**Written evidence submitted by Professor Jeremy Coid (MHB77)**

I have prepared this report for consideration by the House of Commons Public Bill Committee on the Mental Health Bill.

**Personal Experience**

I retired in 2016 as Professor of Forensic Psychiatry at St Bartholomew's and the Royal London School of Medicine and Dentistry where I was Director of the Violence Prevention Research Unit. I was also Consultant Forensic Psychiatrist to the East London NHS Foundation Trust covering a catchment area of the boroughs of East London and part of urbanised East Essex from 1987-2016. From 2017-2020, I was Professor of Epidemiology in Psychiatry to Sichuan University, China, on a part-time basis carrying out research and teaching.

My experience in giving expert testimony in criminal trials in the Crown Court is extensive. I have prepared reports for solicitors and the crown prosecution service, and for Mental Health Review Tribunals and in Childcare Proceedings. I have previously given evidence to Inquiries. I have given Ministerial Briefings.

I was Consultant Forensic Psychiatrist with clinical responsibility for patients at consultant level for 29 years.

I have published more than 250 papers, reports, book chapters, in peer reviewed journals, one edited textbook and one authored textbook. I have been awarded research grants of more than £5 million during the course of my academic career.

I am currently retired but still carrying out research into mental disorder.

**Summary of Main Recommendations**

1. The Bill is not fit for purpose and should be abandoned.

2. The consequences of the Bill have not been costed and estimates currently vary between £1 to 5 Billion. The NHS cannot afford the new Mental Health Act.

3. The Bill has primarily been promoted by the Royal College of Psychiatrists. However, the Bill does not represent the opinions of the majority of psychiatrists who are members of the college. A survey of members demonstrated that the majority were opposed to each of the main components. Successive administrations have simply ignored the will of the membership since the survey.

4. There have been incorrect claims of scientific "evidence" for some of the proposals for the new Act, for example Advance Directives".

5. There has been a false narrative that the excess of non-white patients compulsorily detained is due to structural racism and this has been used to drive forward proposals. However, there is no evidence that the clinical practice of psychiatrists in operating the MHA 1983, many of whom are non-white themselves (currently 43%), is racist. The majority

of patients with psychotic illness and detained in the UK are white. There are regional differences. There is a true excess of black patients with psychotic illness relative to white for reasons that remain scientifically unknown and are likely to be complex.

6. The Bill as it stands is highly bureaucratic and the only means to slow down compulsory admissions seems to be by increasing bureaucracy in these proposals. No consideration appears to have been taken that the true cause of the rise of compulsory admissions is due primarily to insufficient beds and inadequate treatment of patients, together with fragmentation of services nationally. The Act will not redress this.

7. Certain proposals will prove dangerous to patients and to the public, including removal of police stations as places of safety without adequate replacements.

8. It is probable that NHS mental health professionals will decline to use powers given to them under section 50 Removal of patients by authorised persons. However, this may become a market "niche" for private sector contractors.

9. In considering the cumulative effects of the new inclusions to the Bill, the "Calocane" test should be applied regarding public safety (see below).

## Commentary on Sections of the Mental Health Bill

### 1. Code of Practice

(2B) Statement of Principles

Choice and Autonomy

This is illogical in a situation in which a person's reasoning and behaviour is so disturbed and abnormal that it is being decided whether they must be detained for their own and/or the protection of the public. Because they are unlikely to change their mind through persuasion (and would not be in their current situation if they were) "choice" and "autonomy" have become mere words which have no meaning, and with no relevance to reality. Patient "choice" has a political meaning in a different context in which politicians and others, for example, promise that patients can choose their doctor, which hospital they can attend, etc. It has little or no meaning in the context of compulsory detention and it has been inappropriately borrowed from another context.

The 1983 Act already allows consideration of the views of carers and good practice usually means that this has been taken into consideration. "Other interested parties" is unclear and seems to be potentially overcrowding and prolonging the process, particularly if this refers to "Advocates". It is unclear what happens next if medical practitioners decide to go against the patient's "choice" (which involves every case of compulsory detention - otherwise it would be informal admission to hospital) the views of carers and other parties. This will have future legal ramifications which will cost time and money to the NHS.

Least restriction

There can be no argument against this principle and it was exactly the same for the 1983 Act

Therapeutic Benefit

A key purpose of the practice of medicine and nursing is that clinical practice should have therapeutic benefit. Sadly, some conditions are incurable and little or no therapeutic benefit can be achieved, with some mental health conditions remaining unchanged. Some individuals can remain a danger to themselves or others for many years. Fortunately, these cases are uncommon. But they exist, and in the case of autism and learning difficulty a small number are detained without therapeutic benefit for prolonged periods. The same can be seen in secure hospitals among a small group suffering from severe mental illness.

Treatment should always be "appropriate" and there are already legal consequences for clinicians whose treatments are inappropriate, with firm practice guidelines.

The person as an individual

These principles are unclear and may not be what they appear. Further guidance is needed from whoever drafted them on their meaning and purpose . There can be no disagreement about treating patients with dignity and respect. It is basic medical and nursing practice to do so. However, it is unclear what is meant by "considering their attributes" and "past experiences". Are these their racial and ethnic "attributes" ? Their social status ? Whether they have a known psychiatric diagnosis ? Or something entirely different ? Does "past experiences" refer to childhood adversity impacting on their current mental illness ? Previous experience of the mental health system, say as an inpatient, or the criminal justice system ? The possibilities seem endless and the reader is left guessing.

## 2. Application of principles to Wales

I have no clinical experience in Wales to advise on these clauses.

## 3.Application of the Mental Health Act 1983: autism and learning disability

2(a) the definitions of "autism", "learning disability", and "psychiatric disorder" are inadequate, potentially misleading and not fit for purpose.

There is a wide range of severity associated with a diagnosis of autism and a wide range of intelligence associated with learning disability. This can range from autistic individuals in high-functioning occupations who are socially well-adjusted, to those whose behaviour is so disturbed they must be confined to an institution for their own and others' safety for many years and whose behaviour remains largely unchangeable. The main concern over this section is what in future will happen to the latter group at a certain cut-off level of severity on the autistic spectrum. Above that level, it is irrelevant because, with declining severity, treatment is unnecessary. As is detention.

For learning disability, similar difficulties apply.

For both autism and learning difficulties, behavioural problems which can lead to danger to self and others cannot be conveniently placed at the door of "psychiatric disorder". It can be integral to the conditions themselves.

Psychiatric disorder as a co-morbid condition is common in both learning disability and autism. There would appear to be greater risks for comorbid psychopathology in these individuals due to underlying brain changes. But there are many cases where psychiatric disorder will not be found but the individual still poses risks and still requires detention. Medical professionals cannot be expected to give incorrect or false diagnoses of co-occurring psychiatric disorder to facilitate compulsory detention under the new Act when existing grounds for detention have been removed.

The committee may wish to see some of these unfortunate cases for themselves. With the closure of so many specialist beds, many are now in the private sector. It is highly likely that permission will be granted and the committee can then judge for themselves if these individuals can be accommodated in less highly-staffed facilities and/or fend for themselves. The committee may be able to see for themselves whether such individuals may pose a risk which would result in their detention in secure services or prison as a result of precipitously being returned to the community.

### 125A Children and young people with autism or learning disability: reviews

I do not have sufficient clinical experience of children and young people to comment on these clauses.

### 125B Other people with autism or learning disability: reviews

My only comments are that this section appears overly bureaucratic and that too many people who will never read these reports seem to be involved.

### 125C Reviews: supplementary

Again, there seems an unrealistic expectation that all these organisations will read the report. This seems a tick-box exercise and the purpose for it is unclear and unexplained.

### 125D registers of people at risk of detention

This seems to be unnecessarily bureaucratic and the purpose is unclear – unless whoever drafted it already knows the serious shortcomings of the proposals for people with learning difficulties and autism and is afraid they will "fall through the cracks" of the service and get lost among the homeless and in prison.

The legality of these registers is likely to be challenged - at more expense to the NHS.

### 125E Registers: duties relating to commissioning of services, etc.

This may be unrealistic in the setting of insufficient resources for the social care of severely mentally disabled people with autism and learning difficulties. A high ideal, but an unrealistic one which may be impossible.

(3) I am unclear about the meaning of "market function." Does this mean that the intention is to open up the patients to a more free "market." Which means shifting responsibility (and funding) to private providers ? If so, I would point out that this section of patients is largely catered for already by the private sector due to a severe shortage of NHS beds for persons with autism and learning difficulty. It is the private sector that will be most severely financially affected by the new Act.

### 125F Guidance

I have no comments

### 125G Interpretation of Part 8A

I have no specific comments to make on this, other than not finding it at all clear. I would strongly advise that including capacity law in any part of a new Mental Health Act will only serve to confuse clinical practice and is unnecessary. The 1983 Act functions effectively without capacity law. All procedures will be prolonged and potentially confused by its inclusion. It is a recipe for disagreement between professions.

### 5 Grounds for detention

***Mental Health Bill [HL]***

**In section 5(4) (detention for six hours pending application for admission), for paragraph (a) (but not the "and" at the end) substitute—**

**“(a) that the patient is suffering from mental disorder to such a degree that serious harm may be caused to the health or safety**
**of the patient or of another person unless the patient is *5* immediately restrained from leaving the hospital by a constable**
**or other authorised person;”.**

**In section 20 (renewal of authority for detention of patient detained in pursuance of application for admission for treatment etc), in subsection (4),**
**for paragraphs (c) and (d) substitute— *10***

**“(b) serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment,**

**(c) it is necessary, given the nature, degree and likelihood of the**
**harm, for the patient to receive medical treatment, *15***

4. **(d) the necessary treatment cannot be provided unless the patient continues to be liable to be detained, and**
5. **(e) appropriate medical treatment is available for the patient.”**

This is very strange and suggests that the proposer of these clauses has little personal experience of mental illness or compulsory detention. Police constables are not involved in providing care within hospital to be at hand, for example in Section 5, and it is inappropriate to use a test which appears to encourage the calling of the police to restrain patients. The committee is reminded of Seni’s Law which was enacted following the unlawful killing of an inpatient in the Bethlem Royal Hospital by police who were called to a ward to restrain a psychotic patient by the ward staff. The police are not a resource that can be called upon in this manner. This proposal is totally at odds with the fundamental principles of the Bill, contradicting notions of “least restriction” and “The person as an individual”.

### 6 Grounds for community treatment orders

The amendment is nothing more than an increase in bureaucracy. It may deter clinicians from offering the treatment a patient requires and adds to cost.

### 7 Grounds for discharge by tribunal

I would like to comment on this section but find it poorly worded to the extent that I am unable to understand it to do so.

**8**

**(1) (2)**

***Appropriate medical treatment***

Appropriate medical treatment: therapeutic benefit

**10**

(1) (2)

*The responsible clinician*

**Nomination of the responsible clinician**

I have no specific comments on sections 8,9, or 10**.**

**Making treatment decisions**

(2)

*Mental Health Bill [HL]*

After section 56 insert—

**“56A Making treatment decisions**

1. (1) In deciding whether to give medical treatment to a patient by virtue of this Part, the approved clinician in charge of the treatment must—
    1. (a) identify and evaluate any alternative forms of medical treatment *5* available for the patient;
    2. (b) take such steps as are reasonably practicable to assist and encourage the patient to participate, as fully as possible, in the decision-making process;
    3. (c) not rely merely on— *10*
        1. (i) the patient's age or appearance, or

        This is very unusual and does not correspond to the practice of psychiatric assessment. No psychiatrist should decide on treatment based primarily on age or appearance. It is entirely unclear to me what is meant by “appearance”. Could this be appearance suggesting ethnicity ? Is this a strange way of asserting that the clinician should not make decisions on the grounds of ethnicity and therefore not be racist ? This should be removed or clarified.

        2. (ii) a condition of the patient's, or an aspect of the patient's behaviour, which might lead others to make unjustified assumptions about what medical treatment might be appropriate for the patient; *15*

           This is incomprehensible to me as a clinician. It makes no sense and whilst no one should make a clinical decision based on unjustified conclusions, I fail to see how other parties' unjustified assumptions come into the decision-making of the individual clinician responsible for the patient's treatment. This section is both illogical and confusing. It is unworkable and should be removed.

    4. (d) consider the patient's past and present wishes, feelings, beliefs and values, so far as it is reasonable to regard them as relevant and so far as they are reasonably ascertainable;

       Whilst it may be good to consider the patient's past and present wishes and all clinicians should consider these, and do consider these, the situation may have changed and the clinician should have freedom to act in the best interests of the patient.

    5. (e) consider the relevant views of the following, so far as they are reasonably ascertainable— *20*

        1. (i) anyone named by the patient as someone to be consulted on the decision in question, or decisions of that kind;

        2. (ii) the patient's nominated person and any independent mental health advocate from whom the patient is *25* receiving help by virtue of section 130A or 130E;

        3. (iii) any donee or deputy for the patient;

        4. (iv) any other person who cares for the patient or is interested in the patient's welfare and whom the approved clinician considers it appropriate to consult; *30*

           It is unclear how many of these individuals have to be consulted and whether the process can go ahead if none are available or in the situation of a medical emergency

    6. (f) consider all other circumstances of which the approved clinician is aware and which it would be reasonable to regard as relevant.

2. (2) Where the patient lacks capacity in relation to matters that, in the opinion of the approved clinician, are relevant to the decision, the *35* approved clinician must also consider any wishes, feelings, views and beliefs that the clinician thinks the patient would have in relation to

those matters but for the lack of capacity (including any relevant written statement made by the patient when they had capacity).

It is currently unnecessary to consider capacity in most circumstances and the Bill introduces an area of capacity law which will be open to wide interpretation and disagreement

3. (3) In subsection (1)(e), “relevant views” means— *40*

    1. (a) views about the nature of the patient’s past and present wishes,

feelings, beliefs and values,

2. (b) where the patient lacks capacity in relation to matters that, in the opinion of the approved clinician, are relevant to the decision, views about the nature of the wishes, feelings, views *45*

**Clauses 16,17,18**

I do not feel adequately briefed to understand these amendments

**19 Remote assessment for treatment**

I would strongly advise against permitting the future use of live audio and video links for the examination of patients, particularly those in which decisions are made on compulsory detention or treatment against the patient’s will. There is a high risk that important signs and symptoms will be missed. I believe every patient has the right to expect a face to face consultation

The committee may not be aware that the forensic Faculty of the Royal College of Psychiatrists attempted to persuade the judiciary that this practice should be permitted during COVID 19 lockdown for Part III of the Mental Health Act 1983 and that this was considered unacceptable. This meant patients had to have a face to face examination before they could be compulsorily detained following offending behaviour.

**20 Capacity to consent to treatment**

My personal recommendation is to remove capacity law from the new Mental Health Act for reasons given above.

21 **Care and treatment plans**

Although it is good practice for every patient to have a Care and Treatment plan, the terms of these clauses suggest unnecessary bureaucracy and the list of persons to be consulted appears unrealistically long. Clinicians do not have the time to carry out these procedures at the expense of time from other patients. It is likely that this will descend into a tick box exercise or prove totally unworkable in most services.

### 22 Consultation of the community clinician

This section appears an attempt to limit the current fragmentation of responsibility between inpatient and community services.

### 23 Conditions of community treatment orders

I have no comments

### 24 Nominated person

The replacement of patients‘ nearest relatives with a nominated person is likely to cause major difficulties in some clinical settings. It is of interest that there are proposals for a range of options when a nominated person proves unsuitable, hostile, the patient changes their mind (which is common in acute mental illness) or attempts to obstruct the patients’ care and treatment.

Removing the family in decision-making is a radical step which may appear appropriate to those who are without the clinical experience of families as the key and essential supporters of mentally ill persons. It is interesting that the family in eastern cultures, such as China, are paramount in the care of the mentally ill, where family members are legally responsible for the behaviour of their relatives in Chinese mental health law. This may cause difficulties for south Asian communities and it is of interest that patients of south asian heritage are less likely to be brought to hosptail by the police than other ethnic groups, include whites in England and Wales due to family intervention.

I would recommend that this is abandoned and replaced with nominated persons only for those with no family or whose families aro o far away to take part in the proceedings.

### 29 Detention periods

I have no specific comments other than that the committee might wish to consider where this part may incur uneccessary costs and ultimately delay discharges due to lack of personnel to operate it.

30, **31, 32, 33**

I have no specific recommendations

34 **Discharge: process**

I have tried but an unable to understand why it is necessary to consult someone who belongs to a different profession other than that to which the responsible clinician belongs. Before discharging a patient. This could be because the Act intends to facilitate non-medically trained professionals becoming responsible clinicians and there is concern regarding their clinical decision-making. However, it appears to be slowing down the through-put of patients through scarce beds.

**35, 36, 37, 38, 39 40**

I have no specific comments

41 **Independent mental health advocates**

It is unclear what this section now refers to. Previous drafts highlighted the role of advocates in the proposed new Mental Health Act and that they should match the ethnic group of the patient. Their role would appear to have been that of challenging clinician's decision-making, including in the situation of a medical emergency. Great importance was attached to Advocates by the proponents of the new Act. However, this would have required the training of a substantial number of persons and the creation of a new profession. There are more than 50,000 sections a year for advocates to become involved in. Somewhat out of contexta and quite paradoxical in the situation of 10,000 current mental health nurse vacancies.

It is also unclear whether these advocates have any powers under the Act.

The committee may wish to clarify this.

**42, 43, 44**

I have no specific comments

## 45 Advance choice documents

In reality, Advanced Choice documents will not be available to clinicians in an emergency because IT systems are not ready to make these available unless the emergency (or "crisis") occurs in the same NHS trust as the previous treatment or crisis. It is not currently possible in the NHS to obtain documents from different locations reliably. There is a risk that valuable time will be wasted trying to locate these documents which may then have no legal bearing on the decision ultimately made by the clinician who has to evaluate the patient's need for compulsory admission.

The notion of an advance directive is borrowed from physical medicine but applied very differently. Examples are that the patient does not want to be resuscitated should they go into cardiac arrest or coma because of the risk of poor quality of life of pain subsequently. It is claimed that research shows that advance directives reduce compulsory admissions based on a meta-analysis of studies (Molyneaux E et al. Crisis planning interventions for people with psychiatric illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open 2019; 5 (4) e53.) Closer examination shows this is not exactly true, somewhat misleading, and that "crisis planning" is NOT an advanced directive. The studies show differing results. For example, the largest study and that closest to real life clinical management showed no difference between those who had had crisis planning meetings and those who did not. It is important that most of these studies did not involve a "advance directive" document and it is important that the committee are not mislead by claims or suggestions that they were. Overall, the meta-analysis showed there were fewer compulsory admissions among those who had crisis meetings. However, they did not reduce admissions. This most likely meant that persons who had a crisis meeting were more likely to agree to an informal admission. But they were admitted nevertheless.

It would be unfortunate if patients are misled in the future and that by possession of an advance choice document that they cannot be compulsorily admitted and cannot be treated against their will if they are in receipt of such a document.

The Royal College of Psychiatrists has claimed advance directives as the only intervention known to have reduced compulsory admissions and frequently cite the preponderance of ethnic minorities, particularly black people, who are compulsorily detained. However, there is nothing to suggest that advance directives will be either more or less effective for ethnic minorities in reducing compulsory admissions.

My recommendation is that Advance Directives and their limitations are made clear and that they do not become another high ideal, based on meaningless bureaucracy, that raises expectations and damages clinician-patient relationships when these expectations are inevitably unfulfilled. Ideally, they should be removed from the Act, in my personal opinion,

### 46, 47

I have no specific recommendations or comments

### 49 Removal of police stations and prisons as places of safety

The committee will be mindful of the very serious state of affairs in UK mental health services and that the Act is likely to be passed in the backdrop of a national beds crisis. Patients are waiting for beds in corridors and mentally ill patients are spilling over into services for physically ill patients. Because so many beds have been closed, Forensic secure services now cease to function as before and all have waiting lists for admission from prisons. This means that many of the ideals of the new Act are impossible to fulfil. It some services, "section 136 suites" have been created. But these have ceased to function and patients are held in unsuitable conditions awaiting beds, with the legality of their detention uncertain.

The relationship between the police and mental health services continues to deteriorate and the police are increasingly refusing to attend mental health crises.

Whereas the police may welcome the removal of police stations and prisons as places of safety, I am hard-pressed to think how the NHS can replace them. I can only use my imagination to consider how matters will deteriorate if this is passed and would strongly advise its removal.

I have never personally encountered the use of a prison for a patient as a place of safety according to the Mental Health Act and therefore am unable to understand why this has been proposed**.**

### 50. Removal of patients by authorised persons

This is one of the most contentious sections of the Bill and I understand representations have been made to the secretary of state by several parties to remove it. It is important to consider what will happen if this is included. Firstly, it is unlikely that mental health professionals will be willing to become "authorised persons". The duty of authorised persons is current that of the police and it is possible that this has been inserted into the Bill due to concerns that the police are no longer able or willing to perform these duties in some areas leading to patient difficulties and even deaths.

It is probable that the private sector mat see this as a market opportunity but would require regulation and trsining, together with indemnification.

### 51. **Remand for a person's own protection etc**

I regret that I am unable to comment confidently on this section and do not understand its origin. It seems in contradiction to the use of prison as a place of safety in section 49. As this would primarily involve the magistracy who are currently instructed not to remand for psychiatric reports unless absolutely necessary to reduce the demand on prison places, I wondered if the magistracy or indeed the judiciary had had any input into this section. I understand that it has previously been good practice to remand such cases into hospital but hat this rarely occurs due to lack of beds.

**The Calocane Test**

**The case of Valdo Calocane will be well known to the committee. Briefly, he suffered from paranoid schizophrenia, had previous interactions with health services and police, killed three people and seriously injured three other people in Nottingham city centre.**

**There have been several reviews and inquiries and there will be another inquiry chaired by Her Honour Deborah Taylor. There have already been severe criticisms of his management by the police and mental health services who may have put the public at risk by not acting or intervening in a timely fashion to prevent the tragedies from occurring. These include failing to intervene to ensure Calocane received adequate supervision and took medication when it was known that he had repeatedly refused both, and where mental health professionals had deemed him a danger to the public. Also failure to ensure continuity of care once discharged into the community and failure to treat him as an inpatient for an adequate period to ensure his condition had sufficiently improved before release. As a result his condition appears to have deteriorated until he posed a grave and immediate danger to the public. He was not apprehended until he had acted violently on the basis of his untreated symptoms of mental illness.**

**The key test for each of the proposals in the Bill should therefore be the likely benefit that Calocane would have received from each of them and whether they would have increased or lessened public protection:**

**(i) For the principles of choice and autonomy, it could be said that Calocane was allowed total choice and autonomy according to those principles and that his case exemplifies the misapplication of such principles in cases of severe mental illness where there is risk and the outcome of not intervening is uncertain.**

**(ii) There is one report in which staff have been criticized for not putting Calocane on a Community treatment order to ensure he took medication in the community before being released from hospital. The bureaucratic additions added to the Bill for CTOs would only have increased these difficulties and discouraged necessary intervention.**

**(iii) the new conditions for deciding on treatment would only have placed yet further bureaucratic burdens and disincentives on the urgent need to have intervened to treat Calocane.**

**(iv) there is nothing to suggest that the addition of capacity law would have had any effect other than to further complicate the care of Calocane.**

**(v) there is nothing to suggest that an advance directive would have made any difference to the outcome and finding such a document in a medical emergency, which Calocane had become, would only have served to waste more valuable time and resources.**

**(vi) I am concerned that "nominated persons" and "advocates" may slow down the entire process in an emergency, preventing clinicians from acting effectively, possibly challenging their decision-making.**

**(vii) in the event that Calocane had been apprehended by police before the homicides, the most appropriate action would have been to take him to a police station as a place of safety on section 136. He was homicidal and it is unlikely that mental health services could have coped with him or adequately restrained him without the police, or kept him in a corridor in A&E whilst attempts were made to find a bed which would have had to be in a locked ward. The case demonstrates the serious implications of removing this current component of the Act and the important need for police discretion in the apprehension of mentally ill persons who are potentially violent.**

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