon Lawton-Smith:** I am Simon Lawton-Smith. I am head of policy at the Mental Health Foundation.

**Dr Chalmers:** I am Dr Julie Chalmers. I am a consultant psychiatrist. I am the specialist adviser on mental health legislation to the Royal College of Psychiatrists.

**Naomi James:** I am Naomi James. I work for NSUN—the National Survivor User Network.

**Q2 Chair:** Thank you very much. I would like to open the questioning by asking you what you think the impact has been of the change in the test under the 2007 Act, which introduced the test of “appropriate treatment” rather than “treatability”. I remember that when I was Secretary of State I was told that there was a very small group of patients for whom compulsory treatment would be in their and society's interests, but for whom that was felt by some professionals not to be possible within the current legislation. Has that problem been addressed by this change of wording in the Act? Have there been any other changes that you would like to draw to our attention?

**Dr Chalmers:** It is a very interesting question. As you know, it caused considerable debate at the time. From the psychiatric perspective, certainly, there was a lot of concern around preventive detention. As you say, that change focused on a very small group of people with antisocial personality disorder. I think that it has had very little impact on the practice of psychiatrists,

perhaps because the approach to personality disorder is going to be shaped not particularly by legislation but by new initiatives and other treatment methods. Putting that to one side, has there been any impact? I can really give you only anecdotal evidence, from talking to my colleagues in the forensic faculty. They would say no. Some hard evidence I might be able to give you would be to look at the rates of admission under part 3, which relates to admissions from court under the Mental Health Act. The figures suggest that, unlike civil detentions under sections 2 and 3, where there was a rise of 5% last year, we are seeing a kind of static picture. There has not been an explosion in this group of people—acknowledging, of course, that it was a small group. So, as far as we can tell, there has been no significant impact.

**Q3 Chair:** Was the change motivated specifically by that concern about people with personality disorder, or was there a broader policy reason for changing the test from “treatability” to “appropriate treatment”?

**Dr Chalmers:** I was not part of the alliance at that point. Alison Cobb, who was, may be able to answer that for you.

**Alison Cobb:** At the time, there was certainly a discourse around public protection. I think personality disorder was part of that, but there was a more general feeling that there might be people who, in some sense, should be treated who might not be able to be detained if there were not some more flexibility over the definition. Of course, I am now speaking to the policy intention behind the legislation. As the Mental Health Alliance, we would tend to assess the impact by the alliance's values and the ambitions that we would have had for legislation. However, I think the policy intention behind the Act was around a sense of having to ensure that people could be detained if that was felt to be necessary.

**Q4 Chair:** There have been rising numbers of detentions. Why is that? Is it true that people have been detained under the new Act who would not have been detained under the old Act, or is it simply a rising incidence of conditions?



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26 February 2013 Alison Cobb, Simon Lawton-Smith, Dr Julie Chalmers and Naomi James

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**Alison Cobb:** As Julie said, leaving aside community treatment orders, which are, of course, new—

**Chair:** We will come on to them.

**Alison Cobb:** Leaving those aside, I do not think there has been a particular change in the reasoning and the clinical decision making. There are quite a lot of reasons that could help to account for the rise in detention, which concerns us very much.

**Dr Chalmers:** As I said before, the main rise in the number of detentions is under part 2 of the Act—people coming under section 2, which is the assessment section, or section 3, for treatment. In fact, there has been a subtle change in the balance between sections 2 and 3, with more section 2s occurring and the number of treatment orders under section 3 dropping. Overall, since last year there has been a 5% increase. That has to be concerning to all of us, because the trend is for the number to rise, although I think it is flattening out a little bit.

The interesting question is: why is that occurring? I do not think there is a simple answer to that. There are complex reasons, and different factors may operate in different areas. However, the one bit of research evidence that we have, which would certainly chime with professional experience, is a study in 2011 by Patrick Keown and colleagues in Cambridge, which showed that there was an association—I am not saying that this is a causal link—between the reduction in bed numbers and, in the next year, an increase in involuntary admissions. Beds seem to be part of this story. The CQC presents a very powerful argument in its most recent report outlining what it is like on some psychiatric wards. It recognises that there is good practice in some areas but also highlights one of the key things for me as a practitioner—the fact that bed occupancy is extremely high. In over 50% of the wards that the CQC surveyed there was more than 90% occupancy. You might think, “Well, there is 10% leeway,” but you need quite a lot of wiggle room in order to move people in and out of hospital. In around 15% of hospitals surveyed, I think, the wards were 100%-plus occupied; there was a report of 27 people in 19 beds. That has the effect that the concept of a stitch in time—a voluntary admission to prevent deterioration—is no longer open to us, because there is so much pressure on the beds. You have to be very unwell before we would think about bringing you into hospital.

Again, the CQC reports discussions with AMHPs—approved mental health professionals—that suggest that, in some areas, being detained is the ticket to getting a bed. Even worse, there are cases where people have been detained under the Mental Health Act but no bed has been found. In fact, there was a case that went to the European Court in which somebody was left in a police station awaiting a bed. That was found to amount to inhuman and degrading treatment. So there is an issue around beds. I think something about the reduction in the number of beds and the nature of the in-patient experience is having some impact on the increasing rates of detention.

**Q5 Chair:** The implication of what you are saying is that, on occasion, people are being sectioned because it is the only way of getting them into hospital.

**Dr Chalmers:** People are saying, “We don’t want to come into wards because they are overcrowded.” Because people are very unwell, they can be very disturbed environments. Again, the CQC highlights that, while there is good practice in some areas, on some wards there is little access to psychological treatments or even to meaningful occupation in the day. I know that Naomi can expand on that for you, if it would be helpful.

**Naomi James:** I think there are a number of different reasons for the increase in detention. Last year NSUN conducted a member survey that revealed that 11% of our membership of community groups and peer support services had been cut. That was not including those that had actually been closed. People felt that there was a real reduction in their quality of life. They saw being in hospital as an absolute last resort, because of the deterioration in quality of care. That is in addition to evidence such as the national study by King’s college that over a third of approved mental health practitioners are under high stress, have low job satisfaction and, indeed, meet criteria for depression themselves.

There are a number of different factors. NSUN itself has produced a report on care plan approach, conducted by Dorothy Gould. That was particularly interesting. It revealed that, essentially, people felt that in their experience of CPA the choice and control that were promised by the cross-Government strategy “No health without mental health” and parity of esteem were not being achieved. Choice and control have been recognised as a major component of getting well. The value of people being involved in joint care planning for risk and for when they reach crisis has been proven, but that is still not happening on the ground. A lot of the people who are seeking help before it gets to that stage are finding that, to quote them, it is actually a system of neglect. Largely, our membership is finding that people are being turned away again and again. There is no access for 18 months to things like therapy.

Equally, the IAPS programme is failing. It is being reported that people are having to wait longer than 28 days: we are talking two to three months. In addition to not having that support, when people phone their AMHPs they are usually told, “The only option for you is to go to A and E.” If that is the only thing available in medication, I think things will get worse. One of the key things that I would like to bring up is the fact that the East London NHS Foundation Trust, with which we are working, needs to, and is striving to, move people from secondary to primary care. Of course, discharging 900 patients across the commissioning cluster will have a significant impact, and readmission rates may continue to increase over the time.

**Q6 Chair:** We are primarily interested here in readmission rates under compulsion. Do you have statistics on that?

**Dr Chalmers:** I do not think that the Information Centre reports on individuals being readmitted, but it is a critical figure.

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**Q7 Chair:** Are you saying that it is critical but not available?

**Dr Chalmers:** I would have to double-check with the Information Centre on the data that it produces. It may be somewhere in one of the tables. We will have to come back to you on that one.

**Q8 Chair:** It would be worth reviewing, particularly since you describe it as critical.

**Dr Chalmers:** In terms of evidence with regard to that, my experience as a clinician is that people have to be more unwell to go in and, because of the bed pressures, are less recovered when they go out. This is something that the CQC is highlighting when it reviews a range of services. However, I cannot quote the figures at the moment.

**Simon Lawton-Smith:** If I may interpolate quickly, we do know readmission rates for people under a community treatment order, because they are actually counted as the community treatment order is revoked and people are returned to hospital—to a hospital bed, not just for treatment—and then sent out again. About 25% of people discharged under a community treatment order end up having their community treatment order revoked and go back into hospital. However, that is that particular cohort, not all people discharged.

To pick up the point you made earlier about whether there has been an increase in incidence or prevalence rates of severe mental disorder, which is the sort of disorder that might mean that somebody had to be sectioned under the Mental Health Act, the answer is no, as far as I am aware. We are not looking at an increased cohort in the country of people with a psychotic illness—a diagnosis of psychosis or bipolar disorder. What we are looking at is people who may have been in the community, for whom beds were available when they became unwell, but for whom beds are not now available. The threshold for admission to hospital has also risen, so people are that much iller before they can get into hospital.

**Q9 Chair:** But there is a third explanation—the purely bureaucratic one—that, because of the bed availability, a clinician may section somebody whom they would not previously have sectioned, merely in order to get them into hospital.

**Simon Lawton-Smith:** That is possible.

**Q10 Chair:** Can we put any kind of quantum on that? That is a serious civil rights issue.

**Dr Chalmers:** There is a policy position on this, which is that there was a move towards community care, and crisis and home treatment teams. I think the pendulum swung in the direction of “hospital bad, community good”—the idea that it is a failure if you have to admit somebody. That may have percolated through psychiatric practice. People try their best to keep people out because that is a good thing in itself. It is very hard to get them in, so you want to try to avoid getting to that situation wherever possible. However, nobody detains somebody without great thought; people are detained because there is a reason to detain them and because they fulfil the criteria. I

think it is just the situation we find ourselves in because of the complex strands.

I would also like to pick up on one of Simon's points. The rates of illness may not be increasing, but the types of things that help full recovery may be reduced. Access to housing is a major issue—not just a bedsit, but supported housing. The same applies to access to meaningful daytime activity—or even support to get back into some form of work—and support for carers. There is a whole range of other things that need to be in place in order to make the services work effectively.

**Q11 Barbara Keeley:** What patient benefit do you think has been derived from the creation of mental health advocates? Is there evidence that having mental health advocates has improved patients' understanding of their legal status and their ability to exercise their rights?

**Naomi James:** I would like to begin answering that question. We are really pleased, especially at NSUN, to see the increase in access. According to the CQC annual monitoring of the Mental Health Act, it seems to have improved. In fact, there is still some work to do, because it shows that in 2011 65% had access to an independent mental health advocate on ward, moving to 74% in 2012. I must mention that there was disproportionately less access for those on CTOs, which is an important factor. The number of people who are statutorily eligible for the service continues to increase, as people are held under detention, but a quarter of people still do not have access to it. There are a number of different reasons for that. Although there is a statutory requirement, people are not accessing IMHAs early enough. Staff are often unaware of the legal duty on the wards to inform patients. Some of the poor commissioning has meant that people are just not aware of the duty and role description of the independent mental health advocate. It is concerning that, crucially, quite often staff on the ward may make a decision on behalf of a patient and decide that it is in the person's best interests to have an advocate, or not to have an advocate. In either case, that could point to a human rights problem. As thousands are denied their rights, I think there is still work to do. I constantly get people calling me in distress because they want support on the wards or under a CTO and are not getting it. There is also huge confusion between the mental capacity advocacy role and the independent mental health advocacy role. So I think there is little equity of access and the style of provision is variable.

There is also a huge concern that I would like to bring up. People who are in voluntarily feel that they are not given information that they are in on voluntary terms and that they are not given access to an independent mental health advocate. They have certainly been reporting that they feel as if they are under detention when they are not, that they are being held against their will, and being told by staff on the ward, “If you try to leave, we will put you under section.” That compulsion goes against choice and control; quite often people report that that happens for weeks before a care plan is discussed with the service user who is there in distress. That is a major concern. Quite often the language used is all about treatment

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and not about supporting people. An independent mental health advocate could support people with housing and with planning, but that is not their only role. It is their legal duty to inform patients, as it is the duty of ward staff. It is quite important that that is not seen just as the advocate's role.

**Q12 Barbara Keeley:** I will ask about that in a moment. While you are talking about the feedback that you have had and the variability in practice that exists, should we be content with the role of advocates and the fact that it is limited by their not being able to act as formal advisers? Is there a case for extending their remit so they can give more direct expert guidance? You talked about their being involved in various aspects of planning. Is that something that should be looked at?

**Naomi James:** Yes, I think so. I would strongly recommend that.

**Alison Cobb:** The IMHA role is one of the key improvements to the legislation. It is a really valuable provision and safeguard for people who are in a very powerless situation. The university of Central Lancashire report "The Right to Be Heard" really gives a lot of insight into the value of advocates to individuals. The primary thing is to make sure that this right to an advocate is real for everyone who is eligible, but looking at the scope of the role would also be very worth while.

**Simon Lawton-Smith:** The commissioning of IMHA services is passing to local authorities in April, so there is a question about local authorities' skills in commissioning them, their knowledge of what is needed and their assessment of levels of need. I am not saying there will be a problem, but there is potentially an issue there, where local authorities pick up this responsibility from primary care trusts. We will want to keep a close eye on whether an adequate number of IMHA services are, in fact, paid for. The money is moving from health to local authorities to pay for it, but I do not believe it is ring-fenced as such. With local authorities under a great deal of pressure on spending at the moment, I think we need to keep a very close eye on whether the money they have been given to establish good IMHA services around the country is actually being spent on doing that.

**Q13 Barbara Keeley:** We come back to the point about the balance between what the advocates do and what the ward staff do. Do you agree with the CQC's warning that the existence of the advocates means that some hospital staff are not fulfilling their duties to inform patients of their legal rights? You have alluded to that point. Given that 21% of care plans showed no evidence of patients being informed of their legal rights, it seems that some people are falling between staff not telling them and their not even knowing that they have a right to an advocate.

**Naomi James:** That is right. Even in cases where they are trying to access one, people are simply not available. As the new commissioning is happening, even in those gaps where it has been transferred, there is no support for people—and by that point it is too late.

**Q14 Chair:** That is a more serious issue about the standards of professional practice on the wards, isn't it? These advocates are important, but it is also part of the professional responsibility of the doctors and nurses to engage with the patient in that way.

**Naomi James:** Yes.

**Q15 Barbara Keeley:** Do you think it is directly linked and that, the minute advocates became available, staff said, "Oh, I can retreat from that. I don't need to inform them of their legal rights"? Do you see that link?

**Naomi James:** I think there certainly is a link. That is certainly consistent with the report "The Right to Be Heard" and with NSUN's CPA report, both of which suggest that that is true. A lot of work needs to be done to bridge that gap. That is in addition to the actual availability of advocates; sometimes they are just not available. As the rate of detention increases, there are just fewer people to go round. I think there are a number of reasons, but one of the key things is to extend the service to people who are in voluntary detention because they have equal concerns about their rights being breached. It is very important to look at that.

**Q16 Chair:** Can I push Dr Chalmers on this? You said that you are an adviser to the Royal College of Psychiatrists. This is an issue for the Royal College of Psychiatrists, isn't it? Of course it is an issue for resourcing, commissioning and so forth, but it is also a professional issue.

**Dr Chalmers:** It is a professional issue for everybody on the ward, including the nursing staff. It is usually the nursing staff's core job to present the rights and to go back to patients. In the first few days of admission, people may be very distressed and may not want to engage in a discussion about rights, so that should be re-presented repeatedly. That is a requirement. If it is not happening, that needs to be picked up by the CQC and the trust board, and those responsible need to feed it back.

**Q17 Chair:** To return to a theme the Committee returns to quite regularly—particularly post-Francis—it is also an issue for every professional working on a ward, if they see this not happening, to challenge the fact that it is not happening.

**Dr Chalmers:** Yes, absolutely. I think I was saying that. Although that is not the medical staff's key responsibility on admission, I guess, if they see that people do not understand their rights, they should direct them towards advocacy, if it is available. To echo Naomi's point, access to advocacy is variable. We know that, where it works, it can work very well. I am not sure—we would have to debate it a wee bit further and look for evidence—that there is a clear link, and that, where there is advocacy, the nursing and medical staff are not doing that; it may represent something else. That needs further examination.

**Q18 Barbara Keeley:** Can I come back to the point that was made about voluntary patients? There seems to be not just an absence of advising patients about their rights; there seems to be some confusion. I refer

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to the use, with a voluntary patient, of the threat that if they try to leave they will be detained.

**Dr Chalmers:** That is something I feel very passionate about. In my training, I repeatedly say, “Do not do that.” People want to go along with it. If you know that if someone goes in voluntarily and then says, “I don’t want to stay because the wards are very disturbed,” you will section them, that is not very fair. The college is well aware of this issue of de facto detention, which is picked up repeatedly with the CQC. We are trying to make it clear that we have to champion people’s rights. If we think that they are in that situation, and that the patient is the only person who does not know they will be detained if they try to leave, that is not okay. We should be using the Act, because at least it is clear for them and there are safeguards. I think that is bad practice, and there is no way that we would not challenge it when we saw it.

**Q19 Chair:** I have quite a lot of people wanting to come in now.

**Simon Lawton-Smith:** I want to make a very quick point on the right of voluntary patients to an advocate. I may be wrong here—colleagues may be able to confirm whether I am right or wrong—but Wales has passed some mental health legislation. Wales is subject to the Mental Health Act 1983, as amended by the 2007 Act, but later it also published extra legislation that gave extra rights to patients. I think one of those extra rights may be that voluntary patients also have a right to advocacy. If that is right—I am afraid that I do not have the papers in front of me—there is a precedent in the UK for giving a right of advocacy to voluntary patients.

**Chair:** I am conscious of time.

**Q20 Rosie Cooper:** I will be very quick. I have two quick questions. I think that everybody should have a right to advocacy—absolutely—but I want to come slightly from left field and look at a contradiction in what is happening. If, on the one hand, we are saying that there is huge pressure and you cannot get people into hospital and into beds, why would there be pressure within the unit to try and detain people who could leave, unless that was absolutely essential? Why, therefore, would you be duplicitous and not be honest? I just think that is dishonest.

**Dr Chalmers:** You are relieved when people agree to come in and you do not need to use the Act, but you have to be very cautious when you make that decision. In fact, the figures for people who come in voluntarily and are subsequently detained are dropping; I think there is a difference of 1,000 over a couple of years. That suggests that, at the point of assessing someone for admission to hospital, we may actually be asking these questions and saying, “Are we just allowing this to go ahead or are we protecting people’s rights?” There is a view that that reflects good practice. It should drop to very little, shouldn’t it, because it is still a large number of people?

**Q21 Rosie Cooper:** Absolutely. If it is very little, it is not the big point that you are making. It is either one or the other.

**Dr Chalmers:** It is an issue just now.

**Q22 Rosie Cooper:** I believe it is an issue.

**Dr Chalmers:** I could refer you to the figures. It was about 15,000. I think it has dropped to 13,000, so the trends are downwards, but there are still 13,000 people.

**Q23 Rosie Cooper:** If you were one of the 13,000, you would not be very happy.

**Dr Chalmers:** Absolutely. If it will assist you, I can tell you that the number of admissions and detentions of voluntary patients was 13,680. Previously—in 2007–08—it was 14,839. It is a consistent trend downwards, but that is too many.

**Q24 Rosie Cooper:** Rather than just concentrate on the numbers, shouldn’t we ask why a system, a hospital or a ward would work to keep in people who do not want to be in, not give them the advocacy and help they need to move out, should they wish, and then also maintain that there is huge pressure on beds and it can’t get in the people it needs to get in? How does that work?

**Dr Chalmers:** The people who are in voluntarily and the people who are detained are probably not really different in terms of their level of need; they are all very unwell. Probably the only thing that distinguishes them is the decision making that occurred at the point when they came into hospital.

**Q25 Rosie Cooper:** I will leave that; I think that the point has been made. What about people with extra disability such as deafness and communication problems? How do they get their advocacy? I think you said, “Advocacy is variable.” Is it a hell of a lot more variable if you come in with additional disability?

**Dr Chalmers:** I do not have any facts on that, but I imagine it would be a challenge. One of the problems with advocacy services—this highlights Simon’s point about all services going to local authorities—is that there are different kinds of advocacy. Sometimes the same person may have to wear different hats. I presume that advocacy services should have links with organisations that could help with sign language or ways of communicating with people with communication difficulties. I do not know whether Naomi can shed any light on that.

**Naomi James:** Essentially, there is a broader systemic problem in mental health services in general with choice, control and recognising someone’s needs. Every day we have phone calls in which it is quite distressing to hear what people have gone through, let alone what it must be like for them. We have cases where someone has reached an absolute crisis, through lack of services in their own area, has had no access to support and has ended up in the Bethlem hospital for five weeks before a care plan was even gone through. By that point, they had not discussed their needs in terms of communication. I do not want to go into absolutely specific details, but this is not uncommon. You would not really believe it without seeing it, but, being a service user myself, I have been in the same hospital under section and I can well believe that five weeks can go by before someone comes and asks you what your care needs are, or even

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gives you a bit of paper with some information about advocacy.

**Q26 Rosie Cooper:** Are we saying that the core of the problem is that the system is poorly managed, not just that there is a shortage of resources? It is stupid that somebody could be in a hospital waiting for a care plan for five weeks.

**Naomi James:** A lot of service users who are regularly in and out of a community mental health service say that they have never seen a care plan. You have to fight and advocate on your own behalf even to see what the care plan is, let alone look at what the crisis plan might be. It happens before you reach a hospital—before you reach the ward. Once you are in the ward, the staff are under huge pressure and stresses. It might seem like there is money around, but the staff themselves are not able to deliver and provide a therapeutic environment. It is quite focused on risk; that is one of the key factors. Service users have felt that it is focused more on that and on watchful waiting than on action and looking at what your care needs are—simple, basic things that you need, rather than just the medication to keep you calm. One thing that is misunderstood is that, when people are fearful or getting upset, that is co-produced as opposed to just existing within the individual service user. I do not know whether that completely answers your question, but I think it starts with people having a bad experience of care before they go into hospital, so that they are already frightened and scared on the hospital ward—

**Rosie Cooper:** And they spend five weeks in a hospital waiting for somebody to find a care plan as well as some medical treatment. That does not seem like a good resource.

**Q27 Chair:** I think we have probably covered that ground.

**Simon Lawton-Smith:** On the question of IMHAs and advocacy for people who may have a disability, I am afraid that we do not have on us the data for physical disability co-morbid with mental illness. However, I used to work for a charity called Together, which provided advocacy services. I know that there were certainly systems in place to ensure that, if English was not a person's first language, they got advocacy support from somebody from the same community who could therefore do any translation of issues. The answer might simply be for a local authority to include specific clauses about the need also to meet any assessed physical health needs—or communication needs, I should say—every time it issues a contract for IMHA services in the future.

**Rosie Cooper:** Absolutely. Then it can be ignored, like it is mostly in every other service that has it.

**Chair:** At least if it's written down we've got a challenge.

**Q28 Andrew George:** I want to test the merits of the individual basis on which independent advocates operate. The background I come from is partly community work. When mental health forums were established in my area and those with experiences of the mental health services came together, some of

them, at least, found that process more empowering and were able to learn from one another and have shared experiences. It was also a benefit to the service itself, in that it provided a very effective way of establishing feedback and ensuring that there were links between mental health services and other services such as housing. Is there a risk that, by focusing advocacy purely on an individualised, independent basis, you may lose the opportunity to look at a wider picture and bring people together? Or is that a rather old-fashioned way of looking at it, which you would not want to go back to?

**Alison Cobb:** I will start. What you are saying about empowerment is very important. Peer support, for instance, is extremely valuable in assisting people to recover and to feel more empowered. Bringing people together in support groups and action groups to plan and feed into service design, for example, so that they have a much greater say in how services are developed, is really important. Bringing the community, if you like, into the hospital and supporting people to engage in the community, often through the peer support of people with similar experiences, is extremely powerful. I am not sure that that is a substitute for individual advocacy, or if they quite do the same job—but Naomi may have other perspectives as well.

**Naomi James:** Independent mental health advocates, as they stand at the moment, are for people who are under compulsory detention. If we look at the wider social determinants of health, not just the medical model of mental illness, and understand mental illness in terms of social deprivation, there is a huge argument for peer support and peer advocates in the community. One thing we have worked on is improving the networks of service users, particularly in Hackney, where we have worked with the local health authority commissioner and are now working with the clinical commissioner for mental health. We are trying to look at services in terms of choice and control and to move them towards not just involvement in what happens in your life but co-production and discussing that in communities. That is as important as the need for an independent mental health advocate when you have reached crisis.

We have had great successes in trying to support people to have a say on what services work. By doing that, people are able to tackle and to report on the wider social determinants—the causes of their distress in their communities. Of course, NSUN is not arguing that sectioning does not have a place, but that really is meant to be as a last resort. Sometimes it has a place largely in order to take people out of a terrible situation in their community, and for extended periods. In our experience at NSUN, short periods in hospital seem to be doing more damage. In the longer term, someone's care plan can be thought about and careful plans for discharge can be made. However, we have made quite a lot of good inroads in trying to work with commissioners and seeing that service users can get involved in commissioning itself. NSUN has launched Mental Healthwatch, where service users can get together, look at their local services and do research—becoming researchers, and becoming people who can go in and do checks, and enter views

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on their services. While doing so, they are also developing transferable skills for the future. Mental health problems are partly about isolation; that is how they start.

**Q29 Andrew George:** Are there well-established service user groups in most areas, or is provision rather patchy? Where there are service user groups or forums, are they funded by the provider of mental health services, by local authorities or by other resources?

**Naomi James:** Nationally the picture varies. We have been lucky to secure a small grant for a few years to map what is happening across the country. We are still investigating and mapping different areas in terms of service user involvement. We are looking at good practice and how that can be used. Our Hackney project was quoted and used as an example by the Joint Commissioning Panel for Mental Health. We are finding that there are pockets, especially in the west, where there is very little, so we are helping people to duplicate good models of working with their commissioners. Even people in hospital, who are sometimes thought of as lacking capacity or being unable to speak for themselves, can conduct mystery shopping on the wards while they are there, so that they feel that they are contributing towards service change. I think that is important, especially as there are some areas that are well behind. One example that is worth bringing up today—I just want to get the details correct—is NAViGO. Control and restraint has been one of the major difficulties for our members. They feel that when they are discharged, it is quite hard to get over what has happened to them and that it is a further abuse for which they need therapy. I have some information about North East Lincolnshire, where service users and carers have come together. North East Lincolnshire Care Trust Plus just does not use control and restraint. It provides everyone with respect and dignity training and training in other methods, and that seems to be working rather well. We are trying to find all the learning from that, since there have been quite a number of deaths in custody recently, as I am sure you are all aware. We would very much like to find out exactly how this can be replicated in other areas.

**Dr Chalmers:** Can I make a point to add some balance? I am going to wear my college hat here. It is really important that Naomi highlights good practice, because it is easy to focus on the bad; we have got into that mode a little bit here. I am not defending bad practice at all—it has to change—but there are some places where they are getting it right. I think we should add that balance. I know that a lot of colleagues—colleagues in all the disciplines—are working in very difficult circumstances and trying to do their best. It is very demoralising to get constantly criticised. We need to be criticised and to step up to the mark, but we need to be balanced about that. With regard to the wards, there are some interesting initiatives. Have you heard of the star wards? There is a site called Wardipedia highlighting what makes things good. That is service user-generated. The college, too, has done work on the 10 points that make a good ward. We are trying to drive up standards, in

collaboration with service users. I just wanted to give you a more balanced view at this point.

**Chair:** Thank you. Grahame would like to move this on, I think.

**Q30 Grahame M. Morris:** The purpose of this session is not to be overly critical but simply to assess how the Mental Health Act 2007 is working. There are lots of areas where we are seeking your views on how it is operating. If you do not mind, I would like to ask you a few questions about places of safety. A little earlier, Mr Lawton-Smith told us that we should not worry about the increasing cohort of patients who are sectioned under the Mental Health Act, but it is a fact that there has been a significant growth in section 136 detentions—at least, detentions into hospital—using the Act. Dr Chalmers mentioned some of the issues around police cells. In your opinion, are the police now more willing to use the powers available to them under the 2007 Act, under section 136, knowing that patients can then be removed to hospital?

**Dr Chalmers:** I will pick that up. As well as wearing my alliance hat, I am the chair of a college-hosted multi-agency group that involves the police, the ambulance service and a range of people, so I also speak from that perspective. You raise an interesting question. The answer, in short, is no, it was not the power to convey, which was the change that came about with the 2007 amendment—but I think that there is something happening around section 136. One of our problems has been that we have not been able to collect complete data. There have been only two points in the last seven years when we have got a data set. Those were when the IPCC undertook a survey counting the number of detentions in police stations and linked that with the Information Centre figures. Otherwise, the CQC has been able to report only Information Centre figures, which count the admissions to hospital places of safety.

This year, as part of the initiative of the multi-agency group, ACPO collected the most accurate figures that it could from police stations, and we have the Information Centre figures. What those show—if it would be helpful to you to have this level of detail—is that between 2005–06 and last year there has been an overall 26% increase in the use of section 136. The balance has changed, because money was made available to build hospital places of safety but not to provide revenue to staff them. The buildings may be there, but it is not always the case that they are fully staffed all the time. In 2005–06, 11,500 went to the police station and 5,900 were in the hospital place of safety. That has shifted, so now 8,677—to be exact—go to the police station and 14,902 go to a hospital place of safety. So 37% are still going to police stations. This is not acceptable, because the code of practice clearly states that people should go to a police station only in exceptional circumstances. However, it seems that once a hospital place of safety has opened, the police have enthusiastically adopted the ability to take people there. That might be suggested by the numbers, but an unpublished study in Nottingham, where the previous chair of the committee that I now chair works, also showed a doubling in figures for use

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of section 136 when the hospital suite opened. I do not know what that means.

The police are certainly concerned about vulnerable individuals out there, but when they come to either a hospital or a custody suite we are only detaining less than 20% of them, so there is quite a mismatch with what psychiatrists and AMHPs view as a mental disorder needing to go on to have further treatment in hospital. The Information Centre counts only the detentions, but we will be able to track voluntary admissions. That is another piece of work that we have been doing to try to get better data on this. However, there has been an explosion. It means that last year 23,000 people were picked up by the police, but only a very small proportion of them end up in hospital. That can be a very aversive experience for some people, particularly if they go to a custody suite.<sup>1</sup>

**Q31 Grahame M. Morris:** You have answered the other question I was going to ask about what the evidence is anecdotally; you mentioned the case that was taken to the European Court. A little earlier, Naomi mentioned people presenting at A and E and really not knowing where to go—perhaps as a consequence of lack of in-patient beds. I had a really terrible tragedy in my constituency, where a young mother presented at A and E. She was not diagnosed properly, was sent home and strangled her two-year-old little boy. That was an absolute tragedy. What is your general view on the use of police cells or custody suites as places of safety?

**Dr Chalmers:** I think I have already answered that. I think they should be used only in exceptional circumstances. Distressed people need to come to a hospital setting and be looked after.

**Naomi James:** Can I add that it is inappropriate to be told to go to A and E as the first point? That is something that could really address the prevention of people's entry into hospital under detention. I myself am a service user, and I have been there. The first thing they did was take me to a police cell, which was the most distressing thing that has happened in my life. I felt that, if I had been taken somewhere more appropriate, that distress would not have happened, let alone the fact that the detention sergeant did not get an approved mental health professional to see me within 12 hours of detention in that cell. My experience is just one of many where this is happening. To hear that the statistics are not even being kept is just not acceptable. I think it would be hugely important if people could start to collect those data. There is also the issue of the number of transfers within a single admission, because stability within mental health is also quite crucial to people's experiences of care. That is why people tend to try to wait until there is an absolute crisis point, because there is no easy access in and out to support.

**Q32 Grahame M. Morris:** Very quickly on that point, are the police reluctant to use the powers they have under the 2007 Act to remove to a place of safety people who are a danger to themselves and others? The CQC said that the police were using powers under

the 2005 Act on some occasions because they thought it was perhaps easier to do that.

**Dr Chalmers:** As I said, the power was to convey from a police station to a hospital. Those data are not kept at the moment, but it is occurring. That was a useful addition to the Mental Health Act. On the MCA, I think that there has been clear guidance. The Met has published a view, after a particular case in which a woman was removed, so I think the police are clear that they cannot use powers under the Mental Capacity Act to remove and detain somebody. I do not think that the police are reluctant to use section 136. There are two things. There is a question about pathways. Our group is trying to work on diversion before the police have to use the powers under the Mental Health Act. In an ideal world, could they phone a crisis team? People who were willing to go to hospital would be diverted there. There are some interesting initiatives. In Tees, Esk and Wear Valleys NHS Foundation Trust there is a street triage team—a mental health professional is out on the beat with the cops. It is in its early phases, but it is an interesting idea, because at least the NHS staff can access crisis teams. That is another thing about thresholds. Crisis teams may be unwilling to accept calls from the police. In fact, crisis teams are often asking the police—in the police's opinion, perhaps—to do their work for them.

With regard to the statistics, it has been a real bugbear for us to know just where we stand, but the positive thing is that the college group has been able to join up the key people. I know that in the Information Centre and in ACPO there is a great will to get these statistics right. That is being worked on, and we will be asking more detailed questions of the statistics. That is a positive thing.

**Q33 Dr Wollaston:** Before I start, can I state for the record that I am married to a consultant forensic psychiatrist in the NHS, who also provides advice as part of the parliamentary liaison committee for the Royal College of Psychiatrists? I would like to turn to the issue of community treatment orders. Does the panel feel that community treatment orders have achieved their original aim of actually improving treatment in the community for people with mental illness?

**Simon Lawton-Smith:** It is interesting that you say that the original aim was to improve treatment in the community. The original aim, as I understand it from the Department's literature and what Ministers said at the time, was to make sure that patients took their medication. That is a slightly different thing because, collectively, we would interpret treatment to mean many things other than just medication. It would mean access to psychological therapies, being helped to get good housing and contact with social networks so that you can get on with your life and be helped to recover, rather than just management of the clinical symptoms. Having said that, I think the situation with the community treatment order system that we have is interesting. We know that, on the whole, psychiatrists are in favour of it. A majority of psychiatrists welcome the fact that there is now a power to discharge somebody under a community treatment

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<sup>1</sup> Ev ??, paras 2–3



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order and to impose conditions in that order that mean that they have to turn up to take their medication, and that there is a power, if they judge that a person is not complying with the conditions of the order, to bring the person back into hospital to receive the treatment—which is invariably medication—for up to 72 hours.

We know that in some cases it is helping people to stay well in the community. This is evidence that we have from professionals working in the field who have done their own local surveys. For example, a recent piece of published research looking at approved mental health professionals' perspectives on community treatment orders in the north-west of England—it was published only about a week ago—said that community treatment orders helped earlier identification of relapse, access to housing and reduction in risk of avoidable harm to self and others. What they did not do at all was help with employment, education, training and social activities. At the same time, they added to the stigma of having a mental illness in the community. So there was a perception from that particular cohort of AMHPs that they were useful to a degree. They did help encourage people to take their medication, which was often something that helped people stay well in the community and helped to tackle some of the worst symptoms of serious mental illness. At the same time, patients are very divided about them. Some people are quite happy to say, "Because I am on a community treatment order, I do not turn up to have my medication. As a result, I have not been relapsing." Others find it an incredibly severe restriction and feel that it is contrary to human rights and destroys the relationship between themselves and their professionals, because it is not a voluntary relationship of support but a compulsory relationship. So there is a very mixed picture among people who are actually subject to community treatment orders.

I would like to add one or two things very quickly. Earlier I mentioned that some 25% of community treatment orders end up being revoked, with a patient back in hospital. It is difficult to know all the reasons why that would happen. It is possible that people were discharged from hospital earlier than they should have been, maybe to free up a bed. There is no firm evidence on that, but it is obviously a danger when there is such pressure on beds. Maybe people are actually too ill to be in the community, even under a community treatment order. The nature of severe mental illness simply means that, whatever care you get in the community—it may be excellent—you may still become unwell and need to go back into hospital. What that demonstrates is that community treatment orders have not been a panacea in terms of keeping people well in the community if they have serious mental illness. That needs to be borne in mind.

We also need to bear in mind the fact that the 5,000 or so people under a community treatment order at the moment in England have added significantly to the total number of people subject to the Mental Health Act. Before the supervised community treatment and community treatment order power was put in place, as of 31 March 2008, there were 14,500 people detained under the Mental Health Act. As of 31 March

2012—four years later—there were over 17,000 people detained. There has been an increase in the number of people detained on that day—31 March—plus 5,000 under community treatment orders, so there is a significant new cohort of people under compulsion. Of course, there is a view that we should be looking at mental health legislation that is designed, yes, to provide care for people who are very unwell, may lack capacity and need treatment—possibly compulsory—for their own safety or the safety of others, but that at the same time mental health legislation should not be there to increase the number of people detained. We should be looking at systems that actually reduce the number of people detained, because services in the community and voluntary services are good enough for that.

**Q34 Dr Wollaston:** The number of CTOs is higher than was originally predicted, isn't it? It was predicted to be about 400 to 600 a year, but in fact last year there were 4,220. Is there any evidence that they are being used inappropriately, or that they are having the effect of reducing the number of people in hospital?

**Simon Lawton-Smith:** I will take those questions in reverse order. They do not seem to be reducing the number of people in hospital, as there are now more people in hospital under the Act than there were five years ago.

**Q35 Dr Wollaston:** Those are overall numbers. But of this group of patients—

**Simon Lawton-Smith:** These are patients whose level of need, it is decided by clinicians, is such that they need to be treated under the Mental Health Act, rather than as voluntary patients.

**Q36 Dr Wollaston:** What I mean is, has it made it less likely that this particular group of people on CTOs will be in hospital, because they are on CTOs? I am not looking at the wider figures.

**Simon Lawton-Smith:** I do not think it is possible to pick out that particular cohort and say, "If they were not on community treatment orders, they would be in hospital." You could not put those 5,000 people back in hospital now, because there are not enough beds. It would then be a question of whether those 5,000 people on community treatment orders would therefore just be in the community voluntarily, or whether those 5,000 people on community treatment orders would be in hospital beds, but 5,000 people who are currently in hospital beds would be in the community.

**Q37 Dr Wollaston:** Can I pick up on the figure of 5,000? I have data of 4,220.

**Simon Lawton-Smith:** I am sorry. I have been using the figure of 5,000. The latest data we have, as of 31 March 2012, is 4,764. Are those Care Quality Commission data or NHS Information Centre data?

**Q38 Chair:** It must be NHS Information Centre data, because we have the CQC numbers, which are not quite the same. The order of magnitude is similar.

**Dr Wollaston:** I just wondered whether we had the same data.

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**Simon Lawton-Smith:** There are significant data issues here. It was 4,764 on 31 March 2012. We know numbers are going up all the time, because more people are being placed on community treatment orders than are being discharged from them. When I say 5,000, that is probably a slightly conservative underestimate, but I think 5,000 is probably accurate as of today. What is quite interesting with the data is that the total number of CTOs made since 2008 is 14,295. If you then remove the 3,509 revocations, for people who have gone back into hospital, and the 3,922 discharges—people who have been discharged from an order and are now just living in the community without an order—you actually end up with a figure of 6,864, so there is clearly some issue around the data. I think 5,000 is probably as accurate as we can be sure of at the moment.

**Q39 Dr Wollaston:** Right. I come back to the point about whether there is any evidence that they are being used inappropriately, because the other issue is the huge variation around the country. Some places are not using them at all. How do we account for that level of variation? Is it because some people are not using them where they should be using them, or because they are being used inappropriately in some places?

**Simon Lawton-Smith:** I could not say to you that they are being used inappropriately. I do not have the evidence to suggest they are. Every clinical decision on a supervised community treatment and community treatment order is for an individual clinician to make, with the AMHP.

**Q40 Dr Wollaston:** But it is extraordinary, isn't it, that there are some parts of the country where they are not being used at all.

**Simon Lawton-Smith:** For example, in the survey we did of psychiatrists, I think that of over 500 psychiatrists who responded, 325 said they found them a useful thing to have and 74 did not. I certainly know of one or two individual psychiatrists who have said to me that they would never use them because they think they are unethical; that is their personal opinion as psychiatrists. Some of the variation will come about because of demography. For example, we know that there are higher levels of both detentions in hospital under the Mental Health Act and people being placed on community treatment orders in London. We know there are higher levels of serious mental disorder in London. To a certain extent, the geographical variation may depend simply on things such as the nature of the housing people have, levels of unemployment and levels of income.

**Naomi James:** We have looked at data from the CQC in 2011 that state there is 19.5% use among BME communities, so there is something around discrimination and race equalities that may need to be looked at.

**Q41 Dr Wollaston:** We will come on to that specifically later, so perhaps we can return to it. Do you have evidence of patients being returned to detention and having their CTOs revoked because of

breaches of the CTO conditions? Is that power sometimes being used unlawfully, in your view?

**Simon Lawton-Smith:** You may correct me if I am wrong, but under a community treatment order it is up to the responsible clinician of the patient in the community to decide whether it is necessary to take the patient back into hospital. The community treatment order has conditions. If you do not meet those conditions, it is not automatic that you will be taken back into hospital. There should be a dialogue between the patient and the doctor about why the patient did not meet them, whether they can work their way around the issue and whether the conditions need changing. I do not know whether the other witnesses have a view on inappropriateness.

**Q42 Dr Wollaston:** Is best practice being followed, or are people automatically being sent back to hospital?

**Dr Chalmers:** There are mandatory conditions to see the second opinion appointed doctor and to come back to be reviewed by your responsible clinician to consider whether the CTO should be renewed. If you do not stick to these, that could be a reason for recall. Normally it is a point of negotiation and does not involve going to that level of coercion. Then conditions can be put in place. This is a good practice issue, and something on which I have a personal opinion. I certainly do not think we should tell people how to live their lives, but some doctors have felt that they have the power to put in place a lot of unreasonable conditions. There may sometimes be very reasonable conditions about, for example, staying in supported accommodation, if you really think that there is evidence that staying in that setting would maintain your well-being. Are there inappropriate conditions? Again, you do not know the individual clinical details, but the CQC reported—not in this year's report, I think, but in the previous report—that about 30% of people who had been placed on a CTO had shown no evidence of disengagement. That worries me, because it is against the spirit of what the CTO was about. I am talking about people who have never demonstrated that they have not taken their medication. I do not think we have this level of detail. I would be worried if you had a CTO after your first illness, unless there were exceptional clinical circumstances. It is something about which the college has concerns, and on which we want to issue good practice guidelines. We are waiting for the report of the OCTETO study; there is a very large randomised controlled trial, of which you may be aware, run by Professor Tom Burns. It is about to report and will be published in *The Lancet* within the next month. It will tell us whether or not CTOs are a good thing. It may start to give us some indications of where psychiatrists have been overenthusiastic, perhaps, in their wish to keep people better.

**Q43 Dr Wollaston:** Notwithstanding the point you make about geographical variation in the level of severe mental illness, it still strikes me from hearing what you are saying that there is a huge degree of variation, with some doctors deciding that they just happen to think CTOs are unethical and others

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overusing them. Given the degree of stigma that we have heard is attached to them, is this just a good practice issue or is it actually a professional probity issue?

**Dr Chalmers:** As Simon said, you work in different settings. For example, as a community psychiatrist, I have only one or two people on CTOs. In other settings where you have assertive outreach teams and people with complex serious mental illness, a lot of homelessness, other social adversities and a history of non-compliance, my colleagues may have up to 20 people on CTOs. So there are practice-setting differences. I think that CTOs split the profession initially. Some felt that they were overly paternalistic, particularly as under the Act as it was there were no impaired decision-making criteria, which felt more ethically correct. Others were quite keen. Tribunals raised the issue continually in the early phases, and I think members of the profession were confused about whether they had clinical discretion. There was quite a push from the tribunal service for us to consider placing people on CTOs. If we did not, they would adjourn and come back and ask us what our decision making was around that.

**Q44 Dr Wollaston:** The Committee would probably be interested to know whether, in your opinion, this is something that should be left to the profession to sort out, or whether changes to the Mental Health Act are needed.

**Chair:** Or has NICE been involved.

**Dr Chalmers:** As far as I am aware, NICE has not made any comments. Of course, recently the Mental Health Alliance did suggest an amendment to the CTO conditions, which was to have a criterion of impaired decision making as part of those, but that was turned down. I look to Alison and Simon for the details on that.

**Alison Cobb:** The Mental Health Alliance has always argued for significantly impaired decision making to be a criterion for compulsion at all. We did argue the case for having it as a criterion for supervised community treatment during the passage of the Health and Social Care Bill, but that was unsuccessful. Another possibility in terms of strengthening rights might be to include the conditions of supervised community treatment within what can be appealed to a tribunal, and to have tribunals consider those.

**Q45 Dr Wollaston:** Naomi, what is your opinion from the service users' perspective?

**Naomi James:** I want to refer to the recent report on service users' experiences of CPA and being subject to compulsion. Experiences of those subject to compulsion were the most negative in the report, particularly in relation to the "never" categories; 23% said that they did not feel respected and that their knowledge of self was not respected, versus 4%. On the issue of whether their care plan focused on things that helped them recover, 22% felt that it did not focus on what they thought recovery meant. Again, the focus on risk in the care plan is imbalanced; 29% felt that risk was the major factor. That seems to indicate that things like CTOs and the lack of choice and control have a negative impact on people. There is

also the stigma and discrimination of being in the community and having to be subject to this without choice. People could be involved. There is evidence that joint crisis planning reduces compulsion, so I think that there is something that can be done.

Taking into account the fact that 30% of CTOs are used in cases where individuals do not have a history of doing the wrong thing and do actually comply with medication and the support that is offered, I would say that there may be a case for saying that they are overused, and that surely impaired decision making should be taken into account when using CTOs in the future. The "T" in CTO is supposed to stand for treatment, but treatment is more than medication; it is the wider social experience. One of the major issues for people is what happens on discharge. Simple issues such as having no money are causing them to look for other means of income. That is very dire. People feel a sense of alienation, and feel that they do not have access to social networks, or even have a presence in their community, if they are subject to such conditions. I think that tends to hide them away, and they don't feel part of society when they are under compulsion.

**Simon Lawton-Smith:** May I add two things very quickly? Scotland introduced a similar system of community treatment orders a couple of years before England. It did have an impaired decision-making clause in the conditions for someone to be placed on a community treatment order. What happened in Scotland was that, after two or three years of the Act, there were about 400 people under community treatment orders in Scotland and 400 fewer people detained in hospital under the mental health legislation up there. That seemed to me to be a perfect position, because, if community treatment orders are meant to offer a least restrictive alternative, I think most patients would say that they would rather be in the community, albeit under an order, than in a not very therapeutic in-patient ward. So I always cited Scotland as having got the balance right. In fact, the data seem to suggest that in the last couple of years the number of people detained in hospital in Scotland has been going up, while the number of community treatment orders has also been going up, so they seem to be having a bit of a reversal of that trend. The worrying thing, particularly for us, is that, as I have mentioned before, community treatment orders in this country do not seem to have led to any reduction in detentions or in the number of people who are detained in hospital under the Mental Health Act at any one time.

I will mention quickly one other thing that has not been picked up so far. An assessment of the Mental Health Act 2007 was made at the time; it was a resource impact assessment of the sort that is made for all legislation. At that time, it was estimated that by 2014–15 the introduction of supervised community treatment in England would have saved the NHS roughly £34 million a year through a reduced number of beds; obviously, people being in the community is cheaper than hospital care. If you are asking questions about the impact of the 2007 Act, it would be interesting to ask how well we are doing in reaching that saving of £34 million that was in the estimate for the 2007 bill.

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The other thing I would like to mention relates to the 30% of people who do not have a history of disengaging from services. The way the Care Quality Commission put it was that in 30% of cases of people under a community treatment order there was no history of non-compliance. It is very interesting that, at the time when the Bill was going through, there was a definite feeling—I believe it was given by Ministers as well—that this was an order to help stop the revolving-door syndrome, which was people going into hospital with a mental illness under the Mental Health Act, being discharged, becoming unwell, going into hospital, being discharged and becoming unwell again. It is absolutely admirable that we were trying to tackle that problem. I think there is an issue if someone enters hospital for the first time as a young man with, say, psychosis, and is immediately discharged under a community treatment order, without any evidence that they will necessarily not take their medication, relapse and have to go back into hospital. There is a real danger in that. We would like the Committee to think about asking questions about why there are significant numbers of people under community treatment orders who, it appears, were not intended to be included in the legislation. The Department of Health leaflet on community treatment orders that was issued at the time actually specifies how SCT should be used. During the House of Lords Committee stage, Lord Warner stated, “One thing that has not changed as much as we would like, however, is the continuing number of revolving-door patients,” so he specifically mentioned CTOs in terms of revolving-door patients. We are worried that they are being used perhaps inappropriately—that might be one way of looking at it—for patients who do not have a history of continuing non-compliance.

**Q46 Dr Wollaston:** To come back to my question, is that a problem with the legislation or is it a problem with the way doctors are using CTOs inappropriately? Is this a medical issue or is it something we should change in the legislation on mental health?

**Chair:** It is too easy, isn't it, for Dr Chalmers, in particular—forgive me if I take you as representative of the royal college—to say that there is a difference of view and that there is a debate within the profession? It is very difficult to draw up legislation if the professionals responsible, with the psychiatrists in the lead—but not only psychiatrists, obviously—have differences of view about what good looks like, to put it simply.

**Simon Lawton-Smith:** But the legislation allows somebody to be discharged under community treatment order after one episode. The Mental Health Alliance argued in its early days that there should be something specifically in the Mental Health Act—in the primary legislation—saying that there had to be a history of non-compliance and disengagement. That was rejected by the Government at the time.

**Q47 Chair:** Okay, but the question for this Committee is: should we be going back to the Government with this and other points? At the very least, it is salient to have a clear view from the professionals on what the right legal framework is to

allow them to deliver the best quality of service to patients.

**Dr Chalmers:** I do not think it is a simple matter, because it is a balance between how much you respect autonomy, and well-being concepts and that kind of paternalistic view. Rather than “paternalistic”, which sounds very negative, I should say putting more focus on well-being, which may respect autonomy but also give weight to other factors. You cannot necessarily legislate for that clinical judgment, can you?

**Q48 Dr Wollaston:** Presumably there might be occasions when you might want to be able to use an order when it was a first admission, if you thought someone was a severe risk to themselves or others. Surely this is something the profession should be getting a grip on.

**Dr Chalmers:** The evidence was that there was no evidence that they were helpful in other jurisdictions. We have this study—which is very interesting in that it is a randomised controlled trial, so it is scientifically more powerful, perhaps, than some other methodologies—that may give us some indications of how the orders are used. I think the way forward is to have a further dialogue about that, once we have some research evidence, to think about good practice, to look at and debate the ethical issues, to take in the views and to look at the issue again. I can't give you the answer about how you should change the legislation now. It needs to be looked at very carefully, but I do not think we have all the evidence yet.

**Q49 Chair:** That is understood. What I do not think is reasonable is to come to the Committee and say, “We are doing randomised controlled trials, but we have not completed gathering the evidence. There is debate within the profession, but we look to the Government to resolve it for us.” It is really for service users and the professions to be clear about where the evidence suggests good practice lies.

**Dr Chalmers:** That is exactly what I was suggesting.

**Q50 Rosie Cooper:** Could you give us an idea of the consequences of not having adequate access to an independent advocate? Do you think that that is a general problem, or are there particular groups that are not given access to independent advocates?

**Naomi James:** There is a massive problem with access to independent mental health advocates. We have just discussed the importance of safeguarding in the Act and, indeed, within decision-making processes such as those for CTOs. It would certainly help if people had more access and—I guess I am repeating myself—if people who are not under compulsion also had access. There are specific groups we could look at. I quoted the fact that 19.5% of those on CTOs are from BME communities, so there is a question of disproportionate use there. Having access to an advocate is crucial for specific groups. I think there should be further training and support for the advocates. We have a number of issues about advocates not being able to deliver, or not being in the best position to support people, mainly because they have been brought in too late, when a decision-making process has already happened. Equally, if

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more people are going to be under CTOs, there needs to be more investment. Having the same amount of money to commission the service will cause a lot of problems. These people need support to be able to do these jobs and to do them well so that they know their role inside out and are able to support people. When an advocate is paired with an individual, it needs to be an appropriate pairing. I think that there are groups that are not gaining access to advocates. I do not have statistics to tell you exactly what the breakdown is, but I am sure I could find some details.

**Q51 Rosie Cooper:** No, that is fine. Which groups?

**Naomi James:** Because of the disproportionate use and the potential discrimination that is happening within mental health and the overuse of the Act among BME communities, I would certainly say that that needs to be looked at in detail. As you have pointed out, there are other people who have learning difficulties. We need advocates who are specifically trained in that, because people are just not able to represent their views, or to be involved in very simple decisions in which they could be involved. It is a bigger issue.

**Q52 Rosie Cooper:** Okay. I will link that to a question I was going to come to in a minute, and will move further on. Do you think there should be a standard definition of deprivation of liberty? If you do, what should it look like and why don't we have one?

**Dr Chalmers:** What an interesting question. The judges themselves have struggled with it, haven't they? Where would my personal opinion sit within that judicial view? The problem you are highlighting is that one of the criticisms of the deprivation of liberty safeguards is that there is no clear definition of deprivation of liberty. While that may be difficult to work with, it also reflects the reality—and actually reflects something about increasing the protection of human rights. Unlike under the Mental Health Act, where detention is seen as being locked up—a locked door in a hospital—the concept of the deprivation of liberty safeguards, the case law and the description of what might constitute a deprivation of liberty are much more holistic. I think it has a value because of that, as it pulls in things that relate not just to article 5, the right to liberty: a lot of the cases have arisen because people are not getting access to their families. There is something quite rich in the concept, but, given that, there are difficulties of definition. I would think that it needs more debate.

Perhaps there could be clearer guidance. At the moment, a number of cases have taken us to very strange places in terms of what may or may not constitute a deprivation of liberty. I am thinking particularly of the case in Cheshire West, where a very disabled person was kept in a body suit. I do not know whether you are aware of that, but there has been a debate through the different levels of the court about whether that was or was not a deprivation of liberty, with very intrusive care and staff exercising full and effective control. A view has been expressed—I think the case is in the Supreme Court or, if not now, then soon—that the very illness itself might constitute a deprivation of liberty, as it reduces your liberty, which

might not sit well with wider, softer European law about the rights of the disabled. That case has put people in a tailspin about what exactly deprivation of liberty is.

Elsewhere, at the Department of Health, I have expressed a view on what I think would be helpful. The case law can be very confusing. It was helpful when there was a sort of DOLS group and the Department of Health published a sort of resume of the case law, to give some kind of interpretation—a kind of practical “What does the law mean?” I know it may want to resist that, but somebody needs to do it. Experts need to get together and say, “This is what we think. This is the consensus view on what the law at this point means for practitioners”—a very easy-to-read kind of thing. I think that would be helpful, and I'm sorry that it has been lost. Rather than giving an absolute definition, we need more finessing, understanding and interpretation by the right people of what the case law means for me as a practitioner on the ground.

**Q53 Rosie Cooper:** As that is almost core to moving on, why hasn't anyone done it?

**Dr Chalmers:** Done what I have been suggesting? I know; quite frankly, it frustrates me as well. I think it has not happened because it is a hard thing to do—the goalposts are always moving—but I guess it could be done.

**Rosie Cooper:** Somebody should stick up a straw man. Let's get on with it.

**Q54 Chair:** It does not actually need to be the Government doing that, does it?

**Dr Chalmers:** I think that practitioners feel so unsure about this area that they do want guidance from some kind of body with authority.

**Q55 Rosie Cooper:** Okay, I will take you at your word. You say that it is about guidance, professionalism and good practice—all of that—so let us go back to very early in this debate, when we talked about saying to a patient who is in voluntarily, “If you leave, we will section you.” Funnily enough, it will not be the health care assistant who says that; it has to be a clinician of some status or standing—a nurse, a doctor, a psychiatrist or whatever. If they are doing stuff like that, do you not think that the board of the hospital, the chief exec and/or the GMC should see the actual threat to a patient to continue to deprive them of their liberty—in what for me is a dishonest way—for whatever reason, as going to the core of the professionalism you are talking about? Everybody is sitting around looking for somebody else to provide all that leadership and professionalism, and nobody is saying, “It's me. I'm doing it now.” Why not? Do you think the GMC and people like that should be dealing with it?

**Dr Chalmers:** I have already expressed my view on de facto detention and how I think that is unacceptable. Yes, there is an issue for professionalism and training, but you are presenting this as if people are doing it for malicious reasons; you have used very negative language. I think they are actually trying to do their best to protect the person

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from risk. We as a profession have been driven into being very fearful about therapeutic risk taking, because of the other issues that we have discussed before.

**Q56 Rosie Cooper:** But, if a policeman did what you have just said and deprived somebody of their liberty, they would have to answer for it. Why doesn't the medical profession have to answer for what it does?

**Dr Chalmers:** Because, as you said in your initial question, the definition of deprivation of liberty is a difficult one. The situation that I think you are describing relates to de facto detention on general psychiatric wards. That group of people is different from the ones the deprivation of liberty safeguards are there to protect, because the index case of HL was in a psychiatric hospital, and you could have argued that his rights would have been protected by using the Mental Health Act.

**Q57 Rosie Cooper:** Let us go to the core of it. Should hospitals and/or the GMC be interested when, for whatever reason, people not telling the whole truth indicate that a voluntary patient will be sectioned if they try to move?

**Dr Chalmers:** I think that hospitals should be very interested in how they treat their patients and in the fundamental principles of fairness, respect, honesty and all of that. It is not just an issue for the GMC. It is unfortunate that you should focus just on doctors, although we are important in this; it is a wider professional issue. In fact, a lot of these statements may relate to health care assistants, who may misunderstand the nature of this. That is my experience on the wards; you may have a different experience.

**Chair:** Rosie, you have put the point and got the answer. Health questions start at 11.30, so we are under a bit of pressure this morning. Grahame wants to come in on this.

**Q58 Grahame M. Morris:** Alison, you have been really quiet. Could you tell us your opinions on this issue of safeguarding? Are there any differences in the application of the safeguards between NHS providers and private sector or independent social care providers?

**Alison Cobb:** Are you asking about the DOL safeguards, in particular?

**Grahame M. Morris:** Yes.

**Alison Cobb:** I do not have data on that. I am not sure—

**Q59 Grahame M. Morris:** Is there any sort of anecdotal evidence that there are issues here? In terms of our role, is there anything that we should do to support the smaller providers to ensure that proper safeguards—advocacy and so on—are there?

**Alison Cobb:** Thinking of smaller providers, there are real issues with support in terms of understanding and applying the Mental Capacity Act as a whole, understanding what the Mental Capacity Act means about working in people's best interests, understanding at what point the DOL safeguards become relevant, using and applying the safeguards

and applying for authorisations. Certainly, when the alliance looked at experience earlier in the introduction of DOLS, there was quite a lot of variation in people's understanding, even to the point of thinking that, if staff were working in someone's best interests, DOLS did not come into it because they were working in a person's best interests—which was completely missing the point. There is a need for training and continuing support, however that is provided. We should have a national focus on DOLS and how they are implemented, and we should support people to do that well. The people who are giving the care and treatment in conditions that amount to a deprivation of liberty are responsible for activating that process. It depends on them, so it is totally fundamental that they know what they are doing.

**Q60 Grahame M. Morris:** Mr Lawton-Smith may be able to answer this question. In your evidence, you express concern about a "lack of protection for anyone deprived of their liberty in care settings" that are not hospitals or registered care homes. What sort of care settings were you referring to in that regard?

**Simon Lawton-Smith:** I am sorry; not hospitals or—  
**Grahame M. Morris:** Not hospitals or registered care homes. Some concerns were expressed about lack of protection for people who were being deprived of their liberty. I wondered what settings you were referring to. Are they in the community?

**Simon Lawton-Smith:** I appreciate that you have asked me the question directly, but I have to say that it would be helpful if I could pass it over to Julie, who is our expert.

**Alison Cobb:** Is the concern around people in supported living arrangements, to which this law does not apply?

**Q61 Grahame M. Morris:** I just was not clear. Is that what it is?

**Alison Cobb:** I think that would be our concern.

**Dr Chalmers:** Yes, the safeguards are not available to those in supported living. One of the fundamental requirements to be caught by the deprivation of liberty safeguards is that you lack the capacity to make the decision about the arrangements for your care and treatment. People in supported living arrangements have a tenancy, and you have to have capacity to have a tenancy; it is rather circular and convoluted. However, they are vulnerable people, aren't they? They may or may not need these deprivation of liberty safeguards, but they certainly need safeguards if they lack capacity, because it might be borderline—and capacity is decision-specific. You could have capacity for tenancy but might need the safeguards of the Mental Capacity Act for serious medical treatment.

You asked about the different settings. We know that the majority of patients who are subject to deprivation of liberty safeguards are in care homes, which are mainly in the private sector, aren't they? The NHS accounts for a small proportion. Of 1,500 people, cross-sectionally, who are deprived of their liberty under these safeguards, only 200 would come from hospital settings. That begs the question: are hospitals picking that up? Care homes seem to be making more of the applications, but they have more numbers. An

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issue that may be more interesting than the settings is the variability in the application of deprivation of liberty safeguards.

**Q62 Grahame M. Morris:** Is there any reason why they should not be applied in an independent living environment? Does the Act prevent the application of DOLS?

**Dr Chalmers:** I know Lucy Bonnerjea from the Department of Health is here, so I will defer to her. However, as I understand it, it does not extend to supported living settings. I raised a point about variability, which is something that the alliance would like to bring to your attention; you are no doubt aware of it. The first thing I would say is that we must have a caveat about raw figures. Currently, that is how it is reported—just in terms of numbers. As far as I am aware, these figures are not currently expressed per 100,000 and then further finessed for skewed age demographics as well. One of the experts at SCIE tells me that, if you look at the raw figures for certain areas, it looks as if they make very few applications, but when you correct them and give the number per 100,000 they come within the national average, so I think we need more definite figures. However, it is curious that in the recently published six-monthly reported figures there is one place that made no applications. That does beg a question. It is either a beacon of exceptionally good practice in use of the MCA—

**Chair:** Or—dot, dot, dot?

**Dr Chalmers:** Or not. Or something in between, perhaps.

**Q63 David Tredinnick:** I want to ask you about ethnicity and detention. Have the reforms in the 2007 Act done anything to tackle the disproportionate presence of some ethnic minority groups within the mental health system, or have the provisions actually made it worse?

**Alison Cobb:** I will pick this up. I am not sure whether the changes are responsible for making it worse. Certainly, it has not improved. The NHS Information Centre and the Care Quality Commission figures show a continued disproportionate representation of people from some black and minority ethnic groups in both the population of people who are detained and those on supervised community treatment. That applies particularly to black groups—African, African Caribbean and some mixed groups. There is a principle in the Mental Health Act code of practice that addresses diversity and individuals—I cannot remember the exact words—but I do not think that that on its own would provide sufficient leverage to tackle this issue. I am not sure what other changes that were introduced could have had such a reduction as an objective.

There are a number of reasons why this over-representation may be happening. It is an area of real concern to us. Attention has been drawn to it year after year, and it seems very difficult to change. There could be a number of issues, from high levels of illness to coming to services later, when people are more likely to be in crisis, to decision making that may be based on stereotypical interpretations of how

someone is behaving. The whole “circles of fear” phenomenon is still likely to be a very important factor. The study on that was done 10 years ago, but I imagine that the phenomenon is still likely to be very current. It suggests that people from black communities may be afraid of services and have fears around being detained, medication or how they might be treated. The impact of that results in damaged trust and people not wanting to engage with services and, perhaps, delaying making contact with services until really late in the piece, when it may be more likely that the Act will be used. There is also an interaction between that and fears within mental health services, which kind of compound each other.

**Naomi James:** I want to add something from a more recent study by Dorothy Gould, on service user experiences of recovery under CPA. The key findings relating to ethnicity were that, in their answers to the questionnaire, African and African Caribbean men and women were particularly dissatisfied with mental health professionals’ lack of openness to non-diagnostic explanations of mental distress. Their ratings for recovery services provided under the 2008 care programme approach were also mostly lower than those given by participants as a whole. Just to add to that, on the idea of circles of fear, we work with a largely BME group in Hackney, to which I referred earlier. There is great concern about restraint and coercion. I think the deaths of BME health service users have contributed to this circle of fear. Sean Rigg’s coroner’s report last summer described excessive use of force and poor leadership by the Met Police. In addition, the pending coroner’s report is expected to be critical of excessive use of force, again, in South London and Maudsley’s crisis care of Olaseni Lewis. Some of the learning from where trusts have stopped using that, and how that can be replicated, would assist with some of the fear around accessing mental health services, and people leaving it until the very last point and ending up getting sectioned.

**Q64 David Tredinnick:** Chair, we are very short of time, but I have one other question. No mention has been made of drugs. We have a situation where the black or black British community is 3% of the whole population, 10% of the in-patient population and 15% of those receiving community treatment orders. What impact do you think marijuana and skunk have on mental health in this community?

**Dr Chalmers:** Probably the same impact that they have on all communities.

**Q65 David Tredinnick:** The point is that they may be disproportionately used in that community, because there is a cultural aspect to this.

**Naomi James:** There is a study by Curtis in 2006 about London having higher psychiatric admission rates in deprived, low socio-economic areas. Obviously, high unemployment rates, alienation and people feeling a lack of community, stigma and discrimination can lead to people disconnecting from the community. Of course drugs do have an impact on people’s mental illness, but the issue is why they are using them in the first place, and whether they are



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using them to manage their condition—from their perspective—or to manage their social condition as well. It is worth bearing in mind as important factors the wider social determinants of where those people actually live and potentially work.

**Dr Chalmers:** Can I make an anecdotal comment? I work in north Oxfordshire, in the leafy shires, where we have a predominantly white British community. My assumption is that every young person I see is smoking weed, as they say. It seems a common occurrence among the young—and the not so young. I do not think I would focus that concern on one particular community; it is an endemic problem.

**Q66 Chair:** If we looked at the incidence of in-patient care and CTOs by socio-economic group rather than by ethnic group, do you believe that we would find that the discrepancy for ethnic groups is more about their socio-economic breakdown than about any kind of ethnic breakdown?

**Dr Chalmers:** It may frustrate you if I say yet again that there is a study that is about to be reported; we have heard preliminary results, but I do not have permission to share those with you. It is the AMEND study, which has looked into the issue of trying to factor out things such as ethnicity and place of residence. I think it may have an interesting contribution to make to that.

**Q67 Chair:** We look forward to it. When is it likely to be available?

**Dr Chalmers:** It is by Professor Swaran Singh. The Department of Health may be able to give you more details, but he has certainly presented preliminary results, so it should be available within the next few months or so.

**Chair:** Okay. We shall act as a trailer for it, if nothing else. Thank you very much indeed for your evidence. I am sorry that we were a bit rushed at the end, but we have to be elsewhere at 11.30.

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## Tuesday 12 March 2013

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper  
Andrew George  
Barbara Keeley  
Andrew Percy

Mr Virendra Sharma  
David Tredinnick  
Valerie Vaz  
Dr Sarah Wollaston

### Examination of Witnesses

*Witnesses:* **Dr Hugh Griffiths**, National Clinical Director for Mental Health, **Bruce Calderwood**, Director of Mental Health, Disability and Equality, and **Anne McDonald**, Deputy Director of Mental Health, Department of Health, gave evidence.

**Q68 Chair:** Good morning and thank you for joining us. This is the second evidence session we are holding on post-legislative scrutiny of the Mental Health Act 2007 to seek to examine the impact of that piece of legislation five years after it was implemented, to work out what learning experiences are available to us from that. Could I ask you to begin by introducing yourselves and telling us very briefly what the scope of your responsibility is within the Department, please?

**Bruce Calderwood:** I am Bruce Calderwood, the director of mental health, disability and equality at the Department of Health. That means that my team provides advice to Ministers on mental health strategy and mental health policy. We produced the Government's mental health strategy "No Health Without Mental Health". We also provide advice in particular on autism and learning disability. So it was my team that carried out the review of what happened at Winterbourne View. We are responsible for leading on issues of equality in the Department of Health to make sure that we are fulfilling our equalities duties properly.

**Dr Griffiths:** I am Hugh Griffiths, the national clinical director for mental health. I am also a consultant psychiatrist and have been for longer than I would probably care to admit, but it is well over 25 years. I have been in the Department for nearly 10 years. I was deputy national clinical director for six or seven years and for the last three years I have been national clinical director. To summarise, my main role is to provide the clinical input and advice for the policy team.

**Anne McDonald:** I am Anne McDonald. I am the deputy director. I work directly for Mr Calderwood. My branch deals mainly with mental health legislation and secure services.

**Q69 Chair:** Thank you very much. I would like to start by asking you what your assessment is of the effect of the change from treatability to appropriate treatment as the test for sectioning. It was one of the issues years ago: there were groups of individuals with personality disorder that psychiatrists were unwilling to detain under the Mental Health Act. Has that gone away as an issue, and indeed, more broadly, what has been the effect of the change of definition on the practice of psychiatrists when making sectioning decisions?

**Dr Griffiths:** I remember the debate at the time. The problem with the old Act—and I think most clinicians did agree—was in the exclusion, the treatability tests, because it asked clinicians to make a prediction of treatability before assessment, very often. There was a concern that some people who legitimately needed treatment would be denied access to it because of the nature of their illness—that they were not getting treatment. The debate was around an alternative to the treatability test. Of course we needed something because the other legitimate concern everyone had was around preventative detention—and this has to be about healthcare—so the concept of appropriate treatment was brought in.

The evidence that we have—and some of it is still provisional—seems to be that it has not made a significant material difference. The main evidence for that comes from a yet-to-be-published study—so these findings are still provisional—called the AMEND study, which is something that was commissioned through the Policy Research Programme, specifically looking at the change in the definition of mental disorder and, of course, the change to appropriate treatment. It looks as though clinicians have not significantly changed their practice, which is what you would expect because it is enabling legislation; it is just to make it clearer and more helpful. It has not made any difference to the proportion of people with personality disorders being detained, so it does not seem to have had the effect that some people feared and it does appear to be working.

**Q70 Chair:** Is it still an issue in the psychiatry profession that there are some cases where care and extra safety could be provided to the patient and to the community appropriately but where individual psychiatrists are unwilling to use sectioning powers?

**Dr Griffiths:** Clinical opinion and practice vary, but, by and large, I do not think that's a problem. I know of no evidence to suggest that that is a significant problem. In some ways, the change in the Act makes clearer and more honest what people are expected to do. Unless anyone knows different, I have not come across that as a significant problem.

**Q71 Chair:** If we look at the increases in the number of occasions when sectioning powers are used over the period since the Act came in, what do you attribute that to?

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**Dr Griffiths:** We have discussed this and the short answer is that it is unclear. It is not at all clear that it is down to the change in legislation. There was the trend of a small increase prior to the legislation. There could be all sorts of factors to account for it. There is another study that we expect to be published in the late summer or autumn. It is the English National Study of Compulsory Admission, by Warwick university, looking at some of the granular details as to what may lie behind that increase in detentions. So we have no evidence that it is down to the change in legislation, but it is something that we and everyone would be concerned about. I do not think there is a right number of detentions—we do not know what that would be—but any significant change has to mean we ask questions.

**Bruce Calderwood:** What we can say is that the trend in detentions applies not just in this country but also in other European countries. Even in Scotland, where after their Act there was a slight reduction in the number of detentions, in recent years it has gone up again. There seems to be something broader there than just the application of the legislation in terms of what is going on.

**Q72 Mr Sharma:** My questions relate to voluntary admission. The CQC records over 90% bed occupancy in over 50% of wards. With such pressure on beds, is it the case that people are being sectioned in order to gain access to beds as it is not possible by a voluntary admission? In addition to that, are detentions under the Mental Health Act increasing because patients do not wish to voluntarily admit themselves because they are aware that wards are overcrowded?

**Bruce Calderwood:** There is a range of factors there. The CQC certainly pointed to evidence that wards are running “too hot”, as it were. A number of people are certainly suggesting that that is affecting the behaviour of both patients and clinicians. There are other factors that need to be thought about, one of which is around community-based services and whether they are of the right quality. Again, the CQC made some recommendations around what community services need to be like. The conventional view would be that what one needs are extremely good community services that are there when people need them and enough beds, because clearly there is a case for voluntary in-patient care for when people need it. I do not think anyone would pretend that at the moment the optimal balance is there across the country.

**Dr Griffiths:** No. Can I add to that? We know there is some research evidence that there appears to be an inverse relationship between the number of beds apparently available and the number of people being detained, so that may well be one of the factors that underlies the increase for some of the reasons that you say. The other thing to add is that there is enormous variability up and down the country. The Audit Commission—as it was—used to run a thing called the Benchmarking Club for mental health service providers and they would look at the occupied bed days in acute mental health wards. What they found and what the CQC found was that some places are

definitely running “too hot”. Over 90% and certainly over 100% occupancy is “too hot”, too high. The Royal College and others have suggested it should be around 85%, and I think that is about right. The Benchmarking Club also found that there is immense variation; there are a number of places that are running like that but there are some with relative under-occupancy, which, of course, is not right either, because in-patient beds are expensive and the opportunity costs and potential for investment in more appropriate services can be lost. So there is a balance and it seems like it is not being struck right at the moment on the evidence from the CQC. There may be a relationship between that and rates of detention.

**Q73 Barbara Keeley:** A comment has just been made about community services, but mental health patient groups have reported cuts to community services, like peer support, and lack of access to therapeutic services, with some very long waiting times there. Have you made an assessment of those elements being contributory factors to the increase in detention numbers? Indeed, is it the case that the threshold for admission to hospital increased and that we are now seeing people that are much more unwell when they go into hospital than was previously the case because of the two factors—lack of those community services and very tight pressure on beds?

**Bruce Calderwood:** There is a variety of ways in which that can be interpreted. It is fairly clear that the level of severity of illness of people in hospital has increased over time. That could be down to having more effective community services that are keeping people out of hospital.

**Q74 Barbara Keeley:** Let me make the point clearly. That is not what we heard. We heard that there was a lack of community services, they were not effective and they were not available even.

**Bruce Calderwood:** Community services have expanded dramatically over the last 10 years. It has been one of the big investment areas within the NHS. That does not mean necessarily that they are of the right level of quality that you would expect to see everywhere, but, if you were to look at something like early intervention in psychosis, that was a major success story in terms of providing the kind of support that young people need on the first onset of psychosis, to keep people healthy and out of hospital.

**Q75 Barbara Keeley:** You are not answering the question I asked. The question I asked was about groups reporting cuts to services. Unless you are willing to address the fact that we have been told that there are cuts to services, it is not going to be helpful. If you are telling me they have expanded, you are disputing what the patient groups have told us.

**Bruce Calderwood:** I apologise in that case. What there has been over a 10-year period is a growth in community-based services. What we are not sure about currently is whether that growth has continued, reversed.

**Q76 Barbara Keeley:** My point was that, in our taking evidence, groups told us that there were cuts.

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So we have to start from the position of not looking further back but saying there were cuts.

**Bruce Calderwood:** Certainly. There will certainly be reductions in services in some areas. In other areas, there may well be increases in services. We do not know what the overall balance is.

**Dr Griffiths:** Can I add to that? I think I know what you are getting at because I have people saying the same thing to me. Bruce is absolutely right that the investment, in 2011–2012 prices and the 10 years up to that, went up 59%. Most of that was in community services, particularly crisis resolution, early intervention, assertive outreach teams and so on. The latest figure we have for the last year's investment to 2012 shows that, although there was a cash increase of, I think, 1.5%, that is actually a real-terms reduction of 1%. So some places are reporting reductions, which is something that does disturb me.

One of the things that we need to keep an eye on in the future—because I think it is worrying that people are starting to report this—is what local commissioners will do under the new arrangements. PCTs commissioned mental health services in the past and I have to be honest and say they have done that variably. Mental health commissioning is something that I think we have felt could improve. There has been good practice around the country, but it could be improved and I think we have an opportunity to do that with commissioning moving to CCGs.

Something that we have done in the mental health strategy, its implementation framework, and indeed the mandate, is to call for parity of esteem for mental health services across the board. Particularly that will apply to commissioning, where I do not think it has been true in the past that it has necessarily had that, which is why we may see mental health services disproportionately affected. The other thing that can lead to that is that we have had block contracts for mainstream mental health services and not a payment-by-results tariff system that exists for acute hospitals. It is much easier to cut a block contract budget than it is a payment-by-results system and we are bringing in payment by results. It is a little harder to do in mental health, but we are bringing in a system and it is evolving as we speak. The data are now being collected.

**Q77 Barbara Keeley:** I have to say, Chair, I find it concerning that we have had this debate here about the cuts. If you are not aware of cuts, that is concerning. I cannot just advance my own anecdotal evidence in support of that, but I have had constituents taken off therapeutic programmes that have been cancelled. Mind told us that one in five patients has had to wait over a year for access to treatment. We heard that delays were actually leading to mental health professionals saying to patients, “The only way you can get access to treatment is via A and E.” If you, from the Department's point of view, are saying you have this rosy picture that there has been an increase of—

**Bruce Calderwood:** No, that—

**Q78 Barbara Keeley:** That is what you said. I asked you about cuts and you talked to me about expansion.

You need to accept that this Committee, which is responsible for accountability, has had reports of cuts. I, as an individual MP—I do not know about others—have had experience of cuts affecting my constituents and you need a better map of what is going on out there if you do not accept that there are cuts that are causing one in five patients having to wait a year with mental health professionals saying, “The only way you are going to get treatment is if you go through A and E.” That was my question.

**Bruce Calderwood:** I do not deny that there are cuts in some places. What there has been, though, is a pattern over quite a long period of growth in community-based services and that pattern has still been accompanied by growth in people being detained under the Mental Health Act. So it is not as simple as, “There has been a reduction in community-based services and that has caused the growth in the number of people detained under the Mental Health Act.” The picture is very variable. The other thing that has happened—and this makes it difficult to interpret the evidence—is that there was a growth in lots of different types of community-based teams and recently those teams have started to be amalgamated. It is then not clear whether that is a reduction in service or a simple increase in efficiency and a reduction in cost. In some places, doubtless, it will be a reduction in service and I would not possibly deny that. In the mandate that the Secretary of State has set the NHS Commissioning Board, it says specifically, “We want you to put mental health on a par with physical health, and we specifically want you to look at access to mental health services and at the times that people wait for mental health services because of the concerns that people have that waiting times can be too long in some areas.”

**Q79 Barbara Keeley:** A year is too long. If Mind were reporting to us that one in five patients is having to wait a year and—

**Dr Griffiths:** I would want to look behind that. That sounds extraordinary and utterly unacceptable. I do not understand that figure. We have good relationships with Mind and I would be very happy to talk to them about it and find out what lies behind that.

**Q80 Barbara Keeley:** My other question was that we have had these reports and that is the evidence that was given to us, but how can this be clarified? How can we get a better picture? We are being told two things: there are cuts to community services and access to therapeutic services is a problem—people are waiting long periods of time and being told by mental health professionals, “You will have to go through A and E if you want treatment.” But that does not seem to be the picture that you have, and you are looking at whether things happened in alternative ways. We need a better picture.

**Dr Griffiths:** I am not sure that it would be reasonable to characterise all services that way. The fact that it may happen at all—and there may be anecdotes to support that—is unacceptable. As to waiting a year for treatment, I would want to know what that is. Certainly, we are aware that there have been very long waits for specialist psychological treatments for some

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people with certain conditions. In my own area, in the past I've had 18-month waiting lists for specialist CBT, for example, and that is unacceptable. It is one of the reasons why the Government introduced the IAPT programme—the Improving Access to Psychological Therapies programme—so that people with common problems to begin with can have better access. I'd want to understand that “year” figure more—what lies behind it. I am very happy to talk to Mind and find out what it is they are referring to, but I entirely agree with you that it is unacceptable.

**Q81 Barbara Keeley:** It was not just Mind. Naomi James of the National Survivor User Network made the point that the impact of these delays—so not a delay, not a single anecdote, but “delays”—is that patients are apparently routinely being informed by mental health professional that the only way they can access treatment is by A and E. That sounds like a pattern, doesn't it?

**Dr Griffiths:** I want to know what data lie behind that; that is the point I am trying to make.

**Q82 Barbara Keeley:** The Department ought to have a picture is what I am saying to you.

**Bruce Calderwood:** The reason why we have set through the mandate this particular request to the NHS Commissioning Board is that we want from them an assessment of what waiting times there are for mental health services and what the access levels are, and we want them to give us that assessment so that something can respond to it, so that we have a better sense, therefore, of—

**Q83 Barbara Keeley:** We need that too in this Committee.

**Bruce Calderwood:** You clearly do.

**Q84 Chair:** Is there something you can provide to us in terms of—

**Bruce Calderwood:** At the moment there is not something that we can provide to you because waiting times data for mental health services are not collected routinely in the same way as they are for acute services. That is part of the reason why we are saying to the NHS Commissioning Board, “We want you to put mental health services on a par with physical health services.”

**Q85 Barbara Keeley:** I would like you to accept that we have evidence that sounds a bit more than anecdotal and that this is something—

**Dr Griffiths:** But I want to understand the data behind it is my point.

**Q86 Barbara Keeley:** Can I move on to readmissions? The Mental Health Alliance did not have access to data on readmissions. Do you in the Department have evidence that can tell us whether a growth in readmissions has contributed to an overall rise in detentions?

**Dr Griffiths:** I missed what you said.

**Barbara Keeley:** Does the Department have evidence that tells us whether a growth in readmissions has contributed to the overall rise in detention? There has

been an overall rise in detention. Is that due to readmissions?

**Bruce Calderwood:** By “readmissions” do you mean the same people coming back over and over again?

**Barbara Keeley:** Yes, that is what readmission means.

**Bruce Calderwood:** I was about to respond to a different question in that case. I do not think we have accurate information on the same people coming back over and over, but mental health conditions are long-lasting conditions and they reoccur. It will not be the complete explanation for why there has been the growth in the number of detentions that there are, but you would expect a large number of those detentions to relate to the same people.

**Barbara Keeley:** Again, that sounds like something you might want to look at.

**Q87 Rosie Cooper:** If I may, I will quickly try to paraphrase an e-mail I have asked my office to send me after listening to your exchange with Barbara. I recently had a letter from a constituent whose daughter was schizophrenic, had come off her medication and was in a very distressed state, so bad that the police were called and they handcuffed her. An ambulance was called and she was taken to Southport and Ormskirk hospital. She was assessed and told she could go home. The family disagreed because her behaviour was completely irrational—she was trying to unscrew screws from the door, trying to take a kettle away from a doctor—so much so that the doctor threatened to call the police.

They then could not get any help, so the parents decided to take the daughter home but left instructions with the partner to contact the Red Team and the Crisis Team at Chorley. They left messages on the answering phone, giving mobile numbers. The parents had to drive round with their daughter in the car for two and a half hours, eventually getting home at one o'clock in the morning. They got her upstairs with the intention of getting her to bed but she became uncontrollable. They then had to ring the police again. Three officers arrived and she was again handcuffed—and how frightening all this must be—and detained. They explained to the police what had gone on.

The police contacted the Scarisbrick unit and were told to get an ambulance, put her in the ambulance and take her to Southport and Ormskirk hospital where this had all started the evening before. Because they had no help, there was no choice but for it to be left to the police to arrange for an ambulance to take her to the custody suite. She was kept and seen by a police doctor and psychiatric nurse. They left at 4.40 am. The father rang the police station for information and was told that she would be seen by a police doctor at 8.00 am. Then they were told she would be taken to a psychiatric hospital in Bradford where she is receiving treatment.

Can you tell me how that meets your vision of what is going on in the health service and is different from that which Barbara and I see—or any MP may see—on a daily basis? How do you explain that kind of response from the health services you are, in essence, running?

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**Bruce Calderwood:** That is completely unacceptable. It is just appalling.

**Q88 Rosie Cooper:** But it is not unusual.

**Bruce Calderwood:** It happens and I accept that it happens, but what you have just described is completely unacceptable. That should never have happened in that way, shape or form. It is completely at variance with what we are attempting to do. It is completely at variance with the strategy that we have outlined. My personal view is that that should be regarded as appalling practice. There is, we know, an issue in some areas about crisis care, the involvement of the police and the overuse of police facilities to handle crises. It is not as acute as it used to be. It is getting better, but it still happens. There is a lot more to do and we are working with the Home Office and the police forces to make it better. The pattern of events that you have described is awful and unacceptable.

**Q89 Rosie Cooper:** The parents' letter finishes by saying, "When the duty doctor discharged the two officers and said she could go home we felt greatly let down for both [our daughter] and ourselves. We feel the duty doctor was incompetent in his duty of care and that he wanted no more to do with the situation. He gave the impression of 'not on my shift'. If he had diagnosed her problem the second incident would not have occurred, which compounded our distress greatly. As for the Crisis Team it is a team in crisis; we received no help or return phone calls. It is not fulfilling its obligation as a twenty-four help line in West Lancs. With regard to the Red Team, they saw [our daughter] on Friday 1 March, reported that she was well and had never appeared better."

Do we have serious shades of, "We don't have a clue what is going on in the service we provide," and perhaps Mr Francis should come and look at mental health services as they are being delivered? You three are telling me how it might and should be, but I have not heard you really address how it is for my constituents and, I have no doubt, other people around this table. This is real. Lancashire Care is seen to be one of the better mental health providers—that and Lancashire social services. However we get to it, this is what they are delivering to my constituents, not once, but over the years I've had many cases. This was only sent to my office on 6 March 2013, which is why, when I heard that exchange, I quickly asked for it. Yes, you are right, it is appalling. What I need to know is do you really know what is going on, on the ground?

**Dr Griffiths:** Can I respond to that? I still work on the frontline. I still see patients every week. I work in a general hospital and we go and see people who have generally come in through self-harm or attempts to kill themselves. I see problems both in my own service and other services. What you have described is truly appalling and there is never any excuse for bad practice. Where I differ from you is that what people will generally write to their MPs and to us with are the problems, and we see a great many problems. They do not tend to write to people when things are going well. Where I differ also is that to characterise

the entire service as functioning in an unacceptable way like that is, I think, a misconstruction.

**Q90 Rosie Cooper:** Forgive me, but I do not characterise that at all. What I characterise is the fact that you are at the head of this organisation and you have not addressed the issue in any way, in spite of repeated questioning by Barbara about cuts, effects and the downsides to it. We are just presented with the theory of how it should run. I do not characterise the whole service like that at all. What I am saying is, if you do not recognise that this is going on, how, as Francis might suggest, are you addressing the problems if you do not know that they are there?

**Bruce Calderwood:** Can I respond to that? I am sorry if I sounded complacent. The Francis report applies as much to the mental health service as it does to any other part of the NHS. There are examples of fantastic service and there are examples of absolutely appalling service. The job of the CQC is to take a look at where the appalling services are, to actually assess them, to tell the trust about them and to expect the trust to bring them up to adequate standards. The job of the NHS Commissioning Board—and then in future CCGs—is to make sure that the services that are commissioned are of the highest quality. Our job as the Department of Health is to hold them to account and to make sure that they do it. We cannot do it on an individual basis, but certainly, in terms of an overall look at the service, that is what we intend to do. I apologise if what I said sounded as if I do not understand that really bad, poor quality practice happens—and happens not just occasionally but far too often. That is not the impression I intended to give and it is certainly not something that we are complacent about. People write to us about such things. People tell us about such things. It makes me personally very angry and our job is to try and improve the overall standard and outcomes in the system.

**Q91 Barbara Keeley:** Let me come back to the questions I asked because I think it is important. You mentioned that it is the job of the CQC, and the CQC has made recommendations about excellent community services. It is very important that we have debated this point about the state of community services. I would be very surprised if anybody thought that they had been improving in their area, because the stories you tend to hear, aside from awful examples like the one my colleague has just given, are of people losing services, people being taken off therapy, of therapeutic services being taken away. That is the evidence that patient groups gave us.

The second point I made was about readmissions. If it is the case that the pressure on beds is so great that people are more unwell when they go into hospital and are possibly more unwell when they are being released, that is serious. You do not seem to have a picture of readmissions, an understanding of whether that is the issue there. Those two areas are very important, but we will have to leave it because there are lots of other questions I am sure the Chair wants us to move on to. This exchange has not been

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satisfactory; we need better information and you need better information.

**Bruce Calderwood:** I agree absolutely that we need better information. We are about to move to a new, much more regular dataset. It is called the Mental Health Minimum Dataset. We hope that that will give us much more finely-grained information about what happens locally, much more regular information, but I very well accept that the kind of standard information that we have on mental health services is not nearly as good as it needs to be.

**Chair:** Barbara has accurately predicted my thought that we have a range of other questions.

**Q92 David Tredinnick:** But they are all related, I think. Going on from what Rosie and Barbara have said, if you look at commissioning by local authorities, when the Mental Health Alliance came to us, they said that there could be a problem with commissioning of services, not least because the Department of Health, although it will maintain funding for the independent mental health advocates, will not ring-fence that service. Do you think that is a potential problem?

**Bruce Calderwood:** In general, this Government have decided not to ring-fence budgets on the basis that the people in receipt of them need to be able to manage them and their priorities. There are statutory duties, however, that they need to fulfil. In practice, the amount of money that we are giving to local authorities in respect of IMHAs is larger than they were anticipating.

**Anne McDonald:** It has increased to £9.2 million from the £7 million that the NHS had received previously.

**Q93 Chair:** That is an allocation in a theoretical local authority funding formula. It is not a spend by local authorities.

**Anne McDonald:** No. It is the addition that has been made from this coming April to local authority budgets to reflect that new duty—that they have to commission IMHAs.

**Q94 Chair:** But is this money spent by local authorities or is it an allocation through some national funding formula?

**Anne McDonald:** It is allocated through the national funding formula, but it is an addition for next year to recognise this new duty that they have.

**Bruce Calderwood:** So it is not ring-fenced.

**Anne McDonald:** It is additional allocation, yes.

**Q95 David Tredinnick:** The problem with the lack of ring-fencing may be exacerbated because it seems to create a variation in local services. Certainly, this is what the Mental Health Alliance has said—that there is a variation in access to advocacy services across the country. Do you agree that not all patients who should have access to independent mental health advocates do have that access?

**Bruce Calderwood:** Yes; there is variation. The CQC report points to a considerable amount of variation there. The responsibility for commissioning mental health advocacy services has rested with PCTs; it is

about to move to local authorities. So local authorities have not been responsible for that variation. Local authorities do commission other forms of advocacy services, and they commission the advocates for the Mental Capacity Act.

**Q96 David Tredinnick:** Thank you. I understand that variation might be acceptable if there is an area, possibly a more affluent area, where there is less of a need for services, and maybe there is a relationship there. Do you have a system of guidelines that are issued to try and look for anomalies?

**Bruce Calderwood:** There are statutory duties about advocates. People have a right to them in certain circumstances. Any variation that means that people do not have access to a statutory right is an unacceptable variation. That's the first thing to say. The duties apply both to the commissioners in terms of what they need to commission but also, I think, to providers, in making sure that people are aware of their rights.

**Q97 David Tredinnick:** Isn't this also linked to the increase in the rate of detention? Independent mental health advocates are not available to support patients, according to the National Survivor User Network, because as the rate of detention increases there are fewer people to go round.

**Bruce Calderwood:** I don't think that there is any evidence about that. Actually, the evidence seems to be that the problems of lack of access are reducing over time, so the CQC has pointed to improvements. They are not nearly where they should be yet. But I don't think it seems to be related to the rise in detentions.

**Dr Griffiths:** What we do know is that there is another problem that underlies that. That is shown in the preliminary results from, I think it was, UCLan, wasn't it, who did the research into IMHAs? That is the practice actually, people not telling people, as they are supposed to, about their rights for an advocate. So what the researchers have proposed is, rather than having an opt-in system, where you are told you can have it and then apply, you automatically get one unless you say you do not want one. That is something—I don't know if you want to say more, Anne—we are considering at the moment. If that is part of the problem that may well make sense.

**Q98 Rosie Cooper:** I have just heard that exchange and I want to say, going further than that, the Department has suggested that the assessment of diversity and local need will be considered in the handover of commissioning responsibility to local authorities. What will you do to support local authorities in assuming those commissioning responsibilities? These are big. Where will local authorities get that real-time expertise? I have links with this in that both my parents were deaf, so I have grown up in a deaf world. Deaf people will often tell you that they struggle, one, yes, to get advocacy but, two, to get anybody to help them who is more than just an interpreter.

**Anne McDonald:** I think the University of Central Lancashire's research found that it was almost an



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inverse issue, that the more you needed an advocate, the more difficult it was to access them for exactly some of the reasons that you say. What we are considering with the researchers who did that work is how we can take some of that learning out and work with the local authorities as they take on this duty to build their ability to provide the right diversity of all sorts—cultural as well as disability—into their advocacy services. There are areas of good practice where people have developed what they call non-instructed advocacy exactly so that they can work with people who find it difficult to instruct an advocate. It is a skill to work with people with, perhaps, learning disabilities, so we are building on that to work with the commissioning—

**Q99 Rosie Cooper:** What is going to happen to these poor souls while you are building?

**Anne McDonald:** There will be an advocacy service. This is about building a service. There will be people with skills now who can work with professionals to provide that advocacy.

**Dr Griffiths:** The service hasn't changed; it is the commissioning that is changing, isn't it, not the service?

**Anne McDonald:** Yes.

**Rosie Cooper:** It is no wonder we are in a mess.

**Bruce Calderwood:** Local authorities already commission independent mental capacity advocacy services and other advocacy services. So what we are doing in moving this particular commissioning function to them is, in a sense, building on the ability that they already have. Advocacy services exist currently. They are clearly not being delivered in sufficient quantity. In some areas, it is clear that wards are not actually telling people about the advocacy rights that they have. The research that Anne has spoken to has been widely publicised. We are working with the researchers about how to transmit the messages of that through the system, and they have also made recommendations to us that we need to look at, one of which, as you have said, is around whether to have an opt-out service rather than an opt-in service. If we do that, that would reduce the pressures on the advocacy system.

**Q100 Mr Sharma:** There was a very interesting response to the previous question. The £9.3 million allocated to local authorities across England and Wales is not ring-fenced. What measures will you implement to track the use of this resource to ensure that it is used for its intended purpose?

**Bruce Calderwood:** With ring-fenced money you do not track, if you like, whether they spend exactly that amount of money. However, through the CQC, which monitors the availability of advocacy services and whether people have advocacy services, we will know whether advocacy services are there in sufficient numbers to meet the statutory duty. But we will not physically track the pounds because you do not do that with non-ring-fenced budgets.

**Q101 Mr Sharma:** But you have agreed that there is evidence, and many people have the experience, that when money is not ring-fenced then it can be misused

or abused by the system, used somewhere else, but the intended purpose is to use this money for the advocacy.

**Bruce Calderwood:** What we have done is put into the local government settlement enough money for advocacy services in the way in which many Government Departments put money into the settlement for a broad range of services, but it is then down to local government to decide how to spend that money, rather than spending it in exactly the proportions that we have allocated to them. Some authorities may spend more and some may spend less than that. The crucial thing is, do they provide the advocacy services, not exactly how much money—

**Mr Sharma:** Adequate advocacy services.

**Bruce Calderwood:** Yes. The crucial thing is, "Do they provide adequate advocacy services to meet the statutory requirements?", not, "Have they spent the exact amount of money that is buried in the allocation?"

**Q102 Mr Sharma:** We have heard evidence that staff on wards will, on occasion, decide whether it is in a person's best interests to have an independent mental health advocate. Is this in keeping with the aims and the wording of the legislation? Additionally, if you confirm that, to what extent do you expect clinicians to facilitate access to independent advocacy, or are they simply expected to inform patients of their entitlements?

**Anne McDonald:** This is the other side of the equation that staff, the professionals, should be facilitating people's access to advocates. If the first time they explain it to somebody is in the first few days of confusion, then they should be explaining it again and facilitating it. It is not for them to act in somebody's best interests in that way, but they should be facilitating the—am I misunderstanding your question, I am sorry?

**Q103 Mr Sharma:** I do not know whether I am misunderstanding the answer or you misunderstood the question, but certainly there is some misunderstanding here.

**Bruce Calderwood:** They should not be judging whether it is in someone's best interests to have an advocate, but it is people's statutory right to have an advocate and therefore they need to be able to explain the statutory rights if the person does not understand. If the person is in a state of confusion and anguish, which will be quite common when people are first admitted, then they should explain regularly, until the person does understand it. The code of practice is very clear on that. Perhaps I should have said earlier that one of the things we will be doing over the next year or so is rewriting the code of practice to take account of the evidence from the various studies we have been talking about, and also what people are telling us, to make it absolutely clear what best practice is in the way in which the Mental Health Act should be implemented.

**Dr Griffiths:** The evidence seems to be that they are not doing it as consistently as they should, hence the question around, "Should it be an opt-out system rather than opt-in?"

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**Q104 Chair:** Who is responsible for developing the concept of best practice in that context? Is it the psychiatry profession? Is it the policy people in the Department, the Commissioning Board? Where does the concept of what “good” looks like come from?

**Bruce Calderwood:** The concept of what “good” looks like comes from what good clinical practice is, which is primarily—

**Q105 Chair:** No. I am thinking more specifically about this access point to IMHAs.

**Bruce Calderwood:** Right. Here is one of the things where there is a join between what the law says and what the policy intent of the law is and, if you like, how that then connects up with good practice, both good practice in terms of what psychiatrists, psychologists and nurses and other health professionals do—

**Q106 Chair:** I understand that, but it is precisely because it is at that kind of cross-over that I ask the question, who—

**Bruce Calderwood:** So it will be the Government’s code of practice.

**Q107 Chair:** So it is the Department.

**Bruce Calderwood:** Absolutely. It will be the Department’s code of practice, but we will develop it in consultation with professional bodies, patient groups and others.

**Dr Griffiths:** That is exactly how the original code of practice was developed.

**Bruce Calderwood:** Yes, exactly.

**Q108 Chair:** So it is an issue for your division in the Department.

**Bruce Calderwood:** It is an issue for us, but it will not just reflect our own civil service views of what the world ought to be like.

**Rosie Cooper:** Independent mental health advocates can make representations on behalf of patients but cannot formally advise patients or propose a particular course of action even if they believe it is in the patient’s best interests. Have you considered extending the remit of the independent mental health advocate, and what do you see would be the downside of allowing them leeway in advising patients? I am sorry.

**Chair:** Shall we do Barbara’s question first?

**Q109 Barbara Keeley:** There was a final point on that link between what staff do and what the advocates do. There is the CQC warning that clinical staff are actually in some cases retreating from their obligations to inform patients of their legal rights. You have talked about the code of practice, but is it the situation that we need safeguards to check that a patient has been made aware of their rights? It is quite clear that the CQC say that in practical terms nursing staff have much greater contact with detained patients than advocates. They may not have an advocate and they may never get to think about or be aware that they could have an advocate, so the staff are best placed to ensure that patients get this opportunity to understand and exercise their rights. But, if it is the

case that staff are retreating from that, then we need another check, don’t we, somehow?

**Bruce Calderwood:** The check is effectively the CQC. It is its job to say, “Are essential standards being preserved?” and to see that the Mental Health Act is being operated properly. What it does is goes and talks to the hospital when it finds things that are wrong.

**Q110 Barbara Keeley:** I understand that, but it is saying that staff are retreating from their obligations to talk about rights. Because of the existence of the independent mental health advocates they are saying, “There are advocates and we do not need to do this,” but in fact they are best placed to give that advice. The CQC is saying they are not always doing it and are saying, “Because there are advocates, we do not need to do this,” but in fact they do. Whether or not an advocate exists, in terms of advising patients of their rights, the staff who see them every day and have better access to them are better placed to do that and the CQC is now saying that staff are retreating from that. How can we deal with the issue that staff are moving away from what they did before?

**Dr Griffiths:** I had misunderstood your point to begin with, but I think I do get it now. That is alarming, actually, and maybe that is something for the code of practice because clearly the intention of IMHAs is to enhance people’s advocacy and the information they get, not to somehow have it impeded by staff.

**Q111 Barbara Keeley:** But we need additional checks or safeguards, don’t we, because if the CQC is finding that staff are retreating from what they should be doing—“Because there are advocates, we do not need to do this”—then we need a further safeguard? A code of practice does not mean that staff stop doing something that they have started doing.

**Dr Griffiths:** That is right.

**Q112 Rosie Cooper:** In fact, if I might be so bold as to piggyback on to that, the question is, what assurance do you as leaders in the mental health profession have that employees, clinicians, are not withdrawing or retreating from their duty?

**Dr Griffiths:** The answer is that we do not. That is why I think it is a fair point and it is also worrying that people are not discharging their responsibilities to tell people about their rights to IMHAs. That is why, as I say, we think an opt-out system would work best. I am struggling to see what kind of assurance mechanism would work because the main one we have around regulation and inspection is, of course, the CQC—that incorporates the Mental Health Act Commission. Maybe it is a conversation with the CQC. I do take the point but I am just trying to think what those additional safeguards would look like.

**Q113 Rosie Cooper:** Okay. I have chaired a hospital. Assurance: what would I require if I ran a mental health service? I would be saying on every case note, or wherever, “Has this person been given?”—as Barbara might suggest—“access to an advocate?”, a tick box, and you look at the notes and know whether it is done or not and each level of people dealing with the patient will be able to see that. If questioned by a

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board or whoever, they would know. I would see that as basic in providing this kind of service. For me, it is frightening. Every time you speak to anyone in the health service these days you hear, "This is not working. Whose responsibility is it?", then, hey ho, bring in the cavalry—it's the CQC—and they will say whether it is good or not. They look at a model. They do not investigate every case.

**Dr Griffiths:** I see.

**Bruce Calderwood:** Whose responsibility is it? It is the trust's. It is the hospital trust that has to make sure it happens and it is the clinical responsibility of the professionals within that to make sure it happens. The CQC's job is to be the regulator and to say, in general terms, whether this is happening or not. What it does is look at the case notes. That is where it derives its evidence from. But it then becomes the hospital's job to make it happen.

As to whether or not there should be national measures for that, I am deeply sceptical. The thing about the Francis inquiry was that he pointed to a whole series of national measures that everyone was looking at and actually what that took away from was the responsibility of hospitals and professionals to do a decent professional job. So in terms of how things get better, there is stuff that we can do, and I think we can do it in terms of the code of practice; there is stuff that the CQC can do, and it is doing it, and the CQC I know wants to strengthen the way in which it is regulating mental health providers. There is a conversation to be had with professional bodies, the Royal College of Psychiatrists and the Royal College of Nursing, around what professional standards are, but I don't think we will be, in a sense, looking at people's records all the way up the system.

**Q114 Rosie Cooper:** I am sat here as a Member of Parliament doing what I have just said to you: I am looking for assurance that we are delivering out there, and we are not, are we?

**Dr Griffiths:** What you have described is a local governance and assurance process that trust boards should have in place. That is what you are describing.

**Rosie Cooper:** "Should".

**Q115 Barbara Keeley:** Could you not be reminding them of that? Don't you see a role for yourselves in even drawing this issue to their attention? How are all the local boards going to become aware of it if you do not take responsibility for letting them know, "What we are bringing to your attention is that there is an issue here"? There are two things, aren't there? One is staff retreating from their own professional responsibilities for advising of rights and also, we were told, in some cases making a decision on behalf of a patient whether they will or will not have an advocate. In fact, Naomi James of the National Survivor User Network said that she sees that as potentially pointing to a human rights problem. If this exists and is being reported to us, then there must be some responsibility on the Department to get that message out and to make clear to local trust boards what they should be doing.

**Bruce Calderwood:** The Department does not manage local trust boards. It is very clear that it does not have that responsibility.

**Barbara Keeley:** I am not suggesting that you do.

**Q116 Chair:** This is not about managing trust boards, is it? This is about making certain people have their civil rights that are secured by Act of Parliament.

**Bruce Calderwood:** Okay. Our vehicles for doing that are through the code of practice, which we intend to rewrite, and through talking to and holding the NHS Commissioning Board to account. The NHS Commissioning Board, we hope this week, will be announcing their new clinical director for mental health services. One of the things we want to do is sit down with them and go through things like the CQC report to say, "Well, what is going on here? Where are the areas that we can improve?"

**Q117 Barbara Keeley:** Then it has been useful our discussing it because the issues are that the CQC pointed to the fact that staff are retreating from telling patients about their rights, staff in some cases taking over the decision about whether a patient will have an advocate or not and the earlier issues that we talked about of cutbacks and bed pressures causing the earlier problems that we talked about. Those are all issues that it would be very useful for you to raise.

**Bruce Calderwood:** Yes, these are issues that we need to hold the NHS Commissioning Board to account for.

**Q118 Rosie Cooper:** I want to quickly go over the question I asked before, which was about allowing independent mental health advocates to offer advice to patients.

**Anne McDonald:** They can certainly offer advice to patients about the safeguards within the Mental Health Act and explain to them how to take advantage of the tribunal and various other safeguards around their detention, but as an advocate it is that they are speaking for the person. So they can advise about the issues around the detention, but they have to speak on behalf of the person in terms of advocating for them.

**Q119 Rosie Cooper:** When I send for a lawyer, I don't expect the lawyer to translate that I am telling whoever to go away. I would expect them to give me advice about how I should express that view within the legal structures. I don't expect them just to be an interpreter. I am really trying to find out if you think an independent mental health advocate is simply an interpreter.

**Anne McDonald:** No, I think that they are advising the patient and helping them take advantage of the safeguards that surround their detention under the Mental Health Act.

**Q120 Rosie Cooper:** So the notes we have here say they cannot formally advise a patient. Is that your understanding?

**Anne McDonald:** I think "formally advise" is referring to legal advice. They work with the patient to explain—

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**Q121 Rosie Cooper:** Okay, so what you are saying is that, as well as an independent mental health advocate, they also need a lawyer in the room in order to deal with a mental health professional. Is that what you are really saying?

**Anne McDonald:** No. I am saying that, if there is a legal issue to do with the legal points, they cannot formally give legal advice because they are not a lawyer.

**Rosie Cooper:** I get that.

**Anne McDonald:** But they can advise, because they have been trained in the aspects of the Mental Health Act, on how to use—

**Dr Griffiths:** They cannot provide formal legal representation, can they?

**Anne McDonald:** No.

**Q122 Rosie Cooper:** Okay. Let's leave that. We are not going to go anywhere with that either.

What is the logic behind limiting the mental health advocates only to those patients detained under the Mental Health Act or subject to community treatment orders? When I asked that of the last panel, they indicated that voluntary patients—I am not going to say often—had been told by clinicians that, if they tried to leave hospital, then they would be sectioned. Does that go back to the point we have just been making that there is a need for formal advocacy to be extended to voluntary patients as well?

**Dr Griffiths:** I think they have extended IMHAs to voluntary patients in Wales. The reason given at the time, in my understanding, was fairly clear because there already had been advocacy services for all patients in some services. There is some very good practice out there. At the time, it was felt that extending the formal IMHA role to all patients could destabilise some already existing good advocacy services. As far as detaining people in hospital who are voluntary patients is concerned, it is very clear. There are circumstances where voluntary patients who are inpatients need to be detained, for whatever reason—their mental state has changed, the risks have changed or whatever circumstances have changed—and there are of course sections 5(2) and 5(4) in the Act in order to do that, but it is utterly unacceptable to threaten anyone with it. The code of practice makes very clear that it is unacceptable practice to threaten someone. If someone's circumstances have changed, they are thinking of leaving, they meet the criteria for detention and it is appropriate, then, yes, but what you don't do is threaten it and coerce people in that way. I am aware, as you obviously are, that it still happens. To be honest, when I was in training many years ago, it happened more and it was not reported. There weren't figures on it, but it definitely happened. I have to say that I know it does occur and I do not have detailed figures on it, but certainly in talking to colleagues and in my own experience it has reduced very considerably, but it is always unacceptable.

**Q123 Rosie Cooper:** Can I ask about limiting independent mental health advocacy to those patients detained under the Mental Health Act or community treatment orders? What about everybody else?

**Dr Griffiths:** I did explain at the beginning, I thought, that there was a good reason for that, which was not to destabilise existing advocacy services. However, they have extended it in Wales and it will be interesting to see what their experience of doing it is. What I do not know is the extent to which they had those pre-existing advocacy services. That is something I cannot say. But we would be interested to see what happens in Wales.

**Chair:** Andrew, I think, is going to talk about community treatment orders.

**Q124 Andrew Percy:** Yes, and I apologise for being late. When the Committee heard from the Mental Health Alliance, there was considerable criticism made by them of community treatment orders. That was based around them being largely a way of compelling patients to take their medication. Could you give us your view on whether that is a fair assessment but also perhaps expand on that to explain what you feel community treatment orders should encompass?

**Dr Griffiths:** Shall I start on that? They caused a lot of debate at the time and a lot of criticism that they were just about medication and so on and so forth. The intention at the time was very clear and it is the same where they have been introduced across the world. The intention was not just to make sure that people take tablets or injections. The intention was to bring mental health legislation much more in line with modern practice. The previous Acts of 1959 and 1983 were very predominantly based around in-patient care. Up until then, that had been the predominant focus of services. By the 1983 Act, it was becoming much more community-orientated but less so than it is today. Since then, modern services are very much more based and focused around community settings. Therefore, it makes sense to have mental health legislation that reflects that. The intention of community treatment orders was first of all to do that and, secondly, to try and maintain people well in the community, who otherwise might not have been, when they had left hospital.

In my own experience—and psychiatrists differ about this—the majority of my colleagues are marginally in favour of CTOs, it is fair to say. If you speak to different professional or patient groups, you will get different views. I changed my opinion about them over many years. I started off being for them, then against them—I won't tell you why—but the point is I ended up being, overall, in favour of having CTOs because I have had too many patients in the past with long-term and severe conditions who, for whatever reason, once they have left hospital, even with some of the best services around, have really struggled to maintain themselves well and keep engaged with the services. Having some kind of provision that might have enabled us to do that better, I think, I would have supported.

Whether CTOs work or not in the way that we want them to work is another question. Experience around the world in Australia and the States is, frankly, a bit equivocal if you look at the data. There is not really good evidence even though, as a clinician, I think that would be useful. However, the NIHR has

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commissioned—I think it is the world’s first—a randomised controlled trial of CTOs. That is called the OCTET study—the Oxford Community Treatment Order Evaluation Trial. It is led by Professor Tom Burns from Oxford, but it is a national study. That, unfortunately, has not yet published its results. I know they have finished the year-long trial and they are due to publish next month. What they have done is a controlled trial of community treatment orders against section 17 leave, which is what a lot of people would use under the old Act. There were three kinds of provisions before, section 17 leave, guardianship and—I think it was called—after-care under supervision, which was a sort of provision to try and ensure that people stayed in contact with services, which was not used greatly. The point is that we will know, when those results come in, to what extent it may or may not prevent readmission compared with section 17 leave. I am aware that they are contentious, but the issue is about maintaining people well. It is not just about trying to ensure that they take medication.

**Q125 Andrew Percy:** It is interesting because your response was broadly around preventing readmission, what Ministers at the time called the revolving door. One thing the Mental Health Alliance raised at the Committee that they were concerned about was the fact that 30% of people on a CTO have only come into contact with mental health services for the first time. That leads to the question: are they therefore being misused and is that a failure of the—

**Dr Griffiths:** Readmission is what the OCTET study is measuring. I have been very clear that it is about maintaining people well, which is a slightly different thing from just preventing readmission. I have read that figure as well. It is difficult to say because the idea of a community treatment order is not just for people who have already become revolving-door patients—it is a terrible phrase, but I think we all know what I mean when I use it—but also to prevent people becoming revolving doors. So we cannot extrapolate just from that figure and say that it is being used inappropriately. But, again, we will learn more from the OCTET study.

Can I say one other thing? CTOs are being used much more extensively. There was an initial prediction at the time of the Mental Health Act about the number of likely CTOs. I do not know why someone felt it necessary to try and predict the number, but it looked at the time like a hopeless underestimate, which is what it has proved to be. So we do not know and there does not seem to be a right number for CTOs. We would expect them to stabilise over time, but what they do show is that clinicians think they are useful because they are using them. It is a clinical decision as to whether or not you put someone on to a CTO.

**Q126 Andrew Percy:** What you are saying is that you are comfortable with the idea that a CTO is suitable and appropriate for somebody who has come into contact with mental health services for the first time, that it is perfectly acceptable and was the original intention of the legislation. So for somebody who has no history of failing to take medication or relapsing, it is completely appropriate for—

**Dr Griffiths:** No, I am not saying that it is completely appropriate and should automatically be a treatment or a measure of choice. I can see there are circumstances with people who are relatively new where it may be, but it does not mean that it always is. Yes, it is an alarming figure and clearly the intention was to try and help support people who were in and out of hospital to remain better and more stable for longer. But it does not mean that it has to exclusively apply to people who have already been in hospital many times. You do need to have been detained in the hospital before you can go on a CTO.

**Q127 Andrew Percy:** There is also—we heard from the Mental Health Alliance as well, I think—considerable variation across the country by professionals in the use of these. One of the figures we were given at the time was that 45%, or something, was the highest utilisation of them; 4% was the lowest. The “Lowest reported ‘discharge rate’ on to a CTO was 4% and the highest was 45.5%.” Are you comfortable with that variation?

**Dr Griffiths:** It is a lot of variation, but then, again, we would expect variation because different areas have different services, different demographics and are configured in different ways. So you would certainly expect some variation and there is some disagreement within my own profession about CTOs. There are some people who are very uncomfortable with them and others who are very comfortable with them. When you combine the other variables, plus the varying professional practice, it is not surprising. Am I comfortable with it? Actually, I am probably not because they are there for a purpose. On the other hand, it is enabling legislation and these are clinical decisions.

**Q128 Chair:** Is there a school of thought within the profession that would argue for CTOs being available without a patient first having been detained in hospital?

**Dr Griffiths:** I think—and I cannot remember which it is—there is a country that has done that.

**Anne McDonald:** It is Australia, I think.

**Dr Griffiths:** I may be wrong. There is an argument for it. I cannot tell you the Government’s view on it, but I can tell you mine, which is that I think it is a bit of a dangerous road to go down. It really does open up a whole series of very uncomfortable questions and potential problems in practice. My own view would be—and if there is more positive experience of it in other countries then I would like to learn from it—that I personally would be uncomfortable with that.

**Q129 Chair:** So it is a discharge or recall mechanism. It is not a form of free-standing treatment, in your view.

**Dr Griffiths:** Absolutely, yes.

**Bruce Calderwood:** It is based on a clinician’s view on risk. Fundamentally, that is what it is all about.

**Anne McDonald:** I was going to go back to the “original intention” question, because when the 2007 Act was originally debated there was an amendment that tried to restrict it to people who had been detained more than once. That amendment was not made, so

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Parliament's intention was not to restrict it to just that group but to put it to the clinical decision about the risk in the community rather than that group of patients.

**Q130 Chair:** But it is still true that the patient has first to have been detained as a patient in hospital.

**Anne McDonald:** Yes. It is just this question about revolving doors.

**Q131 Andrew Percy:** The Mental Health Alliance point was about using them for people who do not have a history of non-compliance and the appropriateness or otherwise of that.

**Dr Griffiths:** Can I add another thing which may be driving some practice? It was mentioned by the Alliance, and a couple of tribunal chairs I have spoken to have told me this as well. Tribunal practice appears to have changed a little bit in that when reviewing patients on section 3, which is one of the things that many of them routinely do—at least, that is what the tribunal chairs tell me—they ask the question, “Have you considered a CTO?”, because they are anxious that people should consider the least restrictive option at all times. It seems to me that what some clinicians may do is interpret that as meaning the tribunals expect them to be put on a CTO. The tribunals say that is not what they are saying but that they are merely asking whether they have considered it. To what extent that may be driving behaviour is unclear and is perhaps something we need to consider in the future code of practice and so on, but it may well be that tribunals have had an effect as well.

**Q132 Valerie Vaz:** I want to go back to a couple of your comments before we move on to places of safety. I know you are wearing two different hats, as a practitioner and being in the Department of Health, but could you expand on why first you were against and then in favour of CTOs?

**Dr Griffiths:** I can if you want. At first—and I am going back to when I was a relatively junior doctor and a young consultant—I thought they were potentially too much of an intrusion. The way they had certainly been debated at the time was really as treatment orders, so having treatment enforced at home in the community. I was certainly, and absolutely still am, against that. I thought they were probably a step too far and would be administratively difficult. It was actually when I was a young consultant in the first few years and I did a job—looking back on it, it was an enormous job actually—where, because of the nature of the job, I had a very large cohort of patients with severe and long-term mental illness. I realised how inadequate what we were able to do for them very often was, particularly those who would rapidly lose insight and who were perhaps a little bit more chaotic in how they would take their treatment and so on. To watch them continue to relapse and get worse each time they relapsed was something about which I thought, “We have to do better than this.” So, within a relatively short few years, I came to my own personal view that CTOs would be a really useful thing. Certainly,

colleagues in Australia have very often said to us in the past, “How do you guys manage without CTOs?”

**Q133 Dr Wollaston:** Before I start, I need to state for the record that I am married to an NHS consultant forensic psychiatrist, who also provides advice to all political parties on behalf of the Royal College of Psychiatrists. Having got that out of the way, can I follow up on a couple of points? Have you yourself seen the results of the OCTET study and is that something you would recommend the Committee tries to obtain a copy of before we—

**Dr Griffiths:** We have seen provisional data, but we really cannot talk about the data because we did not commission the study and it isn't finalised, and won't be published until next month; it will be in *The Lancet*, I understand. This Committee will obviously be very interested in the findings of the OCTET study.

**Bruce Calderwood:** Because of those conditions, we have not been drawing on it in terms of the replies we have been giving you. We have been trying to pretend we have not seen a copy of it, if you see what I mean, because it is confidential to the people writing it.

**Q134 Dr Wollaston:** Yes, but I think it would be useful for us to know as a Committee whether the findings could have an impact on what we decide.

**Dr Griffiths:** Absolutely, yes.

**Q135 Dr Wollaston:** The timing of it is frustrating. Secondly, I understand that there will be variation in the use of CTOs around the country because of different circumstances, but I think what people would be more concerned about is that, if you were a patient in identical circumstances in different parts of the country, how much variation would there be if the circumstances were very similar? In other branches of medicine, we might expect the Royal College to issue best practice guidelines or perhaps for NICE to do so. Do you think that is overdue for the use of CTOs?

**Dr Griffiths:** That is probably a fair point. Part of the difficulty is that they are so relatively new and the picture has changed very rapidly. We do need to know what the trial tells us, but Bruce has said we are looking to re-do the code of practice later this year anyway. That is one of the things we should certainly include. As to whether there should be professionally-led guidance—whether it is NICE or the Royal College—is a very interesting question. My not terribly thought-through answer would be yes, actually, that probably would be a sensible thing to do.

**Q136 Dr Wollaston:** So it is not something that Parliament should be passing enabling legislation for, but clear guidance would be your—

**Dr Griffiths:** Yes, and to have that around professional consensus. That makes sense.

**Q137 Valerie Vaz:** Turning to places of safety and sections 135 and 136 of the Act, you mentioned earlier, in response to a question from the Chair, about the study that has been done by Warwick. Could I ask who commissioned that?

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**Dr Griffiths:** The overall study—England, and I can't remember what it was called now—was PRP, Policy Research Programme or NIHR?

**Anne McDonald:** It was the National Institute for Health Research and it is called the English National Study of Compulsory Admissions.

**Q138 Valerie Vaz:** It is reporting in the autumn.

**Anne McDonald:** Yes.

**Q139 Valerie Vaz:** You have no view on whether there is a link between the increase in the number of places of safety and the Act—the causal link between the two—do you? Do you have a view as opposed to the study?

**Dr Griffiths:** Section 136 was in the old Act. It is not new. I am misunderstanding your question, I think.

**Q140 Valerie Vaz:** There has been an increase in the number of places of safety. You say that it is not a result of the 2007 Act.

**Dr Griffiths:** No, because it didn't—I mean—

**Bruce Calderwood:** What the 2007 Act did was allow people to be moved from one place of safety to another.

**Q141 Valerie Vaz:** I am coming on to that in a minute.

**Bruce Calderwood:** That is what the Act did. Whether that in itself has actually shifted behaviour is unclear. What there was, though, was an investment programme in hospitals to create more places of safety. That was part of the implementation of the Act, so there is a combination between the legislation allowing one thing to happen and an investment profile.

**Q142 Valerie Vaz:** I am quite keen to hear the Department's view on that. You said a study has been commissioned but it has not been commissioned by the Department. What is your view?

**Bruce Calderwood:** Our view is that there has clearly been an increase in the number of hospital-based places of safety. We have gone from one third of patients going to a hospital-based place of safety to two thirds of patients going to a hospital-based place of safety at a time when it looks as if the police are detaining increasing numbers of people. Two thirds is still not good enough because it is very clear—and the code of practice makes it very clear—that it is justifiable at times to take people to a police station as a place of safety, but it ought to be exceptional. So we are not there yet and there is more work still to do, I think with the police forces and the Home Office, to make sure we can get there.

**Dr Griffiths:** Sorry to interrupt, but—

**Bruce Calderwood:** I feel I have not quite answered your question.

**Dr Griffiths:** Can I answer that? I am sure you are aware that there has been a very significant increase in the police use of section 136 and to some extent section 135 too—but certainly 136. It has gone up severalfold. It is not completely clear why that is, but, at the same time as the number of people they are bringing into places of safety has gone up, the

proportion of those subsequently being detained has gone down and it is less than 20% now. So, clearly, the police have changed their practice. We are aware that they think there are problems with section 136 and the way they are operating it; so we are in dialogue with the Home Office and the police about section 136 because we need to work with them to overcome some of the difficulties the police are genuinely having and understand how their practice has changed.

**Q143 Valerie Vaz:** What I want to try and find out is this kind of difference. The police are detaining people under section 136.

**Dr Griffiths:** Yes.

**Q144 Valerie Vaz:** Do you have figures or are you aware of how many detentions there are at the police station before they move to another place of safety?

**Dr Griffiths:** I see what you mean.

**Q145 Valerie Vaz:** The police are detaining some and then releasing them, and then they are moving them to other places of safety. Is that right? I don't know. I am just trying to find out.

**Anne McDonald:** There does not seem to be a huge number of moves. The police have been actively moving towards taking them directly to the hospital-based place of safety and there are some moves from a police station to a health-based place of safety, but there does not seem to be a huge amount of that.

**Q146 Valerie Vaz:** What sort of figures do you have on that? Can you give us those figures?

**Anne McDonald:** Certainly as to the latest collection we have done with ACPO around the numbers that are going to police stations, they basically then cleaned those out because they would be duplicates, if you see what I mean. It certainly did not look like a very high proportion, but it is very useful for some particular cases.

**Bruce Calderwood:** It feels like we ought to give you a note on this about what figures we do have.

**Q147 Valerie Vaz:** That would be very helpful. You talked earlier about only 20% of people are actually detained by—

**Dr Griffiths:** It is less than that now. It is about 17%, I think.

**Q148 Valerie Vaz:** What kind of reasons are there?

**Dr Griffiths:** Once the assessment has determined whether someone meets the criteria and it is appropriate to detain them—and for over 80% it looks like that is not the case—I do not know what has changed in the police's practice. What I can tell you is that there has always been a relative minority that subsequently get detained. I think there is an issue about how well the police are trained when it comes to dealing with mental health crises. They have a difficult job to do, do the very best they can and it is better that they bring in too many rather than too few, but nevertheless the change is strange. In my own practice, I have seen very variable use of section 136

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by the police, very sensible and appropriate kind of things and also some less so: bringing a drunken 17-year-old to hospital because it is felt their drunkenness is not appropriate. I am not saying that characterises what the police do, but we need to understand what lies behind an apparent change in behaviour.

**Q149 Valerie Vaz:** Do you think it is partly a public order issue that they are using section 136?

**Dr Griffiths:** That is an interesting question.

**Bruce Calderwood:** We simply do not know. There appear to be areas where the police and the NHS are working very closely together and in a sense both parties are happy with what is going on. There are other areas where, for various reasons, that does not happen and either the NHS party or the police party or both, are discontented about the other. One of the things we are looking at is how we can get not necessarily a better standardisation because we are talking about independent organisations but a better understanding of what good practice is and spread that out across the system. That is what we are talking to the Home Office about.

**Q150 Valerie Vaz:** You mentioned children. What is the issue about children? It is quite serious. There are a number of children under 18 who are detained, aren't there, under this provision?

**Dr Griffiths:** Do you mean under section 136?

**Q151 Valerie Vaz:** Yes.

**Dr Griffiths:** I don't have the figures. Do you have the figures for that, Anne?

**Anne McDonald:** I think it was 300 and something in a year, and that is probably an underestimate.

**Q152 Valerie Vaz:** Are those all mental health issues?

**Anne McDonald:** I don't know where they then ended up.

**Q153 Valerie Vaz:** Do we need to know where they ended up?

**Anne McDonald:** Yes. Certainly there are some areas of good practice like Wiltshire where they have a very close protocol so that, if somebody under 18 is picked up by the police, there is an immediate response by the child and adolescent mental health service to work with them and, as you say, to work out what the issue is and how to resolve it. They may not all be actually mental health issues; they may be conduct or substance abuses that need to be dealt with.

**Q154 Valerie Vaz:** Who is keeping those figures, that record?

**Anne McDonald:** The Royal College of Psychiatrists runs an interagency group on section 136 and they are just about to bring out some "what good looks like" guidance but also how police and health service commissioners perform, essentially the flags to look at to see whether your service is delivering what you need for your local people. So it will have raised issues. I am sure that under-18s taken to a police station will be one of those issues that you would want never to

happen and if it did, as a commissioner, you would want to know why.

**Q155 Valerie Vaz:** What is happening at Department level in relation to this? Are there triggers, alarm bells or flags raised about it?

**Bruce Calderwood:** Norman Lamb, the Minister for Care Services, quite recently made it perfectly plain in that regard that it is unacceptable for children to be taken to a police station when they are in a state of mental distress. There are circumstances when it might be the right place to take a young person. That is one of the things that we need to work through with the Home Office around what practice is to see if we can reduce to a minimum the numbers of children in a state of mental distress who end up in a police station. Having said that, there will be circumstances where it is the right thing for an individual to do because it is not clear what is wrong. The crucial thing is that something happens fast and that the child is not left in a police station waiting for an assessment, waiting for help to arrive.

**Anne McDonald:** The other partner in this is the CQC as the regulator. It is part of the work with the Home Office. We may have a notification system perhaps to the CQC so that it could immediately act on what is happening under section 136 in that area if a notification was made of an unacceptable practice; but we need to make sure that those are the right things so that action is taken at the right time.

**Q156 Valerie Vaz:** When is the Department going to have these important meetings with the police, MOJ and everyone else?

**Anne McDonald:** Tomorrow.

**Valerie Vaz:** Excellent.

**Dr Griffiths:** That is a very concise answer.

**Q157 Valerie Vaz:** When can you report to us about what has happened?

**Anne McDonald:** There is an action plan as part of that meeting, so we could report back as to the different actions in that and where they have got to, if that would be helpful.

**Valerie Vaz:** I think so, yes.

**Chair:** It would certainly be helpful.

**Q158 Andrew George:** I want to follow that up with a question about the work that you have been undertaking with the police in reviewing the cases, particularly if it is falling even below the 20% figure that we have for those that are held subsequently being, detained by psychiatrists. Have you tracked cases in the days and weeks after that to find out what actually happens? In other words, how many of those who are released by psychiatrists actually then go on to either harm themselves, for example, or harm others, and thus in fact, in retrospect, perhaps the police's judgment was more accurate than the psychiatrist's?

**Dr Griffiths:** We don't track those, but we do track suicides and homicides, yes. We do not track people who have not been admitted to hospital because that is just one circumstance in which a decision not to admit someone has been made. It happens in a variety



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of other circumstances. We do not track all decisions not to admit people to hospital but we do track what happens with suicides and homicides primarily through the National Confidential Inquiry into Suicide and Homicide, which has been going for well over 10 years.

**Q159 Andrew George:** Does that inform you at all in relation to this particular section of the Act?

**Dr Griffiths:** It can do in terms of individual cases. There are two things, if you like. The National Confidential Inquiry produces aggregate analysis of data and has done some more in-depth studies over time. Of course, if there is something as tragic as a homicide, there will also be an independent inquiry. If there has been some kind of failure around the Act, whether that is section 136 or anything else, that will come out. I can, if you like, give you the latest figures from the National Confidential Inquiry. It reports annually, usually in the summer, July, so the last figures we have from that are July last year.

**Q160 Andrew George:** It would be very helpful if you could.

**Dr Griffiths:** I will try and keep it to the main ones. There is a lot in there and it is a public document.

**Q161 Andrew George:** If you could supply it to us, that—

**Dr Griffiths:** Yes, absolutely no problem. I will give you the headlines, if you like. I should preface it by saying that there are data for each country in the UK, so there are aggregate UK data and there are data for England, Scotland and so on. I will give you the England data. I can talk about the others if you wish. Starting with population suicides, the National Confidential Inquiry uses a three-year rolling average because a completed suicide is not that common. The numbers are relatively low. To try and even out and look for trends, rather than normal cause variation, they tend to use a three-year rolling average. If you look at the ONS statistics, it is each year's figures. The last figure that we have is 2010 and that was actually the lowest recorded level. But if you look at the ONS data, it has gone up for 2011. So the figure in 2010 was 4,021 suicides in England and the latest ONS data for 2011 was 4,509. Whether or not that is statistically significant, I have not done an analysis, but it looks it to me. There may be several reasons why the suicide rate may have gone up, but the most likely bet would be economic downturn. It had been falling pretty consistently for a good 10 years prior to that, probably down to two things, one, relatively economic prosperity and, two, a national suicide prevention strategy, which was renewed just last year.

**Q162 Andrew George:** Can I just intervene because of time and also because the question I was asking was more micro than the macro figures that you are giving?

**Dr Griffiths:** Sure. Do you want me to come on to the stuff around patients?

**Q163 Andrew George:** Yes, sort of case handling: in other words, what lessons have you learned in retrospect?

**Dr Griffiths:** The Inquiry has done a kind of composite report on what are the key themes and lessons, which are generally around the things you would expect and that were in Francis around communication, record keeping, risk assessment and management. There is another piece of research that again has not been published, so it is tentative—it is provisional findings—looking at the risk assessment when people have subsequently gone on to either commit suicide or, more rarely, homicide. Again, treat this as provisional data—shortly to be published—but around two thirds to three quarters look like they have had a good risk assessment and around a quarter to a third, from documentation, look like they have not had a good enough risk assessment. So it is a minority, but that is still too many. However, the trend for patient suicides and homicides is still downward in England. It is less clear in the other countries because the numbers are much smaller but there does not seem to be a trend. But there is a significant downward trend in patient suicides and homicides.

**Q164 Andrew George:** The one case that is weighing heavily on my mind is one where I know that the police wanted to seek to detain someone—and this is pre-the 2007 Act—because they feared that in this case he was a severe risk, particularly to one individual but to other people in general. In spite of their pleading to do so, that person was not sectioned, was released and went on to murder within 24 hours. With regard to the judgment of the police versus the judgment of the specialist, what I am looking for—while the statistics and the general patterns are of interest and relating them to well-being generally in the population is of course of interest—is whether there is any retrospective correlation between the police and your services so that lessons are learned and whether the precautionary approach is being applied appropriately or too zealously. That is what I am really looking for.

**Dr Griffiths:** Like I say, when there is a case like that, it is an appalling tragedy.

**Q165 Andrew George:** There are others that I know of with a similar pattern.

**Dr Griffiths:** If there has been a homicide, there will have been an inquiry to find out what local services have learned, but also what could be more broadly learned. What the NCI have done, about two or three years ago, is provide a composite of the key messages from those inquiries.

**Q166 Andrew George:** This is slightly off piste, but, as far as the issue of place of protection is concerned, another pattern which has not arisen in the questions today is that of mother and baby units and those going through the problems of puerperal psychosis and so on. The issue there of the lack of availability of accessible mother and baby units is one that is not down to the police, in this particular case, but, as far as accessibility of a support service that is appropriate for new mothers, is that something that you have been

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reviewing and looking at to make sure there is adequate support available there?

**Dr Griffiths:** We are moving to a very new system, and mother and baby units have been specialist commissioned. They will be subject to specialist commissioning by the NHS Commissioning Board. Nationally, there are about 10—10, maybe 15—mother and baby units. There should probably be more. I think you are right that there should be more, but it will be down to the NHS Commissioning Board and its specialist commissioning function to determine what and how many.

**Q167 Andrew George:** You will be advising them.

**Dr Griffiths:** No, I will be retired at the end of this month.

**Q168 Andrew George:** But, joking aside, there is a—

**Dr Griffiths:** I am sorry; that did sound a bit flippant.

**Q169 Chair:** Your successor will be advising them.

**Dr Griffiths:** Yes. They will be appointing a successor.

**Valerie Vaz:** You sound so happy.

**Dr Griffiths:** I am aware of that and I am trying to keep it in check. But, seriously, they have appointed a national clinical director. There will no longer be one in the Department of Health. They will be in the Commissioning Board because it will be the Commissioning Board that will be—

**Q170 Andrew George:** The Commissioning Board will be doing that. I will move on to the BME community and particularly the issue of the disproportionate referral or, rather, representation of the BME community in the population of patients subject to the Mental Health Act: about 3% of the population, 15% of cases. What explains that pattern?

**Bruce Calderwood:** Shall I start and then Hugh will come in? There are a number of things, one of which is that there is increasing evidence that there are much higher real rates of psychosis among, specifically, the black and Afro-Caribbean population in this country. There are higher rates here than there are in either the Caribbean or in Africa, so there is something around the experience of black and Afro-Caribbean people in this country as opposed to where they, their parents or grandparents come from, which actually is helping to cause much higher levels of psychosis than in the general population. That accounts for part of the difference. You then have questions around, “What are the issues that clinicians and other people take into account in making the detention?” Some of those questions are around, “Are you living on your own? Are you homeless?” Among the black and Afro-Caribbean population, there are some social demographics that account for a lot of the difference. The AMEND study that will be published soon actually goes into that.

If you ask me the question, “Is there racism in the system?”, obviously there will be racism in the system because there is not a part of British society where you can say it does not exist. But, statistically, it looks as if the much higher rate of the use of the Mental

Health Act can be explained to a considerable extent by some of these demographic characteristics.

The next question is, “What do we actually do about it?” There is a public health question there and one of the things that we would be asking Public Health England to do is to look at that. It is clear also that many black people fear and are really worried about mental health services. So there is something around how the service provision can actually make sure that services are accessible and work better at a much earlier stage in the process than currently exists, because the route into mental health services is often via detention or through the criminal justice system. There are some very real issues here that we need to deal with, but it looks as if some of the fundamental reasons are to do with demographics. I do not know whether Hugh wants to add anything.

**Dr Griffiths:** Yes. It is a phenomenon all over the world that migrant populations have higher rates of mental illness. The reasons for that are not fully understood, but it is not difficult to think of hypotheses. That is true.

As far as the disproportionate rates that you describe are concerned, it has been a subject of very heated debate and there has been a narrative that it must be down to institutionally racist services because of that differential. The latest comprehensive epidemiological study from a couple of years ago was led by a team from Cambridge looking at the epidemiology, the incidence and prevalence of schizophrenia and other psychoses, and shows very clearly that in this country people from black and minority ethnic groups, particularly people from black African and Caribbean groups, have very high rates of psychosis. Quite why that is—as Bruce says, in their countries of origin or their ancestral countries, the rates tend to be the same as they are for the indigenous population here—again they do not know. They have put forward a number of different hypotheses. Racism in society could have an effect on psychosis rates, but we really do not know.

As Bruce says, there is a public mental health issue there that we expect Public Health England to be taking on. But there is another dimension to it—this comes from the AMEND study and is provisional because it is shortly to be published—in that what they looked at as well was that, when you detain someone under the Mental Health Act, it is not just about diagnosis and whether you have a mental disorder; it is about risk. There are many determinants of risk, some of which are contained in your social circumstances. If you live alone, for example, and you do not have any social support, then you are likely to be at higher risk than if you have a supportive family and so on and so forth. When you allow for those social variables of risk and the epidemiology, according to the AMEND study, the race effect disappears. It does not mean, however, that there is not an issue about race and racism in mental health. What it does mean is that it looks like the disproportionate detention is not about institutionally racist services.

**Q171 Andrew George:** I appreciate the fact that there is a lack of evidence, if you like, of the absence

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of racism in the system. It is interesting that you defined that as “therefore, there must”—or you suspect that there must—be racism in the system. But, as far as evidence which was brought to us by the Mental Health Alliance is concerned, there seems to be a disproportionate use of restraint and coercion with regard to the treatment of the BME community within the system itself. Is this something that you have yourselves identified?

In view of the time, I will wrap up a second question in that as well. In terms of their own experience of the system, that is an accusation that has been made to us and that we are aware of. Secondly, with regard to the correlation between patterns of diagnosis within that community that are particularly high, you were saying that the hypothesis has not been sufficiently developed at present, but I would be interested in whether there was any comparable information with regard to those from more deprived socio-economic groups, whether there are any similar or higher levels of mental health problems within those groups, and whether any other correlations have been undertaken that actually identify a socio-demographic cause.

**Dr Griffiths:** If I understood the latter part, I will take that first. There are social determinants of mental disorder and deprivation and so on and so forth among those. But, in doing the meta-analysis around epidemiology, you allow for social variables. You factor them in.

As to the first question about coercion, it is not surprising because people are being disproportionately detained, and that in itself is being viewed as coercive. If you are detained and you do have a psychosis, you are more likely—it is still a relatively low likelihood—to be restrained. I am sorry to get back to my bit of paper from the Confidential Inquiry again, but on that question I thought you might be interested in one figure. They have done a recent study looking at sudden unexplained death from 2000 to 2010 in inpatients. These are not just detained inpatients—they are all inpatients. There were 373 sudden unexplained deaths, 42 of whom were from black and minority ethnic backgrounds but with no clear pattern. From 2002 to 2010 there were 15 post-restraint deaths. We do not know whether the restraint caused those deaths. What we do know is that there was a sudden death sometime shortly after a period of restraint. Four of that 15 were people from black and minority ethnic groups. They are very low numbers.

**Q172 Andrew George:** They are low numbers, but they seem to be high overall. It does seem to be disproportionate.

**Dr Griffiths:** That is over an eight-year period.

**Q173 Andrew George:** I know that the numbers are low and therefore it is less statistically valid to draw that conclusion, I agree.

**Bruce Calderwood:** What there clearly appears to be also is a London effect. The pattern of detention due to the Mental Health Act in London is very different from the rest of the country, and that seems to be, again, to do with social isolation, homelessness and people not having anyone to look after them. It is very difficult to disentangle race effects from the London

effects. Indeed, the analysis of the people who are leading the AMEND study is coming close to saying that a lot of the apparent race difference in the use of detentions can be explained by the London effect because London has a very high proportion of Afro-Caribbean people living here. So, in future, one of the things we need to do is to look comparatively at different parts of the country and have a much better understanding of the demographics. Having said that, I do not want anyone to go away from here thinking we are somehow saying that race differences do not exist in this and are not a causal factor. That would be far too definite a statement for us to be making. We and mental health providers and commissioners need to be very sensitive to that possibility, not least because that is what the perception is in Afro-Caribbean communities and you have to respond to that perception.

**Q174 Valerie Vaz:** What is the comparison in places in the west midlands like Birmingham?

**Bruce Calderwood:** We have not looked at that, but there is another study coming out quite soon.

**Anne McDonald:** AMEND uses Birmingham, Oxford and London as the three cities, and obviously Birmingham has a high Asian population.

**Q175 Valerie Vaz:** And African Caribbean.

**Dr Griffiths:** It is not as high as London's, though.

**Anne McDonald:** Interestingly, if you present for an assessment under the Mental Health Act, the rates or likelihood of actually being detained are very similar between Birmingham and Oxford but much higher in London. It seems to be this social factor in London and age as well, of young people alone. Also, the major transport hubs in London are driving something, with people arriving in London and then having a crisis. So it is not just the race effect that is driving the London—

**Bruce Calderwood:** There is a psychiatrist called Geraldine Strathdee, a leading psychiatrist within a London SHA, who has done a lot of analysis recently about what is going on in London in terms of the application of the Mental Health Act—

**Dr Griffiths:** She is due to complete that soon, isn't she?

**Bruce Calderwood:** Yes. We have not seen that analysis yet, but we hope it will throw a lot more light on this.

**Dr Griffiths:** Can I throw in one other thing to be alert to in the data? Some of the data on this that are quoted use the old census figures as a denominator. In the latest census of 2011, the demographics have changed very significantly and that changes the denominator.

**Q176 Dr Wollaston:** I want to follow up, going back to the migrant effect that you referred to. Do you have comparative data for first, second generation and third generations? Does this effect change with time or is there a time of maximum—

**Dr Griffiths:** Yes and it is in that study. I will probably have to send it to you because I do not want to misquote it. It still persists but is less marked in lower generations. But it does not go away.

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**Q177 Dr Wollaston:** So it continues. For the purposes of the inquiry, it would be interesting to know what you feel needs to be done in early intervention so that we can prevent the first point of contact being the point of detention. What would need to change in your view?

**Dr Griffiths:** I think two things really. First of all we need services that are more sensitive to the expectations and values of different communities, because if people are not accessing them in a timely way there is something wrong in the way they are being presented and so there is an access issue. The second thing is, I think there is—and we have already talked about it—a public mental health issue, which is around I don't think it is enough to say, "It is explained by higher rates." Why are the rates higher, and what can we do about that in public mental health?

**Q178 Dr Wollaston:** That is the point I am trying to ask. What do you think we should recommend needs to happen to stop this being a question that comes up again in 10 years' time?

**Dr Griffiths:** There are two things. Services must be more sensitive to the expectations and needs of the varied population that they serve. We expect this to happen, but it would be no harm if this Committee said it as well: Public Health England is developing a programme on public mental health and, if a significant part of this could look at this race effect, it would be very helpful. I am sorry to add, but one of the key elements of the Government's mental health strategy is around public mental health and well-being. Arguably, for too long, the public health narrative has been rightly around obesity, smoking and alcohol, which are very important things and lead to a number of potentially fatal diseases, but actually it has excluded public mental health and well-being in so doing. I think we are now seeing a sea change and expect the narrative for Public Health England to be obesity, alcohol, tobacco and public mental health.

**Anne McDonald:** The other aspect, again coming from that work that is being done in London, is looking at specific improvement and quality indicators in both community and in-patient services that address the needs of black and minority ethnic people, so again specifically aiming to commission in a way that improves the quality and access for these groups.

**Q179 Chair:** We have run out of time. There is one quick question, which is nothing to do with mental health, which I would like to put at the end to give you the opportunity to make any points that you want to make. It is to do with deprivation of liberty for people suffering from mental incapacity, which is another element of this piece of legislation. Did that passage of the legislation successfully address the issue that it was trying to address, in your view?

**Bruce Calderwood:** In legal terms, yes. The problem was that there was not a legal framework for doing it. There now is. It is patchy in terms of its application. Variation is justified up to a point but some of the

variation is extreme. One of the things we need to do is to talk to the CQC about potentially doing more to look at the outliers there.

**Q180 Chair:** Is it an issue where the Department, from a policy point of view, needs to draw up a clearer definition of what good looks like?

**Dr Griffiths:** Yes.

**Bruce Calderwood:** I think we need to work with others around what counts as good practice, not just us.

**Q181 Chair:** Again, that would be the Department acting as catalyst and co-ordinator, not as the sole fount of wisdom.

**Bruce Calderwood:** Yes.

**Q182 Valerie Vaz:** Do you publish the case law?

**Bruce Calderwood:** We periodically publish information about case law. Case law is changing very fast, as you probably know. There is likely to be quite a significant case going to the Supreme Court in October, which may very well be quite important in terms of the way in which it is interpreted in future. Our sense is that the real experts on this are the people doing the assessment. There is less evidence of people feeling confident about identifying when to make applications to the assessors.

**Q183 Valerie Vaz:** How often do you publish the case law?

**Bruce Calderwood:** There is no particular—sorry, we do not publish.

**Q184 Valerie Vaz:** You used to, didn't you?

**Bruce Calderwood:** We have published case law in the past. Again, we have a code of practice. We also work with people like SCIE and others to get information out there. There is not a particular pattern to that publication, though.

**Q185 Chair:** The legislation includes a provision for you to produce a statutory code of practice.

**Bruce Calderwood:** There is a statutory code of practice.

**Q186 Chair:** Presumably, therefore, if there is wide variation, the implication is that the code of practice might be more tightly drawn.

**Bruce Calderwood:** Yes, potentially. We are not entirely sure what the reasons are yet for the variation and whether it is to do with, in a sense, a failure to understand—the code of practice may make no difference to that—or whether it is to do with the code of practice needing to be tighter.

**Chair:** Thank you very much. Dr Griffiths told us that it is likely to be his last appearance before a Select Committee.

**Dr Griffiths:** First and last actually.

**Chair:** Good luck for the future and thank you, all three, for your attendance.

# Written evidence

## Supplementary written evidence from the Mental Health Alliance (MHA 01)

1. Following our oral evidence session on 26 February 2013, representatives of the Mental Health Alliance would like to provide further information on questions asked by Members.

2. We also have a point of clarification. In Q30, Grahame M. Morris MP said, “A little earlier, Mr Lawton-Smith told us that we should not worry about the increasing cohort of patients who are sectioned under the Mental Health Act,...”. We think that this is a misunderstanding and that it does not represent what Mr Lawton-Smith said but in any case would like to clarify that the Mental Health Alliance’s view is one of concern about increasing rates of detention.

### READMISSIONS OF PEOPLE WHO WERE PREVIOUSLY DETAINED

3. We do not have these statistics for England though it is possible that they could be obtained from the Health and Social Care Information Centre. In Scotland, the Health Secretary provided figures in response to a written question showing that in 2011 nearly 10% of mental health patients were readmitted within 28 days of discharge (1,331 people out of 14,647) (S4W-08246—Health and Social Care (11/07/2012)).

Thornicroft (1992) followed-up 357 psychiatric patients who had been in one of two large North London psychiatric hospitals hospital for over one year; 118 were “new” long stay and 239 “old” stay patients. Of all discharged patients, 97 (27%) were re-admitted at some time during the follow up period. (British Medical Journal, 1992 305:996.)

The CTO revocation rate is (as at 31 March 2012) 3,509 out of 14,295 CTOs made, ie 25%.

### ADVOCACY IN WALES

4. As indicated in our evidence, the Mental Health (Wales) Measure 2010 extends independent mental health advocacy to people admitted to hospital on a voluntary basis as well as all patients detained under the Act. This came into effect in April 2012—<http://www.legislation.gov.uk/mwa/2010/7/contents>.

### JOINT CRISIS CARE PLANNING

5. In our evidence we referred to the effectiveness of joint crisis care planning in reducing the use of compulsion. The research evidence for this is Henderson, C, Flood, C, Leese, M *et al* (2004), “Effect of joint crisis plans on use of compulsory treatment in psychiatry; single blind randomised controlled trial”, *British Medical Journal*, 17 July 2004, 329(7458):136. In this study 13% of those with a joint crisis plan were admitted compulsorily compared with 27% of the control group. A larger multi-site trial has been conducted but not yet reported. <http://www.kcl.ac.uk/iop/depts/hspr/research/ciemh/cmh/projects/CRIMSON.aspx>

### IMHA ACCESS

6. The UCLAN study, *The right to be heard*, found a strong consensus that those who need the IMHA service the most access it the least. The researchers thought that specific groups of people who may be underserved include: people from Black and minority ethnic communities, people with learning disabilities, older people and those with dementia, people who are hearing impaired or deaf, people on CTOs and people placed out of area (summarised on page 94 of the report).

One of their recommendations is that consideration be given to an opt out of, rather than opt in to, IMHA with consultation about how to take this forward. We think this would be well worth considering as a way of ensuring access.

Quality standards for commissioning set out by the researchers include equality analysis to ensure that provision is non-discriminatory and meets the diverse range of needs, and inclusion in IMHA contracts of measures to ensure that the diversity of qualifying patients are able to access appropriate IMHA services.

### DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

7. If the policy intention behind DOLS was to protect vulnerable people, the legislation is not achieving this adequately. Firstly, while recognising that more sophisticated data would be helpful, the great variability of applications suggests that citizens are not having equal access to these safeguards. The fact that care providers have to refer themselves to supervisory bodies is a significant consideration in this.

Secondly, we are concerned about lack of compliance with the requirements of ECHR Article 5(4). As the people concerned lack capacity they are likely to have to rely on a relevant person’s representative (RPR) who may be a relative with no knowledge of the DOLS system. Independent Mental Capacity Advocates are the very people who could help P and the RPR through the system, but the statutory right to be referred to as 39D IMCA is very poor and variable. The Court of Protection is the only option, which can be a lengthy and costly process and, unlike provisions under the Mental Health Act, there is no automatic referral.

## ETHNICITY

8. The reasons for over-representation of people from some Black and minority ethnic (BME) communities in MHA detention and under CTOs are not fully understood and need more analysis. As mentioned in our evidence, when we referred to “circles of fear”, a key study in this area is *Breaking the circles of fear* (Centre for Mental Health, 2002)—[http://www.centreformentalhealth.org.uk/pdfs/breaking\\_the\\_circles\\_of\\_fear.pdf](http://www.centreformentalhealth.org.uk/pdfs/breaking_the_circles_of_fear.pdf). Its findings included “There are circles of fear that stop Black people from engaging with services. Mainstream services are experienced as inhumane, unhelpful and inappropriate. Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community. Black people come to services too late, when they are already in crisis, reinforcing the circles of fear.”

## SUBSTANCE MISUSE

9. The following references may be helpful to Members’ consideration of substance issues in relation to mental health problems.

The 2010–11 British Crime Survey estimated that 8.8% of adults aged 16 to 59 had used illicit drugs (almost three million people) and that 3.0% had used a Class A drug in the last year (around a million people). Neither estimates were statistically significantly different from the 2009–10 survey <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1211/hosb1211?view=Binary>

This includes the finding that “Adults from a White ethnic group had higher levels of any (9.4%) or Class A (3.2%) drug use than those from a non-White background (that is, ethnic groups other than White; 5.1%, any drug use; 1.0% Class A)”.

And see the box under 2.1 of this special BCS report on drugs and ethnicity <http://webarchive.nationalarchives.gov.uk/+http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/drugs-alcohol-research/hosb1310/hosb13101-annex1?view=Binary>

According to the Royal College of Psychiatrists, “Two million people in the UK smoke cannabis. Half of all 16 to 29 year olds have tried it at least once. In spite of government warnings about health risks, many people see it as a harmless substance that helps you to relax and ‘chill’—a drug that, unlike alcohol and cigarettes, might even be good for your physical and mental health. On the other hand, recent research has suggested that it can be a major cause of psychotic illnesses in those who are genetically vulnerable.”

<http://www.rcpsych.ac.uk/expertadvice/problems/alcoholanddrugs/cannabis.aspx>

## USE OF SCT OUTSIDE “REVOLVING DOOR” PATIENTS

10. Care Quality Commission data (2009/10 Annual Report on the use of the Mental Health Act) suggests some 30% of people placed on a CTO have no history of non-compliance with treatment (so are not “revolving door” patients).

The Department of Health has stated in July 2012 (*Post-legislative assessment of the Mental Health Act 2007*, p. 12–13) that “One of the objectives of the CTO provisions was to help tackle the ‘revolving door’ syndrome”, implying there were others. It also stated that “The view was that SCT could be used wherever it was necessary. That could mean using it to prevent people getting into the ‘revolving door’ cycle”; and that criticism of SCT being used more widely than intended “may be a misunderstanding of the original intention of the Act”.

However at the time of the passage of the Bill in 2007, the Department of Health’s own explanatory leaflet on SCT (Mental Health Bill, *Amending the Mental Health Act 1983, Supervised Community Treatment*) stated “SCT will address the specific problem where patients leave hospital, do not continue with their treatment, their health deteriorates and they require detention again—the so-called ‘revolving door’.”

The same leaflet defended the Government’s position on not amending the SCT criteria to include a history of non-engagement thus: “The Government believes that these amendments excessively restrict SCT so that few patients could benefit. They exclude patients who are a risk to themselves, and make it difficult for SCT to succeed in its aim of tackling the ‘revolving door’.”

The leaflet is at:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_073208.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073208.pdf)

At the same time, in a briefing for members of the House of Lords on 30 January 2007, Health Minister Philip Hunt stated “We have listened carefully to calls that the SCT criteria should be tighter. We have thought further about the arguments put forward, but we think that any further restrictions on the use of SCT would be misguided. We are concerned that we would risk neutralising SCT so that it could not address the very problem that it was developed to tackle—that of the revolving door”.

It is possible to argue that Parliament at the time was led by these statements to think that SCT would only be used for *known* revolving door patients, not for any patient that might, in a clinician’s view, *become* a

revolving door patient—which significantly widens the scope of SCT powers, as has been shown by the subsequent clinical practice of placing many people on CTOs who do not have a history of disengagement from services. So the use of CTOs for this cohort is not inappropriate in that the Act does allow such use; but it could be considered inappropriate in terms of parliamentarians’ and others’ expectations of who might become subject to CTOs.

#### SAVINGS FROM SCT

11. At the time (2007), the Bill’s Regulatory Impact Assessment (p.11) put to parliamentarians estimated the costs and savings to be made as a result of the new SCT arrangements. This suggested that there might be net savings to the NHS in England resulting from the introduction of SCT of £34 million pounds annually by 2014–15. However at this time, we have no idea whether these estimated savings have been met, or are on track for being met by the “steady state” year of 2014–15. It would be interesting to know if the Department of Health was keeping track of any savings made by the introduction of SCT.

The Regulatory Impact assessment is at:

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_076476.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_076476.pdf)

#### NUMBERS OF PEOPLE ON A COMMUNITY TREATMENT ORDER (CTO)

12. There does seem to be a discrepancy in the data on the numbers of people under a CTO. The latest NHS Information Centre data (October 2012, p.22) give a figure of 4,764 people under a CTO as at 31 March 2012.

At the same time, the same report (p.20) gives the total number of CTOs made between November 2008 and 31 March 2012 as 14,295, of which 3,509 had been revoked (with a patient returning to a hospital bed) and 3,922 discharged—suggesting there were still some 6,964 people under a CTO. This may be simply a data quality issue (as the report acknowledges), or some patients may have been given over time more than one CTO, but an explanation of the discrepancy would be helpful.

*March 2013*

### Written evidence from a person who wishes to remain anonymous (MHA 02)

#### MENTAL HEALTH ACT 2007

1. The purpose of the Act was inter alia to amend the Mental Health Act 1983 (“MHA”) and the Mental Capacity Act 2005 (“MCA”) in relation to mentally disordered persons.

#### BACKGROUND

2. These comments are from the perspective of an A & E patient (“P”) having collapsed at home and diagnosed with a grand mal seizure (1st), the after-effects of which can last several hours and can result in temporary lack of capacity. The final note in P’s A & E medical record states, “I don’t think this gentleman has capacity.”

Nevertheless, an A & E Consultant referred P for mental health assessment within 2½ hours of arrival without reviewing P in person and the assessment took place six hours after arrival in A & E. P was sectioned under s.2 of the MHA (as amended).

3. P was sectioned unnecessarily and transferred to an acute NHS psychiatric hospital.

On discharge, the Consultant Psychiatrist at the NHS psychiatric hospital wrote that the team at that hospital agreed P had not been manic from the start. However, P had been detained on a Friday evening and was refused access to facilities to apply for discharge until Monday. Four needless days “care” and the resulting complaints (still ongoing after 18 months) have wasted and continue to waste substantial public money.

P is left with the stigma of a section on record for life. Even though an allegedly independent investigator found that, at the time of the mental health assessment, it is, “Undisputed” that P had presented only with the after-effects of a seizure without psychosis, mania or hypomania, the NHS refuses to accept the section as wrong.

In P’s case, the NHS has used more resources defending and concealing the indefensible than it would have taken to settle the dispute at the outset.

4. Unlike alleged offenders found “not guilty” in Court, a section is irreversible unless the patient has the financial resources to apply for Judicial Review. This offends common law and common sense. Detaining patients improperly under the MHA or the MCA violates their Rights inter alia under Articles 3, 5, 6 and 8 of the European Convention on Human Rights.

Yet there will be no cost-effective remedy until:

- (i) NHS Chief Executives and the relevant regulators are informed robustly that complaints processes should themselves conform to Article 6 if they involve serious disputes about patients' Rights, including NHS treatment: it does not necessarily have to be in Court.<sup>1</sup>
- (ii) The culture of denial in the NHS, medical profession and their regulators (identified by Mr Robert Francis QC) ceases to exist.

Recently, P found an Employer Liaison Advisor at the GMC and an NHS Hospital Medical Director agreeing that a referral of misconduct was not necessary. They did not consult the GMC's "Fitness to Practise" Directorate, who, it transpired, would have welcomed it.

5. The assessors justified P's section by dissembling on section forms and related papers: they dissembled again in their evidence to the "independent" inquiry. This is not P's opinion—it is de facto from the written record.

6. It is unnecessary for the purpose of reviewing the MHA 2007 to proffer further information about P's case, unless requested. However, the Department of Health has more (but not all) of the details.

## LESSONS

7. Although the purpose of MHA 2007 was to amend the MHA 1983 and MCA 2005, in relation to mentally disordered persons, from the original event and the complaints process, P identified complete confusion among professionals about the interface between the MHA and MCA.

There is compelling evidence that there is insufficient clarity as to which Act should be applied when mental capacity and mental health issues might exist in a single patient. This leads, for example, to patients, whose capacity might be impaired temporarily by physical ill health, being detained in the disturbing environment of an acute NHS psychiatric hospital.

For example, P is unable to obtain a satisfactory explanation of why doctors can choose on a whim between using the MHA and the MCA. In P's case:

- (i) He was not at the time (and never had been) subject to any of the powers of the MHA.
- (ii) Notwithstanding P's A & E records stating, "I don't think this gentleman has capacity" no "best interests" assessment was carried out before the mental health assessment.

It seems especially perverse to engage the MHA knowing that P had experienced a grand mal seizure (1st) that day, which was likely to result in temporary impairment of capacity.

8. Regardless of (7), P offered:

- (i) To stay voluntarily at the general hospital for neurological monitoring: this would have allowed time for the doctors to see if his capacity recovered.
- (ii) If necessary, to admit himself voluntarily to a private psychiatric hospital for assessment—at no cost to the public purse. In case the medics doubted his capacity, P's wife (as his Nearest Relative) agreed to pay too.

It follows that P did not need to be detained under either Act but the mental health assessors dissembled on the section forms by stating P refused informal admission—even though P's A & E notes confirmed that P offered it.

9. Notwithstanding (8), subsequent research convinces P that confusion between the two Acts contributed to the decision to detain him. For example:

- (i) The General Hospital did not know (until P researched it later and informed them) that it [the General Hospital] was Hospital Manager and the PCT was the Supervisory Authority for the purpose of the MCA. As a result, they did not even consider the applicability of the MCA before referring P for mental health assessment.
- (ii) It is inherently confusing that responsibility for detention:
  - (a) Under the MHA lies with the local authority covering the area where the hospital is located.
  - (b) Under the MCA lies with the local authority covering the patient's home and/or his GP's surgery address.

In P's case, the hospital is in one Local Authority area, whereas he and his GP are in a different area. There are parts of the country where the hospital, the patient and the GP all could have addresses in different local authority areas.

This is a recipe for confusion.

<sup>1</sup> A Guide to the Human Rights Act 1998—paragraphs 3.51 & 3.52 October 2006, The Department of Constitutional Affairs



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## CONCLUSIONS

10. To give state employees the legal right to detain persons without adequate (if any) safeguards or cost-effective remedies in place against unlawful detention is an issue Government should take very seriously indeed.

It offends common sense and Articles 5 and 6 of the European Convention on Human Rights that a person detained improperly under the MHA has the stigma of a sectioned psychiatric patient attached to him for the rest of his life: arguably it is a failure of Government.

11. The confused nature of current legislation (and/or the lack of clarity in the guidance issued to those who enforce it) contributes significantly to the risk of unlawful detention.

Pursuant to (9) above P avers that there is a compelling case for putting both the MCA and MHA under the same jurisdiction.

12. There are also serious inequities inherent in the MHA, for example lack of access to justice for patients detained improperly and/or as a result of gross professional misconduct (including dissemblance) by mental health assessors.

For example, to bring a Civil Claim for unlawful detention, Counsel advises that the patient first has to make application for leave of a High Court Judge even if the case would normally be heard in the County Court. The High Court Judge considers whether the case needs further investigation before making a decision on whether it should proceed.

13. It is innately unfair that, compared to the police:

- (i) Mental health assessors have more powers to detain persons and do so unsupervised.
- (ii) There are fewer safeguards in place for the patient, on the day and thereafter, against unlawful detention.
- (iii) Patients detained unlawfully have no cost-effective means of obtaining a remedy unlike alleged offenders in the criminal justice process.
- (iv) Mental health assessors have a safeguard in place, which is not enjoyed even by police officers, ie the requirement at (12) for a patient to seek leave of a High Court Judge even to issue proceedings for compensation in the County Court.
- (v) Mental health assessors can rely on the ineffectual NHS complaints process (found by P in his area and confirmed elsewhere in the Francis Report) to protect them.

This balance in favour of the assessors should be redressed by legislation.

## SUMMARY

14. P believes that, whereas the MHA 2007 was an amending Act inter alia for the MHA 1983 and the MCA 2005, in respect of mental health, there are strong grounds for a consolidation Act. A new Act would include new amendments to increase clarity and redress the balance between the interests of the patient (and his Right not to be deprived of his liberty) and the interests of the mental health assessors.

15. The MHA regime is a murky, innately unfair process. It is a charter for inter alia:

- (i) Untrustworthy, dishonest and greedy doctors, who earn substantial fees for assessments on top of their generous salaries as (for example) Consultants or GPs.
- (ii) Dishonest, left-wing social workers who, just like in child adoption, revel in opportunities to interfere with the private lives of those they perceive as middle-class: specifically in P's case, those that can afford private health care.
- (iii) NHS Trusts to make their achievements and figures [against their targets] look good by clearing hospital beds in short order when they should admit patients themselves and thereby transfer responsibility (and costs) to another Trust.

16. It is Government policy to reduce the stigma attached to mental illness. "Campaigns" will not achieve this without legislation to safeguard the physically ill from unjustified stigmatisation and whilst the NHS itself discriminates against those perceived as mentally ill.

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**Supplementary written evidence from the Department of Health (MHA 03)**
**FOLLOW-UP NOTE TO EVIDENCE GIVEN BY DR HUGH GRIFFITHS, BRUCE CALDERWOOD AND ANNE MCDONALD**
**1. Q146 VALERIE VAZ**

*The latest figures on use of Section 136*

**USE OF HOSPITAL BASED PLACES OF SAFETY UNDER SECTION 136**

<i>Year</i>	<i>Male</i>	<i>Female</i>	<i>total</i>
2007–08	4,037	2,998	7,035
2008–09	4,893	3,602	8,495
2009–10	6,778	5,260	12,038
2010–11	7,839	6,272	14,111
2011–12	8,532	6,370	14,902

**DETENTIONS UNDER THE MENTAL HEALTH ACT 1983 FOLLOWING USE OF SECTION 136**

<i>Year</i>	<i>Detained following Section 136</i>	<i>Proportion of total number of people taken to a hospital based place of safety</i>
2007–08	2,020	28.7%
2008–09	1,753	20.6%
2009–10	1,922	16.0%
2010–11	2,376	16.8%
2011–12	2,561	17.2%

Included in the Health and Social Care Information Centre publication Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2011–12 were experimental figures collected by the Association of Chief Police Officers (ACPO). These show that during 2011–12, an estimated 8,667 orders were made where the place of safety was a police custody suite, these account for 37% of the overall total of recorded orders (23,569) made under Section 136.

This national count is an estimate, based on figures provided by local police forces. The criteria for searching custody databases to produce these counts was not standardised.

Figures were not collected on the number of transfers from police stations to health based places of safety and ACPO tells us that to collect those numbers would require a manual trawl of police records. Anecdotally, the Department understands that these transfers are not a high proportion of the total number of uses of Section 136.

**2. Q157 VALERIE VAZ**

*Meeting between Home Office and Department of Health on mental health and policing on 13 March*

This meeting took place on 13 March, and included representatives from the Department of Health, the Home Office, ACPO, the NHS and the Care Quality Commission.

These will be regular meetings, co-chaired by the Department of Health and the Home Office, developing national steps which can be taken to support local partnerships between the NHS and police to commission and provide improved services for people suffering from mental ill health in the community.

The group has identified the following aims as its priorities for people subject to detention under Section 136 of the Mental Health Act 1983:

Helping to ensure people receive the most appropriate support by the most appropriate agency or organisation at the right time.

Reviewing transportation and chaperoning, which should be provided by the most appropriate agency.

Working towards a reduction in incidents that escalate and cause harm to the individual or others.

Achieving further reductions in the use of police custody for individuals detained under section 136, so that police custody is used only in exceptional circumstances and for the shortest possible period.

Ensuring that national guidance is followed and effective local protocols put in place and supporting relevant local agencies and organisations to work in partnership, with a shared understanding of roles and responsibilities.

At the meeting there was a discussion about the role of CQC in monitoring and regulating compliance with the Mental Health Act 1983 Code of Practice on police powers and places of safety and the potential for strengthening this to support the aims above.

In addition, the Royal College of Psychiatrists circulated a draft of *Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983*, which had been prepared by an inter-agency working group on Section 136. It is envisaged that the final version of this document, which is due shortly, will support local health and police partnerships in taking joint action to understand local needs and commission services to meet them.

### 3. ADDITIONAL WRITTEN QUESTION

*The Act's impact assessment published at the time estimated that 10% of Section 3 detentions could be avoided by using supervised community treatment orders (CTOs) and we would like to know if this has been achieved. The impact assessment also said that by 2014–15 CTOs would save £34 million per annum through reduced use of beds. The Committee would be interested to know if this saving is likely to be realised and if it would be possible to provide a note on the true costs/savings associated with CTOs?*

At the time of the Act it was expected that the use of community treatment orders (CTOs) would build up gradually over five years, so that by 2013 around 3,000–4,000 people would be on CTOs at any one time. The Health and Social Care Information Centre reported 4,764 patients on CTOs in England on 31 March 2012. It does not appear that the number of patients on CTOs had reached a “steady state” (ie the numbers of patients going onto CTOs being matched by the numbers being discharged or revoked) sooner than predicted, which suggests that the steady state numbers will be higher than predicted at the time of the Act. The greater than expected numbers of patients on CTOs will have an impact on the true costs and benefits of CTOs.

There has been a continuing fall in the total use of Section 3 detentions since 2007–08. This may be due to a number of factors, including the introduction of CTOs, but also the increasing use of Section 2 detentions which do not result in a further detention under Section 3.

Year	2007–08	2008–09	2009–10	2010–11	2011–12
Total use of Section 3	23,660	23,176	23,024	21,823	21,674
Detentions following revocation of CTOs	–	143	779	1,018	1,469

The Oxford Community Treatment Order Evaluation Trial (OCTET), examines the efficacy and cost-effectiveness of CTOs as part of a Randomised Control Trial and this should provide better information on the true cost effectiveness of CTOs.

22 March 2013