Witness Name: Professor Sir Simon Wessely

Statement No: WITN0322001

Dated: 04/12/25

NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF PROFESSOR SIR SIMON WESSELY

Introduction

1. I make this statement in response to a Rule 9 request from the Nottingham Inquiry ('the Inquiry'), dated 15 September 2025.

2. I am a consultant psychiatrist and medical academic. I qualified as a doctor at Oxford in 1981 and then did two years in general medicine, obtaining the MRCP in 1984. I then started psychiatry training at the Maudsley Hospital in London, having passed the Membership of the Royal College of Physicians (MRCPsych). I then was awarded a Wellcome Training Fellowship in Epidemiology, which led to an Master of Science (MSc) in epidemiology at the London School of Hygiene and Tropical Medicine in 1989, and then a doctoral thesis on the relationship between crime and schizophrenia. Following a period at the National Hospital for Neurology, my clinical speciality became general hospital/liaison psychiatry. I became a Senior Lecturer in Psychiatry at the Institute of Psychiatry (IOP) in 1991, with my clinical sessions at King's College Hospital. Since then, I have always been a full-time employee of the Institute of Psychiatry and then King's College London ('KCL') following the merger. I was elected a fellow of the UK Academy of Medical Sciences in 1999. From 2014 to 2017 I was President of the Royal College of Psychiatrists and then the Royal Society of Medicine between 2017 and 2020.

3. I held a series of senior positions at the Institute of Psychiatry, Psychology and Neuroscience at KCL – Reader, Professor and Head of Department of Psychological Medicine, Vice Dean for Academic Psychiatry, and Interim Dean. In 2017, I became the first and only Regius Professor at KCL, and the first Regius Professor of Psychiatry in the UK. In the 1990s I set up the Gulf War Research Unit, which became the King's Centre for Military Health Research in 2003 and is now widely acknowledged as one of the leading centres in the world for military health research. I am the most published global author on this subject.

4. I also was the first Director of the Health Protection Research Unit at KCL working on Emergency Preparedness and Response between 2015 – 2022 and was very active during COVID-19. I hold honorary positions at KCL and the Maudsley Hospital. I am the Civilian Consultant Advisor in Psychiatry to the British Army. I hold honorary doctorates and Fellowships from Sheffield, Exeter, Trinity Hall Cambridge, University College Oxford, Royal College of General Practitioners, Royal College of Psychiatrists, Royal College of Physicians, and I am the only psychiatrist to have an Honorary Doctorate from the University of Oxford. I joined the Board of NHS England ('NHSE') in 2023 and left following the announcement of the closing of NHSE in 2025 but was then reappointed as the new Board's mental health lead five days later.

5. I have published over 900 academic papers since the beginning of my career. I began my post-doctoral career studying medically unexplained symptoms and syndromes and published work about chronic fatigue syndrome. Over the past thirty years I have worked extensively on the health of the military including investigating the impact that the First Gulf War had on servicemen and women. Although there was no specific "Gulf War Syndrome", our investigation showed that the health of service personnel had been affected by service in the Gulf, which led to my giving evidence to the Lloyd inquiry in 1996, after which Lord Lloyd praised our contributions as the first to establish that indeed something had happened, even if the explanations were (and still are) uncertain. In 1998, I co-founded the King's Centre for Military Health Research (KCMHR). From 2003 we began a new cohort study of the health and wellbeing impact of the Iraq War on service personnel deployed to Iraq as part of a long-term study which continues until this day. Our centre undertook a similar study in respect of those who served in

Afghanistan. I have published papers on a variety of subjects related to military health including post-traumatic stress disorder, combat stress, shell shock, Forces Health Protection, vaccination, risk taking, self-harm, employment, Reservists, Very Severe Injury, concussion, screening, stress management, leadership and cohesion, impact of COVID-19, pesticides, peacekeeping missions, forward psychiatry, decompression, suicide, Depleted Uranium, alcohol, children of military families, the physical and mental health of veterans and their families, and women in combat roles, amongst other papers.

6. I have been involved in various reviews during my professional life which has included being coauthor of a "Cochrane Review", which are systematic reviews of various clinical subjects. Our review looked at how best to treat those who have survived disasters. Along with other international colleagues, I advised the Norwegian government after the atrocities committed by Anders Brevik. As President of the Royal College, I was a member of the NHSE Mental Health Taskforce and went on to be part of the team that created the Ten Year Plan for the NHS **(DHSC0000096)** and then the "Five Year Forward View for Psychiatry" **(DHSC0000044)**, launching it alongside Simon Stevens (Chief Executive of NHSE) and Paul Farmer (CEO of Mind). I was part of the group who set up the Commission on Acute Psychiatric care during my time as President of the Royal College of Psychiatrists, chaired by Lord Crisp, to investigate the increase in numbers of out of area placements for those subject to inpatient mental health care, which then made recommendations into the Five Year Forward View for Mental Health, published in 2017. I also became the first and (I suspect), only psychiatrist to brief the full Cabinet on mental health the following year.

7. I have also had a long-term interest in how ordinary people deal with traumatic events and disasters and how people respond to adversity. I have published on civil reactions to the Blitz, the London 2005 bombings, the Litvinenko affair, the Salisbury poisonings and in respect of the swine flu pandemic. I served on Scientific Advisory Group for Emergencies (SAGE) for several years (before COVID-19), as well as taking part in the National Risk Assessment. I have had a security clearance to 'Secret' for over 25 years. I was also very active during COVID-19 – the Health Protection Research Unit ('HPRU') funded by National Institute for Health and Care Research (NIHR) and Public Health England (PHE) had just been refunded under

my leadership for a further five-year research programme, starting January 2020. Within a month, our five-year programme was ditched, and we turned exclusively to COVID-19, producing a large volume of work on the psychological and social consequences of the pandemic. Our rapid review of the likely psychological impact of quarantine (as it was first called) has now had over 25,000 citations, making it one of the most cited papers ever on COVID-19 and in the history of KCL.

8. In October 2017, I was asked by the Secretary of State for Health, on behalf of the Prime Minister, to lead an Independent Review ('the Review') of the Mental Health Act 1983 ('MHA'). I exhibit our Terms of Reference ('TORs') **(WITN0322002),** the key elements of which I set out below:

> *"1. Background*
>
> *The government is committed to delivering parity of esteem between mental and physical health. We want to ensure that people with mental health problems receive the treatment and support they need when they need it, are treated with dignity, and that their liberty and autonomy is respected as far as possible.*
>
> *When considering the functioning of the Mental Health Act 1983, the government notes with concern:*
>
> - *rising rates of detention under the act*
> - *the disproportionate number of people from black and minority ethnicities detained under the act*
> - *stakeholder concerns that some processes relating to the act are out of step with a modern mental health system, including but not limited to:*
>   - *the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent*
>   - *the ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one*
>   - *that detention may in some cases be used to detain rather than treat*

- *questions about the effectiveness of community treatment orders, and the difficulties in getting discharged*
- *the time required to take decisions and arrange transfers for patients subject to criminal proceedings*

2. Purpose of the review

The purpose of the review is to understand the causes of the issues outlined above, as well as any additional issues with the functioning of the act identified via consultation.

The review will work with stakeholders to make recommendations to government. The recommendations will be aimed at improving the treatment and support people receive when experiencing acute mental ill-health.

Some of the solutions are likely to lie in practice rather than the legislation itself. The review should consider practice-based solutions wherever possible.

The review will help government create a forward-looking plan of changes to legislation and practice, resulting in an enduring legacy of mental health support."

9. We delivered an interim report on 1 May 2018 ('the Interim Report') **(DHSC0000087)** and the final report in on 6 December 2018 ('the Final Report') **(WITN0155008)**.

Public protection, autonomy and safety

10. Very many of the questions I have been asked by the Inquiry focus upon the balance between autonomy and protection. That lies at the heart of why we have coercive powers of the state which can decide if people can live in the community or in specialist healthcare settings. The creation of institutions to treat those with mental health problems was a construct of society trying to grapple with how to strike that balance. The best way I can find to explain the thinking and my views upon this balance is to reproduce the forward to the Final Report of the Independent

Review, page 5 **(WITN0155008)**, which I wrote, and which explains what I think about this knotty and difficult balance:

> ***"Why do we have Mental Health Acts?***
>
> *On the one hand, the Mental Health Act takes away your liberty and imposes treatment that you don't want. It can be traumatic, frightening and confusing. But on the other it can help restore health and even be lifesaving. It is an imposition on personal freedom, but it can also help people to become freer from the pain and distress that accompanies the most severe of "mental illnesses.*
>
> *This paradox or tension is nothing new. Society and State have been debating for two centuries or more how to balance an individual's right to autonomy with the desire of a civilised society to protect its most vulnerable. Our cultural and ethical traditions support the concept of autonomy. Allowing everyone to make the decisions that affect their life and accept the consequences of those decisions is a key aspect of respecting the unique value and character of each human person. And in recent years it has become clearer that there is no reason why that should be rescinded simply because an individual is unwell.*
>
> *But our cultural and ethical traditions also support the concept of protecting the vulnerable and those unable to care for themselves. The desire to help a fellow human being in serious distress is one of the more attractive aspects of human nature – and societies seek to encourage this by encouraging charitable actions in giving, respecting those in the "helping professions", or giving legal protection to "Good Samaritans". Moreover, most health professionals (and indeed judges) possess well-developed protective instincts. And most of us, if we see someone about to jump from a bridge, would try to help them step away.*
>
> *Few would like to live in a society in which an individual has precious little autonomy. But nor would we like to live in one that does little or nothing to protect its most vulnerable. And if individuals are ever truly free to choose, which some doubt, they are far less so when they are, in the words of Nikolas Rose, a leading sociologist and critical commentator, "in states of anguish, despair or tormented by voices telling them they are worthless and should die".*

These two strands cannot always live together: choices have to be made. This tension often explains the differing perspective of patients (who understandably put a high value on autonomy) and people like me, professionals in the field of mental health, who made that choice because they believed, with some justification, that they had something to offer to people in such distress - a "treatment" in the broadest sense of the word, be it physical, social or psychological. I grew up thinking that some temporary intrusion on autonomy is a proportional response to an acute or desperate situation, and that this was often best done in a hospital setting. To quote Nikolas Rose again:

> *"Sometimes compulsory admission to a place of safety for a short period of respite care, even where conditions are far from ideal, together with the short term, even involuntary, administration of some sedative medication, can be a way of returning an individual in such a state of extreme distress to a condition where they can make thoughtful decisions about their own lives". (Rose, 2019, p175)*

But it is far from ideal. As Rose continues:

> *"Of course, all too often the institutions in question do not provide safety, respite and care, and the administration of medication is excessive, prolonged and for the benefit of staff rather than patients" (Rose, 2019, p222)*

During the year I encountered many people and many settings which did not conform to Rose's image, but the experiences of too many service users convinced me that he has a valid point. I heard compelling narratives that for some detention left them worse, not better off. Of course, all interventions, and being detained under the Mental Health Act (MHA) is an intervention, have side effects. The treatment that only does good, and never harm, doesn't exist. But we can only help reduce these outcomes if we accept, they happen. I often heard from those who told me, looking back, that they realise that compulsory treatment was necessary, even lifesaving, but then went on to say, "why did it need to be given in the way it was?". And it was that last comment which has given rise to the majority of our recommendations.

So, like Rose, I continue to believe that it is at times reasonable to make a temporary infringement of liberty and autonomy and even impose treatment on people who do not want it. But we have to do better in ensuring that no one is made worse than they would have been without this imposition, more are made better, and all have their dignity respected. Likewise, as far as possible they should still be able to make choices as to how they are treated."

Background to the Review

11. In October 2017, I was appointed Chair of the Review. It began its work shortly after my appointment, and an Interim report was produced on 1 May 2018 **(DHSC0000087)**. The Final Report was published on 6 December 2018 **(WITN0155008)**. The executive summary within provides an overview of the work underlying the Review.

12. The TORs referred to above make it clear that the pressure for this latest review of mental health legislation had not come, as it had in the past, from a particular shocking case. The last major independent review in 1999, chaired by legal academic Professor Genevra Richardson, had been triggered by the killings committed by Christopher Clunis and Michael Stone, and public safety was the driving force behind it. The MHA had last been amended in 2007, and those amendments were preceded by two previous White Papers which sought to grapple with the question of public safety in the context of seriously mentally unwell offenders.

13. The different TORs for our Review reflect different concerns. The Prime Minister at the time, Theresa May, had made it clear that she had been shocked by the number of people with obvious severe mental illness ('SMI') held in police cells during her time as Home Secretary, and also the over representation of those of African or Caribbean descent. Reform of the MHA was made a commitment in the manifesto published by the Conservative Party in the April 2017 election.

14. There were concerns from the mental health charities that our legislation was out of step with developments elsewhere; from disability campaigners that there were substantial discrepancies between the way we treated mental and physical disabilities; and from legal and mental health academics that we were out of step

with, for example, our obligations under the European Convention of Human Rights ('ECHR'). Black community groups, campaigners and charities were also angry with the way in which those of African Caribbean heritage were treated by our services – it was often being expressed that this was a combination of neglect mixed with excessive coercion. Academic and community psychiatrists were also questioning the value of Community Treatment Orders ('CTOs'), this was particularly the case following on from the research published in 2016 by Tom Burns (and others) which had looked at the efficacy of the use of CTOs in comparison to informal coercive techniques and whether they improved rates of psychiatric readmission. The results showed that the use of CTOs did not reduce the rate of readmission in comparison to those not under CTOs **(WITN0322003).**

15. Finally, there was a major push from within the Department of Health and Social Care ('DHSC') and NHSE, backed by influential voices within the Treasury and Downing Street, that something was amiss with the Deprivation of Liberty Safeguards ('DoLS') and plans to revise the Mental Capacity Act 2005 ('MCA') in response to concerns raised following the expansion of such safeguards to a much larger number of individuals without capacity following on from the Supreme Court decision in *P v Cheshire West* [2014] UKSC 19.

16. Finally, no one could doubt that the public perception/media coverage of mental illness/mental health had undergone a substantial shift over the past 20 years. Stigma was steadily decreasing, and for the first time positive stories about mental illness now outnumbered negative ones in the media, as set out in the following exhibited data from the mental health charity, Mind: **(WITN0322004)**.

17. So, the public and political drivers of reform were very different from the previous Independent Inquiry and subsequent legislation, which had introduced CTOs and the (now decommissioned) Dangerous and Severe Personality Disorder programme, which dealt with the detention and management of high-risk individuals with severe personality disorders.

18. When taking on the Review, I had concerns that I, and the Review team, might be subject to various pressures and concerns from elected politicians about our review, the exploration of the issues and any concerns raised, as had happened during previous reviews. This did not come to pass.

19. I believe that I was chosen as Chair because I had no known views on issues around the workings of the MHA, the workings of the ECHR and how that may – or may not – impact upon the way that mental health services operated. I also had no expressed views about whether the MHA operated lawfully given various international obligations in respect of disabled people, such as the United Nations Convention on the Rights of Persons with Disabilities ('UN CRPD') and whether mental ill health should be seen through the lens of disability. I was a consultant psychiatrist, but my clinical consultant post was in general hospital psychiatry, and my academic research work was on unexplained syndromes, and then military mental health and how individuals and populations reacted to adversity. More specifically my work as a consultant did not bring me into contact with many individuals with SMI, and I was only very rarely involved in the processes around "sectioning", largely when I was the duty consultant psychiatrist on call for the Accident and Emergency service at King's College Hospital, where our clinical liaison psychiatry service was and is based.

20. However, I had undertaken a forensic post during my training – i.e. I had worked in a setting which dealt with those who had committed criminal offences whilst mentally unwell. I also renewed some connection with forensic psychiatry during my three years as President of the Royal College of Psychiatrists when I attended the annual meetings of our Forensic Faculty (2013-17). In addition, my doctoral thesis (written 25 years previously, after I had completed my academic training in epidemiology) was on "Crime and Schizophrenia" and had been the first to challenge the conventional wisdom that there was no connection between schizophrenia and violent offending. In fact, there was a connection. Not a large one, but not insignificant. This was the first time this had been shown in the UK (previous evidence had come from Germany and USA, but not the UK), and the finding has been replicated several times. What has been subsequently shown is that moderator for this link is strongly influenced by substance misuse – data on which was not available to me back in 1991. The current authority on this is Professor Seena Fazel at Oxford, whilst Professors Louis Appleby and Nav Kapur at Manchester are the main authorities on the specific links between homicide and Severe Mental Illness. Although my study was the largest of its kind at the time, it was still nowhere near large enough to give information on homicide. Only national

data can do that, mine was restricted to what was known as the Camberwell Case Register, a register of everyone ever seen by the Maudsley Hospital.

Landscape of the Review and its goals

21. As set out in the TORs, the goals of the Review were to make recommendations for improvement in the mental health system in relation to rising detention rates, racial disparities in detention, and concerns that the MHA was out of step with a modern mental health detail. The overarching aims were set out in the Interim Report at page 15 **(DHSC0000087)**, which was to make the MHA work better for everyone. Our aims sought to achieve the following:

    - Service users and carers being treated with dignity and respect
    - Greater autonomy for those subject to mental health legislation
    - Greater access to services for those that need them
    - Making the least restrictive option appropriate to a person's circumstances the default option
    - Improved service user and carer wellbeing
    - Service users and carers supported to be fully involved in treatment as possible
    - Reduced disparities between groups with protected characteristics
    - Greater focus on a rights-based approach
    - Reduced harm and improved safety for all
    - Professionals better able to deliver their expertise.

22. This was a broad set of goals, of which one was public safety. This was not explicitly set out in our TOR, but I would say that it was always something that myself and the Review team and all the groups working on the Review considered all the time. Issues around public safety were never far from my mind, and I made sure that was the case for the rest of the Review team. This was particularly relevant during consultation with the organisations such as Hundred Families, when there were direct discussions about homicide, to whom I knew public safety was paramount. I specifically made sure that those families whose lives had been torn apart by homicide were consulted on early drafts of the Interim and Final Report. I personally shared an embargoed copy of our Final Report with Julian Hendy, the Chair of the

Hundred Families, the only person who received such a copy. I also made it clear on numerous occasions both inside the Review and also in my many talks/briefings/seminars that any perception, whether real or imagined, that our work would result in an increase in violence or homicide, would be unacceptable to public, politics and media, and jeopardise our ability to deliver on our TORs. I also emphasised constantly that we would never do anything that would force a clinician or mental health professional to do anything or indeed not do something that they did not feel was clinically justified. I remember well making these points to audiences of psychiatrists – that none of our recommendations would force them to something they did not feel was "right", whatever that meant, and that the word "never" would never appear in our recommendations. Psychiatry is an inexact science, and risk prediction is a very complex business indeed.

Members of the Review panel

23. Although I was appointed the Chair of the Independent Review, it would not be fair to say that I was responsible for the entire direction of travel. There were three extremely experienced Vice Chairs who each brought deep understanding of different aspects of the Mental Health system, its practical, legal and ethical underpinnings and workings in the form of Steven Gilbert (a service user and Serious Mental Health living consultant), Sir Mark Hedley (a retired High Court judge who had particular expertise in family law, the court of protection and mental health), and Rabbi Baroness Julia Neuberger who was CEO of the King's Fund (a charity which works on health policy) and chair of the Liverpool Care Pathway Review (which examined the ethics of end of life care). I never moved forward on any issue until I was confident that the four of us were in agreement. It was much the same with the core group – I was always aware of the fact that actually I was the least expert voice in the room, and that I had great respect for all of the team, which was more than repaid. When it was clear that there was not consensus then this would be made clear in the Final Report and not become a formal recommendation. For example, I was persuaded during the consultation process and also by meeting with Bipolar UK that we should recommend that people could specify in an advance choice document that they would wish to detained sooner rather than later (this applied to people with bipolar who often had a period of partial insight at the start of their relapse, and would later wish that they had been detained

at that point of time, and not only after they had fulfilled the criteria for detention, but by which time they had done great harm to themselves and others). However, the legal members told me that you simply cannot consent in advance to a deprivation of liberty, so that was that. Likewise, I had views on how we could improve the boundary between the Mental Capacity and Mental Health acts, which I still think would have been a good idea but could not achieve a consensus amongst the core group and the reviewers. So these are outlined in the Report, but not in the Recommendations.

24. As identified, the Review was wide ranging in its nature. It sought to be shaped by those who had personal and professional experiences of the workings of the MHA. A number of different topic groups were established to support and shape any recommendations made. Details of these groups are contained at pages 80 to 375 of the supporting documents to our Final Report **(WITN0155008).** Overall, there were 16 groups.

25. Alongside these groups, there were a number of experts who supported the Review process, who provided further advice. This included service users and carers. Alongside this were specific service user and carer focus groups who advised us throughout the course of the Review. There was also an African and Caribbean focus group which was charged with making recommendations about ensuring that those with this protected characteristic receive the treatment and support they need, they are treated with dignity and their liberty and autonomy is respected as far as possible. I attended some meetings of that group, including one in Downing Street, but only as an observer, and did not take any part in the deliberations. My presence was to show that I took this very seriously but also that I took equally seriously my promise that their report would also be their voice, and independent of mine. The anonymous feedback that I received at the end of the Review (as part of the 360-degree evaluation exercise that I had to do for the GMC in order to revalidate as a doctor) from our service users was very positive. Alongside this there was an evidence and analysis group which advised on data and academic evidence. This included using the evidence which existed, highlighting where there is a lack of evidence and making suggestions as to how that could be overcome. There was also an advisory panel made up of 40 stakeholders which was a forum for both evidence gathering and insight.

Gathering evidence

26. As discussed above, the Review's goals are set out at page 15 of our Interim Report **(DHSC0000087)**. The ultimate aims of the report were set by our TORs, but we also developed a set of goals to help guide our work which were shaped from feedback from our service user and carers' group, as well as our advisory panel.

27. As set out at page 16 of the Interim Report **(DHSC0000087)**, the first phase of our work was to conduct a dedicated service user and carer survey to learn about their experiences of and attitudes to detention under the MHA. We also invited organisations to express an interest in running focus groups for these individuals, to particularly consider issues affecting them – such as people from minoritised ethnic communities, people with learning disabilities, people with autism, children, young people, and carers. These focus groups included those currently detained in secure hospital units (both medium and high secure units). We held a roundtable meeting at 10 Downing Street in February 2018 which discussed priorities in mental health provision for those from African and Caribbean communities. A wide range of different groups who had expertise on issues of race and mental health attended this event. We received over 2,000 responses to the survey we sent out, had over 30 focus groups, had 320 people at workshops and attended over 70 different meetings and events.

28. Alongside the work with those who used or had direct experience of the mental health system, we also undertook workshops in different parts of England and Wales which were attended by service users, carers and doctors and other clinicians and professionals involved in mental health care.

29. Page 17 of the Interim Report **(DHSC0000087)** sets out a summary of the evidence identified in the first phases. This included academic literature reviews on the following themes:

    - Legal Frameworks and rates of detention in Europe
    - Clinical and social predictors of compulsory admission
    - Use of the nearest relative provisions in compulsory detention and ongoing care of people
    - Service users and carers experience of compulsory admission

- Interventions to reduce compulsory admissions
- Advance planning
- Clinical effectiveness of Community Treatment orders

30. I would suggest that these reviews may be of some use to the Inquiry, albeit they are now some eight years out of date. Alongside this, we also commissioned public bodies to undertake bespoke data analysis, including:

    a) Analysis of patient-level data at South London and Maudsley NHS Foundation Trust and Camden and Islington NHS Foundation trust
    b) Interrogation of the Mental Health Act Statistics by NHS Digital.
    c) Data from HM Courts & Tribunals Service.
    d) Data from HM Prison and Probation Service.

    to explore questions around:

    a) Detention rates.
    b) Rates of re-detention.
    c) Comparison of informal and formal admission; and
    d) The success rates of those who applied under the MHA 1983 appeal process to the Mental Health Review Tribunal for discharge from detention.

31. Over 150 sector organisations responded to our formal call for evidence. A full list is set out from page 380 onwards in the Supporting Evidence to the Report **(WITN0322005)**.

32. I further direct the Inquiry to the report prepared by Dr Graham Durcan and Androulla Harris on the key themes identified in the MHA survey that we commissioned **(WITN0322006).**

33. Following the Interim Report **(DHSC0000087)**, we established a number of 'Topic Groups' to provide advice to the Review leadership on key themes identified in phase 1, as follows:

    a) Addressing rising detention dates - What interventions could reduce use of the MHA and compulsory admissions?

b) Maximising autonomy: consent to treatment (Advance Decisions)
c) Detention criteria
d) Patient dignity and safety
e) Advocacy
f) Tribunals, hospital managers, renewals
g) Family and carer involvement
h) Community Treatment Orders
i) Discharge, care planning and s 117 aftercare
j) Asian and minority ethnicities
k) Children and young people
l) Learning disability and autism
m) Interface with Mental Capacity Act
n) The police role
o) Criminal justice system
p) Principles underpinning the Act.

34. I think it important to note that the programme of service user engagement to support the work of the Review was later short listed for a Civil Service Award, and I have been told has been since used as a worked example of how service user engagement can and should be used.

Work with INQUEST

35. I have been asked to provide a summary of work undertaken with INQUEST. I know that they provided a written and oral response to the call for evidence, and this fed into a recommendation that families of those who have died should receive non-means-tested legal aid. As set out at page 100 of our Final Report **(WITN0155008)**, we also heard from INQUEST and other stakeholders that the way deaths are investigated can be inadequate and that they were calling for independent investigations following any death of someone detained under the MHA. We chose not to make such a recommendation for the reasons set out at page 101 of the Final Report **(WITN0155008)**. We said this here:

> "*One thing that we heard time, and time again is that where there are lessons to be learned following a serious or fatal incident, these lessons are not being*

shared nationally so that everyone can benefit, and to prevent similar incidents elsewhere. We think it is crucial that mechanisms are put in place nationally to make sure this happens. We support the recommendation made by the Angiolini report for an independent office for article 2 compliance, accountable to Parliament and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning and the consistency of its application at a national level: we think this recommendation should be reconsidered. We understand that the Department for Health and Social Care has recently committed, through the Ministerial Board on Deaths in Custody, to explore options for how we can learn nationally from Prevention of Future Deaths reports from coroners. We also encourage providers to follow guidance outlined in the National Quality Board "Learning from Deaths' report. Finally, research commissioned by NHS resolution published in September 2018 outlines useful learnings related to suicide. We would hope that all such learning is pulled together continuously and systematically and embedded within the new Mental Health Safety Improvement Programmes led by NHS Improvement.

We think that there is a good chance that these measures, taken together, will make a considerable impact in improving the ways in which we investigate deaths, support the bereaved and learn from investigations. For these reasons were not recommending substantial further changes, in particular automatic independent investigations in all cases. However, this must be kept under review in consultation with the key stakeholders in this area. If, after five years, improvements are not seen, then we recommend that this issue is revisited"

36. I also recall a request to meet them, which I believe they did not accept although I no longer have access to the relevant material to be able to provide any further detail on this.

37. Public protection was a constant presence in all our minds and was certainly considered and explored for the purposes of the Review. There is a lot of emphasis on risk and balance between risk and patient rights. The Interim Report was based on a call for evidence around the decision to detain, which is necessarily driven by risk, and whether there was a need to look at risk threshold as part of phase 2 of the Review.

Final Report

Summary

38. The Final Report sets out our main findings and recommendations at pages 65 to 209. It is difficult to do justice to the size, shape and nature of the report within this witness statement. The best way of doing so is to read the executive summary prepared by myself and the vice chairs which provides an overview of the principal findings and overarching thinking that drove our detailed recommendations (exhibited here and pages 16-34 of the Final Report) **(SW1/5 - WITN0155008)**. Broadly, I summarise our main recommendations, and our general approach below.

39. There is no question that a civilised and caring society needs mental health legislation; there are times when people have to be deprived of their liberty for their own safety and health, and that of others. The way in which this is done can be substantially improved, and this is what we set out to do.

40. In particular, we understood that we needed to take more account of how people wish to be treated, even when, or especially when, they are deprived of their liberty without ever having been convicted of a crime. We do this because people still have rights, even if, in extremis, their right to liberty must be overridden. We also do this because we know that the more account we can take of people's wishes, choices and preferences, the more likely they will be to cooperate with treatment both when detained and afterwards. I emphasise that this is in no way unique to psychiatry, the same applies to the rest of medicine.

41. Our recommendations also brought up to date lots of other issues such as who can be a 'nearest relative', which had lingered from the Victorian era. The evidence was also compelling that people of Black Afro Caribbean heritage were substantially more likely to be detained under the Act, including an eight-likelihood that they would be subject to a CTO. We considered abolishing CTOs, as many wanted, but decided instead to reform the process, ensuring it aligned with the new detention criteria that the decision is not seen as an easy option. We also recommended requiring better clinical justification for continuing CTOs in any given patient. We also "tidied up" a number of other areas, such as improving the patient voice,

access to advocacy services and ensuring that treatment planning was more rigorous and involved relatives/nominated person more than in the past.

Risk

42. As for the risks of serious violence by those with mental illness, reviewing this was not part of our TORs because there was a general consensus on this within the academic literature and amongst mental health professionals. It is now accepted there is a small but significant increase in the risk of serious violence by those with SMI, that the risk to self is an order of magnitude greater than the risk to the public, and that this is strongly increased by concurrent substance misuse. This is an enormous topic with a great deal of literature and other information. I am not best placed to discuss or describe these issues in detail. The Independent Review took advice from Professor Louis Appleby on trends in homicide by those with SMI. I would suggest that if the Inquiry wishes to have detailed evidence and information on this topic then he is the best person to approach.

43. I am asked by the Inquiry how such risk was assessed by professionals. Further to the extract above, I am not sure I am able to comment on the issue of how professionals should assess risk, as that is not the type of clinical psychiatry that I do. I do know that it is a highly subjective, context specific decision-making process. Professionals will look to a range of issues including the patient's history (previous harm to self or others, previous serious self-harm, previous compliance or lack of it, previous illness, previous detentions under the MHA, forensic and criminal history and so on). Previous or current substance misuse is also a crucial risk factor. The current history is also considered carefully – in particular a pattern of increasing severity of illness, decreasing or no insight and increasing irritation or aggression will be seen as important. Access to methods of self-harm will also be taken into account. Likewise, as the Evidence Reviews at the end of the Review confirm, police presence before and during the assessment is a strong risk factor for subsequent detention.

44. They will also consider a host of factors that might decrease the need for detention – sometimes known as "safety nets" – the presence or absence of a supportive individual or family, access to other means of support and so on, whereas living alone or in rented accommodation increases the risk. As well as interviewing the

patient/service user, and consulting the existing records, the clinician will, where possible, interview family members or friends, or other professionals such as community workers, or members of the police or ambulance services.

45. All of these will be part of a process in which the clinician is exploring the reasons they have for thinking a patient will or won't do something which, in the end, is a matter of judgement. This is collectively called "formulation" and is at the heart of clinical assessment and understanding. It is not a 'tick-box exercise'. These have been tried and offer no improvement on a psychiatrist's judgement. Risk assessment was not the ubiquitous term that it is now, but it is not, nor has ever been, an exact science. There is extensive literature on the subject, some cited within the Final Report **(WITN0155008)**, such as the works of Beck (Ulrich Beck, Risk Society. Sage, 1992) and Szmukler (Szmukler G, Men in White Coats: Treatment under Coercion. Oxford University Press, 2018) but it is a topic that was outside our TORs and is not something that was foregrounded in our Review. There was and still is a strong body of opinion around the world that risk should not be used to determine detention, but capacity. Some follow the lead of the UN CRPD (or more specifically its interpretation by the committee empowered to examine and review the Convention), which basically states that detention for mental disorders is incompatible with current views on disability, discrimination and human rights.

46. However, as will be clear throughout the report, we did not question or challenge that risk should remain a core principle – we never considered removing the requirement that detention could only be justified on the basis of a) the presence of a mental disorder, however defined and b) the presence of significant/substantial risk to self and/or others. The way in which this is defined or assessed by professionals, as I have set out above, is not a hard science. In what is by definition a crisis situation, professionals will also often make a swift judgement that action is going to be needed but then ensure that this initial judgement remains justified on the facts/history as it unfolds.

The use of Community Treatment Orders (CTOs)

47. This a very large topic, covered in many places in the Review, in both the Interim Report at pages 35-36 and at pages 132-140 the Final Report **(WITN0155008)**, as

well as by the CTO Topic Group, the specific research commissioned by the Review as set out below.

48. There was also no clear consensus within the Review panel at the start. But it was an issue that was within our TORs and therefore needed to be determined, which it was. I summarise our thinking on this in the following paragraphs, and how we reached the recommendations that we did.

49. My starting point was the evidence on the effectiveness of CTOs. Very unusually for mental health legislation, there have been three randomised trials conducted on CTOs, of which one was in the UK. Conducted by Professor Tom Burns, the results did not show any particular benefits for CTOs, for example in reducing hospital readmissions. We commissioned a systematic review and meta-analysis on the subject, which is set out at pages 262 to 266 of the Final Report **(WITN0155008)**. The Review looked at the randomised trial, as well as before/after comparisons and other weaker designs, but did not find any compelling evidence to support the use of CTOs for a variety of outcomes. Meanwhile, we were all aware of the evidence that those of African Caribbean heritage were substantially more likely to receive a CTO than those of any other ethnicity – the accepted figure during the time of the Review was an eight-fold difference **(WITN0322007)**.

50. It would have been easy to simply drop CTOs all together. I am in little doubt that if we had taken a vote at the start of the Review, the majority opinion would have been to get rid of them.

51. I had reservations about this. Although Professor Burn's trial was remarkable in that it was done at all, there were still problems that could not be overcome, and I write as someone who has a particular interest in randomised controlled trials ('RCTs') since I have co-authored a book on this with the well-known statistician Professor Brian Everitt.[1] For example, in the Burns trial the most unwell patients were excluded from randomisation. In theory, the most severe cases should be included but that would require a huge, if not improper, appetite for risk. Before and after comparisons, which tended to give more positive results, unfortunately have

[1] Everitt B and Wessely S, Clinical Trials in Psychiatry. Wiley, 2008.

significant limitations due to the exclusion of the most unwell patients, which limit the confidence that one can have in these results.

52. It would have been easy, and welcomed by many stakeholders and service users, to simply recommend dropping CTOs altogether. But it was not that simple. As we wrote at page 133 of the Final Report **(WITN0155008)**:

> *"But on the other hand, we have heard from service users, carers and professionals that there are a small number of people for whom CTOs represent the least restrictive option. Whilst small in number, especially compared to the approximately 5,000 CTOs in existence, this has raised enough concern that repealing CTOs entirely could have a detrimental impact on some service users. In particular, concerns have been raised around patients given a section 37 hospital order (following commission of a criminal offence) and the role of a CTO to support step down [between High, Medium and Low security settings, then ultimately back to the community] (where there are no section 41 restrictions to enable conditional discharge)."*

53. On the negative side, we were well aware of the fact that many professionals, and some service users, believed, with some justification, that CTOs were one way to get better clinical care and support. It was certainly true (and right) that once a CTO is in place, there would be more follow-up, and greater access to services and there may be some professionals that might 'game' the system. Whilst we understood this, such actions would certainly be well-intentioned, but it was wrong; it was definitely not the purpose of CTOs – which were intended as a "least restrictive option" and not just a loophole to access services.

54. In support of continuing CTOs, albeit with modifications, I was also impressed by a visit to a particular supported housing/hostel scheme in East London, "Look Ahead", where a number of patients were living, having been moved from either high or medium secure units, but were still too unwell to live independently. Staffed by social workers, who I recall used the word "customers" to refer to the patients/service users, and supported by a weekly visit from a psychiatrist working at the nearby hospital (East London NHS Foundation Trust), all the social workers were convinced that the hostel/housing scheme would collapse without CTOs, and

their "customers", would swiftly relapse and be recalled to either medium or high secure units.

55. So, our conclusion at page 133 of the Final Report **(WITN0155008)** was first that:

> "*we must ensure that there is a greater focus on community services for those with serious mental illnesses. Better community provision, better discharge planning, and a statutory care plan are vital to ensure that no one's access to care following discharge is dependent on the use of a CTO. This will create a better situation for all service users, and remove perverse incentives to use CTOs.' We also concluded that "We need to remember that CTOs can be an unnecessary extension of the coercive powers of the MHA into people's lives, and it is clear from what we have heard they can feel like a punitive rather than therapeutic measure."*

56. As well as proposing measures such as better discharge planning and the statutory care plan, we also proposed measures specific to CTOs. As stated at page 134 of the Final Report **(WITN0155008)**:

> *"We are increasing safeguards at every stage so that decisions are never made by a single professional and requiring a higher burden of proof for their use and continued use. We hope that by doing so, the scope for subjective decision-making and unconscious bias will be reduced significantly. In line with other recommendations to increase the transparency of the detention process, and 'show the workings' of those who take the decisions to use the powers under the MHA, we believe the changes we are proposing should reduce the number of people from ethnic minority communities who are placed on CTOs."*

> *"As well as reducing the number of people placed on CTOs, we also intend to give greater protection to people subject to them than is currently the case. This includes greater attention to the conditions that can be included within a CTO (requiring that they must have clinical benefit and can be reviewed by a Tribunal) improved access to IMHA outside hospital, and more opportunities to challenge the order."*

57. Summarising this, I would say that our intention was to tighten the rules on instituting a CTO, and also do the same for ending one. The general principle that I used when explaining this to stakeholders and service users was that instead of the patient on a CTO having to prove that they would not relapse if a CTO was not renewed (which of course is very difficult to prove), we would shift the burden of proof to the Resident Medical Officer (RMO) to provide evidence for the opposite – that there was good reason to believe that a person *would* relapse if the CTO was removed. The details of the proposed changes are provided in the Final Report and the supporting documentation, but this was the underlying rationale for the proposals. The Vice Chair of the Review, Sir Stephen Hedley and our legal advisor, Alex Ruck Keene KC, played the principal role in deciding the technical details of what changes would be needed to achieve the desired goals.

58. We also concluded that if these changes, once implemented, still showed after five years that the overall number of CTOs, and in particular the strong ethnic bias that was clear and obvious, had not changed, then we would recommend that the Government then act to remove CTOs.

59. I am aware that events after the Review have complicated matters. First, the recommendations of the pre-legislative scrutiny panel in January 2023 **(DHSC0000151)** were to go for an immediate withdrawal of CTOs, against our recommendations. But I am led to understand that this has itself been reversed. However, as I have said before, I am no longer directly involved in these discussions or decisions, and better and more accurate information will need to come from DHSC.

60. Our final recommendations in relation to CTOs can be found at pages 139 to 140 of our Final Report **(WITN0155008)**, which I set out below:

    - *"The criteria for CTOs should be revised in line with detention criteria.*
    - *The onus should be on the RC to demonstrate that a CTO is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the patient and others. The evidence threshold should be raised for demonstrating that contact with services has previously declined, and that this led to significant decline in mental health.*

- *Applications for a CTO should be made by the inpatient responsible clinician, with the community supervising clinician who will be responsible following discharge, and an AMHP.*
- *The Nominated Person/ Interim Nominated Person will have the power to object to both applications and renewals of CTOs.*
- *CTOs should have an initial period of 6 months, renewed at 6 months and then 12 months. Each renewal must involve two approved clinicians and an AMHP, unless the tribunal has recently reviewed the order.*
- *CTOs should end after 24 months, though the RC should be able to make a new application.*
- *As well as considering discharge, the Tribunal should, when refusing to discharge from the CTO, be able to order changes to the conditions of a CTO.*
- *If no appeal is made to the Tribunal in each time period, there will be an automatic referral.*
- *The recall criteria should be updated, and the process should be reformed to make it simpler.*
- *Recall to alternative locations should be considered.*
- *As set out in our chapter on Advocacy, IMHA services should be commissioned specifically for people on CTOs that requires providers to proactively approach the patient and offer their services.*
- *If put in place, the effect of our recommendations on CTOs should be reviewed in no more than five years' time, with a view to abolish CTOs if outcomes are not improved."*

Use of CTOs in certain groups

61. I am asked whether we found evidence that professionals avoided restrictive practices for patients from African and Caribbean communities due to concerns/publicity about disproportionate overuse.

62. I can understand that this will be an issue for the Inquiry. I do not recall the issue surfacing during the various consultations that we undertook. Our starting point, as laid out in the TORs, was that the robust evidence showed that there was an eight-fold increase in the likelihood of being subject to a CTO if you were of Afro

Caribbean heritage. Even accepting that individuals in these communities are more likely to suffer from a mental health disorder (there is statistical evidence to support this, but this is subject to widely accepted socio-economic and societal factors) there is nothing to suggest that this is anywhere near eight times as likely. So even if this was occurring in individual cases, the direction of travel was in the other direction. I do not know whether or not this has happened subsequent to the publication of our report.

Capacity

63. I am asked about the use of the MHA or MCA in respect of hospital admissions including when making decisions about mental health care and treatment. This is a complex question, and it is referenced in several sections of our report. For example, we drew attention to service users' experience of the misuse of capacity assessments as set out below at paragraph 97.

64. Our proposals for addressing one of our TORs, which referred specifically to the confused and confusing dividing line between MHA and MCA were set out at pages 127-128 of our Final Report **(WITN0155008)** as follows:

> ***"The dividing line between the two Acts***
>
> *We are recommending that the law should be amended so that only the MCA framework (DoLS, in future the LPS) can be used where a person lacks capacity to consent to their admission or treatment for mental disorder and it is clear that they are not objecting.*
>
> *We are aware that 'objection' is not always easy to identify, especially in people with cognitive impairments. We are also aware that, whilst it may be relatively easy to determine whether or not someone is objecting to treatment in a psychiatric hospital, it will not be so easy when the patient is in a general hospital but treatment for a mental disorder is being considered. However, as set out above, objection is the term that is currently used in both the MHA and MCA and is a familiar enough concept not just for professionals, but for anyone. We think it is the right dividing line between the MHA and the MCA, and we agree with the statutory definition for 'objection' in the MCA which will be maintained in the Bill. However, clear guidance will be required as to what*

objection looks like in practice in both the MHA and MCA Codes of Practice, and what practitioners should do where a person who was previously objecting is no longer doing so (and the other way around).”

65. It is important however to note that very late on during the debate in the Lords on the DoLS/Liberty Protection Safeguards MCA legislation, Baroness Barker introduced an amendment to the effect that would allow use of the MCA only for risk to self, and not risk to others, we believe not knowing about our proposals. Unfortunately, this would have had the no doubt unintended consequence of making our proposed interface unworkable, since “risk to others” was, as I have already indicated, always at the front of our minds.

66. Finally, I think it is important to add that throughout the time of the Review, we were fortunate to have the services of Alex Ruck Keene KC who is by common consent the authority on these issues, and who wrote the specific legal sections around the MCA/MHA overlaps.

Sharing of information

67. I am asked about the sharing of information and the effectiveness of multi-agency working. I am afraid I have no recollection of this issue or whether we found any evidence to any barriers to the sharing of information. There was an issue in relation to the data collected from patients that received both NHS and privately-funded care which gave the effect of ‘double counting’ on some points but I direct the Inquiry to DHSC who will have better access to any evidence gathered on the issue, if there is any.

Final Report: conclusions and recommendations

68. I am asked about whether the desire to increase patient choice, reduce compulsions and reduce racial inequality underpinned our conclusions. My answer is yes, and they were an explicit function of the Review as contained within our TORs. I think it important to emphasise again, however, that the importance of public protection was always part of all these discussions. I think I can say that there was not a day in which we were not considering this. From the first to the last, and the final press conferences/launches, I thought constantly about public protection. It was also a recurrent topic in the briefings I gave to politicians; as part

of the Review, I would meet with members of Parliament, from both Houses and all parties (except the SNP) regularly on an informal basis to discuss the Review's progress and answer questions. None of these were minuted as our civil service team was not involved. I do recall broad requests for reassurances about public protection from some Conservative MPs, including such a request from the Secretary of State for Health at the time, but I cannot recollect specific details at this distance.

Choice and autonomy

69. I refer the Inquiry again to my foreword, page 4 to the Final Report for our approach to this topic **(WITN0155008)**. My colleagues and I concluded that this had to be a balance – hence we rejected the argument that autonomy was paramount (the UN CRPD approach), but we also rejected the alternative; that people who were detained under the MHA should have no choice over how they were treated. What we proposed was a carefully calibrated process in which we would see more of patient choices being considered, but subject to certain restrictions. For example, we rejected the idea that patients could simply refuse all treatment (as happens I think in Ontario, if the patient has capacity, under the Health Care Consent Act (HCCA)) since this would lead to prolonged incarceration on the grounds of unmitigated risk. Likewise, an advance directive would not be considered if it was contrary to accepted medical evidence (e.g., "I will only accept homeopathic treatment"), or impossible to carry out (e.g., "I wish to be treated only by this consultant/the Queen" etc etc). Likewise, we agreed that no professional could be forced to administer a treatment or process that they did not think was safe or effective. This would be a red line. We did not want to create a climate that would mean professionals going against their own judgements. The only caveat was that the professional would then need to give a written summary of why they had come to this conclusion. In other words, "show their homework". For this to be effective, electronic forms would need to be the standard. Professionals can simply leave such entries blank in a paper-based form, whereas an electronic form could make such entries a requirement for completion i.e., one cannot 'click' to the next page or 'send' the form until all entries are filled. All of this would depend on adequate funding for an electronic version of the current legal documents.

70. The example that I used very frequently in explaining our proposals to a wide variety of audiences was that if a patient had in an advance directive indicated that they would prefer medication rather than an injection, then we would expect the professionals to try and comply with this or provide cogent reasons why they could not. But if in fact there was non-compliance with the medication, or there was compliance but not clinical benefit, then an advance directive could not override clinical judgement. In every meeting I had with professionals, I always emphasised that nothing in our recommendation would force a clinician either to give or not give a treatment or course of action against their professional judgement. They would, however, have to be prepared to justify those decisions more than they had in the past.

71. I recall that there was opposition to this, and many of our other conclusions, from some of the service users who were taking part in the Review. I recall the National Service Users Network being particularly vocal on this. They considered that we should accept the pathway laid down by the UN CPRD, of which the UK was a signatory. However, I, the Vice Chairs, and the majority opinion of the Review team were not in favour of this, and the principal reason was because we felt, and I still feel, that this would not be in the interests of protecting the public. This is also laid out in my foreword to the Final Report, page 4 **(WITN0155008)**.

Least restriction

72. It is difficult for me to explain the rationale of this principle when I do not believe there would be any reasonable objection to it. If you have ever been detained against your will, you will know that it is an unpleasant experience. Protection of the individual from excessive force by the state underpins the laws that govern all civilised society. Any interference with an individual's ECHR Article 5 rights, in particular, must be justified and in accordance with law. To build a regime on anything other than the least restriction necessary would surely be considered tyrannical.

Therapeutic benefit

73. The case for why admission should have a therapeutic benefit is I think rather clear cut. The opening paragraph to the section at page 143 of the Final Report **(WITN0155008)** reads:

> "*Nikolas Rose, the influential sociologist and scholar of mental disorders and society, recently wrote that "Undoubtedly, inpatient facilities for crisis care are needed, and in many countries, these are shockingly underfunded, understaffed and quite the reverse of the sanctuary that those in severe crisis need"*[2]*. Whilst we believe the services that are offered in England and Wales are better than can be found in many comparable countries, we know that they are far from ideal, and in need of improvement. A fundamental ethic for this Review is to achieve better and more therapeutic experiences for those who are detained under the Mental Health Act."*

74. I am not sure that needs any further justification. However, I was very struck by the comments of one of our core group, Kate King MBE, *"I understand looking back that being detained under the MHA saved my life. But what I can't understand is why was it such a fucking awful experience?"* If we believe that SMI exists, and that hospitals, not prisons, are the best place to treat SMI, then one does need to justify why admission under the MHA must serve at least some therapeutic purpose. This is particularly cogent when it comes to those with autism and/or learning difficulties. Time and time again we heard harrowing stories of people with SMI, learning difficulties or autism being detained in secure settings for no reason other than nowhere else being available. At times this was described, rather unpleasantly, as "warehousing". In those cases, detention, far from being therapeutic, was instead creating a cycle of despair and violence towards self and staff.

The Person as an individual

75. Kate King MBE, quoted above, also added *"And why was I often not allowed to choose whether I wanted coffee or tea, or sugar/no sugar?"* Again, sentiments such as those expressed so clearly and forcefully by Kate were far from unique, and I

[2] Nikolas Rose; Our Psychiatric Future. Polity Press, 2018., p 182

heard the same thing time and time again during our engagement activities and beyond.

76. It was clear to us that when people were deprived of their liberty because of serious mental illness, they were simultaneously deprived of most of their autonomy. It was a leitmotif of our extensive service user engagement programme that this was the case. There were far too many voices for us to ignore; voices that spoke eloquently about the fact that they had taken little or no part in how they were going to be not just treated, but in many other aspects of daily life. Many remarked on how the environment in which were being held felt like being treated as infants or small children, surrounded by an obsessive preoccupation with risk, everything plastic or nailed down. This would often have the effect of making someone's condition worse.

77. At the same time, we were also conscious of a very basic principle of medical practice – that the more a person is involved in decisions about their treatment, the more likely they are to comply with them. This is established across medicine, in every speciality, and psychiatry is no exception.

78. So, in treating a person as an individual, and recognising that they may have their own individual choices and preferences, is a fundamental part of respect for dignity and autonomy. It is not something that can never be overridden (as some do argue), but something that should always be considered.

79. I also draw the Inquiry's attention to the passages in the Final Report (see for example page 146) **(WITN0155008)** in which we cite evidence that about one third of care plans show no evidence that the patient themselves had any involvement in the process. Once again, it really does not need extensive research to confirm that the less a person is involved in these processes, the less likely they are to co-operate with them.

Alternatives to detention

80. As I have said above, I do not think it is controversial to suggest that a key principle of an act that gives the State power to deprive someone of their liberty is that such a deprivation should be the least restrictive option for the shortest possible time. The European Convention on Human Rights (enshrined into UK law under the

Human Rights Act 1998) makes it clear that detention for the purposes of mental illness has to be justified as necessary and that significant safeguards must be in place (under Article 5 of the Convention). Article 8 is interpreted as enshrining the right to dignity and autonomy to develop one's own personality. That can only be compromised by a public body if such is for a legitimate aim and is necessary in a democratic society.

81. One assumes that no one is arguing that you should lock up every single person with SMI forever. Our actions should be proportionate to the perceived risk and intended goal of treatment. The evidence we heard and the visits we made left no doubt that many feel that the cuts that had happened in social care had contributed to rising admissions to mental health units. For example, a collapse of self-supporting and supported housing, a lack of crisis intervention centres, a shortage of social workers; these all had a detrimental effect on crisis care. The dwindling numbers of supported housing projects suitable for those with SMI had also played a part, even if impossible to quantify exactly how much, in the rising levels of detention that were part of our TORs.

82. Overall, we did not find, however, and there is little evidence to suggest, that the contraction of such services had increased the risk of, for example, homicide. The last 70 years has seen a dramatic decline in mental health beds. From 1961, when Enoch Powell's famous 'Water Towers' speech was delivered, to the present, we have moved from having 95% of care being delivered in asylums, to nearer 5% now. The biggest changes have occurred in the last 30 years. Such changes have occurred across the entire NHS, but the reductions have been greatest in psychiatric beds.

83. What is noticeable is the absence of a correlation between decline in beds and a rise in homicides. The presence of such a correlation would not prove cause and effect, but it is clear that there is no such correlation. In fact, there has been a slow decline in the number of homicides for several decades, although more recently there has been little change, with a possible small increase in the last three to four years. However, this may be due to delays in prosecutions and outcomes due to COVID-19 in 2020. It is worth noting that a decision was made by NHSE in 2018 to decommission research into people under mental health care who have been

convicted of homicide, although the NHS will be re-commissioning the NCISH to provide data relating to homicides.

84. That gives us the background, and why it is not correct to say that reductions in beds might have led to increase in homicides. On the hand, one can make a reasoned argument that the decrease in alternatives to detention has played a part in recent increase in detentions (one reason for the MHA Inquiry). Given the overwhelming consensus that being sectioned under the MHA is not a pleasant experience (and may of itself increase the risk of further detentions, since many people told us that because detention was such a bad experience, they had tended to try and avoid contact with our services afterwards, at the expense of further relapses, and further episodes of detention), all of this suggests that a general principle of least restrictive options for the shortest possible time, is in keeping with the general theme of reducing detentions, and/or making them less aversive, without jeopardising public safety.

85. In the end there is probably no single reason why detentions started to increase over the preceding decade. It is not just due to the expanding population, since the increase is in rates, not absolute numbers. And as I discussed in my foreword, changing attitudes to risk have also played a part, as well as fear. Finally, there has been the influence of specific judgments, including *Rabone*,[3] (which decided that there the state's duties under Article 2 of the European Convention on Human rights could include voluntary patients in certain circumstances) as acknowledged by Baroness Hale in her speech to the Royal College of Psychiatrists in 2018, that *'is bound to make practitioners less inclined to use formal care'* **(WITN0322008)**. These judgments can cause practitioners to lean towards 'defensive medicine' where there is a concern about risk and risk management overcoming other factors.

86. Turning to alternatives to detention, again, the report contains detailed discussions of this in numerous places. For example, starting at page 103, **(WITN0155008)**:

"Research and evaluation

[3] *Rabone v Pennine Care NHS Trust* [2012] UKSC 2

The Review set out to identify examples of interventions that have succeeded in reducing the need for admission, either under the MHA or as a voluntary patient, which we could then recommend are expanded. However, it has become clear that this is not possible because of a lack of solid evidence base, we have only, therefore, been able to draw provisional conclusions. Improved research and evaluation are needed to inform the future design, commissioning and funding of services and interventions. This should cover alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and the social factors that lead to crises.

…

Alternatives to detention and interventions to prevent crisis or the escalation of crisis

The Review has heard numerous examples of services which have been reported as being extremely beneficial, either in a time of crisis or in preventing crisis. These services are often provided by voluntary sector organisations, not-for-profit organisations and carer and service-user led organisations, and deliver a range of care and support. This includes helping people with, or at risk of developing, a serious mental health issue to address or manage factors which we know can trigger crisis, or limit improvement, such as housing and accommodation, relationships, and debt management. Whilst we would advocate a focus on prevention and supporting people, so they do not reach crisis, there also needs to be alternatives to detention to ensure that a consideration of the least restrictive option is possible. AMHPs have a specific responsibility within the regulation of their profession to consider least restriction and alternatives to detention as part of the assessment. AMHPs report that this is improved when they have access to crisis teams and community alternatives to admission, but arranging alternatives to detention can be challenging in areas where partnership working is poor and services are reduced.

We think a broad view should be taken when thinking about interventions that can prevent the need for admission. To help this Review the National Survivor

User Network (NSUN) conducted a survey of its members asking them to identify support they would have found helpful either when in crisis or at risk of one, or which they would like to see in place. Respondents suggested that the key to recovery is often being heard and understood, receiving a compassionate approach, gaining access to a variety of options and being offered support when reducing/coming off medication. This included access to user-led initiatives and/or initiatives which were non-clinically based, and those which were tailored towards people facing more than one type of disadvantage. We believe such services have an important role to play in the system, but like everything else would stand a greater chance of attracting the attention of commissioners when accompanied by sound evidence.

…

Ultimately, we think there needs to be more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well. There is consensus that there needs to be both investment and improvement in community mental health services. Services that are disjointed, and under-funded, lead to more people falling through the gaps and ending up in crisis. People need to be able to access good quality community services quickly and consistently across the country and we need to see the full implementation of NHS England's efforts to address this, including through the forthcoming Long-Term Plan. This should also be a priority of the upcoming Green Paper for Social Care, as an integrated approach to crisis services is most effective. Care should be taken to consider the needs of people with learning disabilities, autism or both, to make sure interventions are in place to address their specific needs."

Changing the criteria for detention

87. I refer the Inquiry to the relevant section of the Final Report (starting at page 109) **(WITN0155008)**, where we talked about the near absence of informal patients in our hospitals, wards and units, which seems to be returning us to the Victorian age where there was no such thing as an informal patient. We also drew attention to the remarkable lack of information on whether or not a person has capacity when

they are detained, which meant that there was no reliable information on exactly how many sectioned patients did or not have capacity to refuse or accept admission. This was one of many reasons for pushing for the digitalisation of the MHA, since we recommended that it would in future be impossible to complete a section without recording a capacity assessment. We did not suggest that psychiatrists did not routinely assess capacity, we think they do, but it is not recorded in an accessible way. The absence of such data restricted our options in the Review.

88. In those sections we also discussed directly the criteria for detention, page 110 – 111 of the Final Report **(WITN0155008)**:

> *"New criteria for significant harm*
>
> *Under the current legislation, a person can be detained where it is 'necessary for' or 'justified in the interests of' the patient's health or safety or for the protection of others. We think this sets the bar too low. Because 'health' encompasses 'mental health', a person can be detained under the Act to avoid any deterioration in their mental health or relapse even if there is no other risk. This may have allowed professionals to become increasingly risk averse; to become too quick to use 'risk' as a catchall justification when they are afraid of consequences that may never happen, indeed probably won't happen. This has not been helped by a lack of provision of community alternatives that could mitigate harm. A major concern for service users is that consideration of risk has become the only way patients are understood and treated; that they are seen:"*
>
> *"Primarily as risk entities, rather than as human beings who are in need of compassionate care and treatment"*
>
> *"We want to reverse this trend; to use new detention criteria to give professionals the backing they need to take more risks with risk. We believe the Act needs to be more explicit about how serious the harm has to be to justify detention and/or treatment, or how likely it is that the harm will occur. We are recommending that there must be a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. But our recommendations will not work if they are seen as 'stand-alone'. If the*

Government agrees, tackling the problem of risk aversion must happen across the board. There is little point in mental health professionals deciding to accept a greater perceived risk if the courts, regulators, media and others do the opposite."

89. Since the publication of our report, the new draft has modified this. In practice I suspect either the wording of our original proposal or the final version will not have the impact that one might expect, because clinicians and social workers will continue to make on the spot assessments of the situation facing them, taking into account a very wide range of information, only one of which will be the precise wording of the Act, and make what we call a "gestalt" decision on whether or not admission is the best or indeed only outcome. From recollection, this section fell within Sir Mark Hedley's area of expertise, and he therefore has a major role in suggesting this change to 'substantial'. In any case, I understand that in the final version of the Mental Health Bill, still with Parliament, this has been changed. I direct the Inquiry to DHSC for further clarification on this issue.

90. My limited experience of "sectioning", but very much confirmed by conversations with professionals during the Review, was that the decision whether or not to "section" someone is an intuitive, patterned-based, 'Gestalt' judgement made by the mental health professional which will include factors such as realistic alternatives, previous history, level of disturbance, presence or absence of family support, level of violence, likelihood of compliance, consequences of a faulty judgement and so on. On the basis of all of that, the psychiatrists and then social worker will make a clinical decision on whether to admit and then write their recommendations in the light of the existing wording of the legislation.

91. I am asked to explain why the pre-existing requirements 'set the bar too low'. I can only answer this by referring the Inquiry back to our TORs. The starting point was that the number of detentions was rising, but the reasons for the rise were not clear; there was no real increase in the prevalence of SMI, nor its severity, nor was there compelling evidence of significant changes in rates of suicide/homicide.

92. I am also asked to explain what level of risk would amount to a substantial likelihood and what degree of harm would be considered significant. Again, I am afraid I am unable to answer this substantively because risk judgements are context

dependent. How "substantial" does substantial have to be? I don't know and nor can anyone else. In the end the psychiatrist or approved Mental Health Professional ('AMHP') will make up their own minds on this, and act accordingly. All we are doing in reality is asking for better documentation of their reasons. I learned from Sir Mark (and others) to appreciate just why our mental health legislation contains a series of checks and balances, including but not limited to HM Courts and Tribunal Service, and also why we do often rely on the judiciary to make decisions where there are competing rights/interests, and where there are apparently irreconciled differences between patients and professionals, and within professionals. The definitions of significant, substantial and many other terms comes within this.

93. We were under no illusion that any change in the wording would be sufficient of itself to achieve uniformity of approach by practitioners. It would depend on the Code of Practice. But perhaps the strongest influence on psychiatrist and social workers' risk judgements comes from legal judgments, not the MHA itself. For example, *Rabone* is felt to have played a large part in reducing the thresholds for detention, as confirmed by Baroness Hale in her speech, referred to above. It is always very difficult to quantify these assessments, as there is no "control group", but I think there is a widespread consensus that this was one reason behind the steady increase in detentions that were part of the background to the Review.

94. As to how risk would be assessed under a new criterion, I do not see how this would not change. The assessment of risk is not just science, it is also an art, as is medicine as a whole. We heard plenty of evidence to this effect, going back over many years. For example, it is well established that risk check lists do not provide any benefit and are not recommended in relation to mental health, unlike for example in airline safety or surgical safety, when they are of clear benefit. What we were asking for was that psychiatrists or AMHPs give more thought to what they are doing, think about alternatives (which they probably do anyway), and put those thoughts down on paper.

95. I have been asked about the wording of the proposed amendments in the Mental Health Bill and the extent to which it differs from my proposals. I must direct the

Inquiry to DHSC to answer this question as I played no part in drafting the Bill or choosing which of our recommendations to adopt or amend.

Reducing the initial period of detention

96. I have been asked to explain the rationale behind the recommendations to reduce the initial period of detention from six to three months, which had considerable support amongst stakeholders. I can go no further than the reasons provided in our Final Report, for example at page 117 **(WITN0155008)**, namely that our main driver for the proposed changes are to ensure that patients are not detained for longer than is absolutely necessary.

Using the MCA framework for decisions as to admission and treatment

97. I have been asked to explain the recommendations and rationale behind the proposed use of the MCA framework. I do not believe I can go further than the extract below from pages 223 to 229 of our Final Report **(WITN0155008)**, which is a good guide to our position on this matter:

> ***"THE FUTURE DIRECTION OF TRAVEL – FUSION OF THE MHA AND MCA***
>
> *We have set out earlier in this report that we think there is still a need for an MHA. We have also set out where we think the dividing line is between the MHA and the MCA. In our interim report, we said we would consider whether or not the MCA and the MHA should be 'fused' together as a longer-term option. We were also specifically asked to consider this issue by the Government as part of its response to the 2017 Law Commission report into Mental Capacity and Deprivation of Liberty.*
>
> *The question of 'fusion' has been raised by many stakeholders during the course of the Review. There are two possible, but quite different, legal models which people have in mind when they talk of fusion:*
>
> *1. The first is to keep the MHA separate from the MCA, but make use of MHA powers dependent, either largely or entirely, on the ability of the person to make their own decisions concerning their treatment. In Scotland, the patient's ability to make decisions concerning their treatment must be significantly impaired*

because of their mental disorder.245 The Indian Mental Healthcare Act passed in 2017 is much more radical because it broadly relies on a capacity test for both detention and treatment.

2. The second is to replace the MHA and MCA with a new Act that 'fuses' the two together and makes all forms of care and treatment dependent upon mental capacity. In other words, either the person must consent, or care and treatment have to be provided to them on an alternative basis. This has been done within the Mental Capacity Act (Northern Ireland) 2016 which has been passed but has not yet been implemented. The Northern Ireland Act allows people who lack capacity to be treated on a "best interests" basis.[4]

This report has set out a number of ways we want to increase the attention paid to a patient's mental capacity under the MHA. The overarching aim of this Review is increasing respect for the choices made by people about their treatment. Someone's ability to make decisions, or be supported to make decisions, is key to this. That is why we have proposed aligning MHA decisions with the best interest's test contained in the MCA 2005. We considered including the Scottish concept of 'significantly impaired decision-making ability' ('SIDMA') into the detention criteria but, were concerned that this might cause confusion between SIDMA in the MHA and mental capacity under the MCA. We were also not persuaded that the introduction of a test such as SIDMA would significantly reduce detention.[5]

We have considered the arguments in favour of taking the much more radical step of fusing mental health and mental capacity law together in the long term. We accept there is a strong argument in principle that maintaining separate mental health and mental capacity laws can lead to discrimination towards those with mental health problems. We recognise the human rights arguments

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[4] *It would be equally possible to provide another basis to "best interests," which the Committee on the Rights of Persons with Disabilities finds problematic. The Assisted Decision-Making (Capacity) Act 2015 in Ireland (again, enacted, but not yet in force) sets out an alternative framework, more closely tied to the language of Article 12 of the CRPD. Ireland will retain separate mental health legislation, so this Act does not represent a fusion model.*

[5] *Although the use of detention under the 2003 Act in Scotland was initially significantly lower than under the preceding 1984 Act, it has recently returned to the previous level.*

in favour of fusion. As powerfully put by Lady Hale, President of the Supreme Court, fusion:

seems […] to come closest to reconciling our conflicting international human rights obligations. It is predicated on respect for human dignity and autonomy and individual values and preferences. It does not discriminate between the treatment and care of physical and mental disorders. It covers all kinds of decision-making.[6]

Fusion would also make it easier for people on the ground, as they would no longer have to find their way around the complex overlap between the two Acts and few would doubt that this would be an improvement. Our Review has recommended a new 'dividing' line around objection to admission and/or treatment (see the 'Deprivation of Liberty: MCA or MHA?' section) that should reduce the complexities, but the reality is that they will remain as long as the two pieces of legislation co-exist.

Ultimately, given the difficulty of bringing two complicated pieces of legislation together, and the amount of time fusion legislation would require (experience in Northern Ireland tells us that at best this would take a decade, and probably longer), we have decided not to recommend the Government does this now. Instead, we think that the immediate challenge is to bring both the MHA and the MCA 'up to date'. Essential reforms of both the MHA and MCA are needed now whatever the outcome of the 'fusion' debate.

More importantly, we think that there are five 'confidence tests' that would need to be met, before fusion is started. If these tests are met in the future, we think that the Law Commission should be asked to draft entirely new legislation with input from disabled people.

Test one – the views of service users

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[6] *See Lady Hale, 'Is it time for yet another Mental Health Act?" Speech to the Royal College of Psychiatrists Annual Conference, Birmingham on 24 June 2018. See also George Szmukler, 'Men in White Coats:' Treatment under Coercion (Oxford University Press, 2017).*

In line with the CRPD's requirement to involve service users fully in the decisions that affect their lives, we think that a key confidence test is whether fusion has sufficient support from service users. During our engagement processes we heard a number of service users outlining a key concern about a capacity-based mental health system, or full fusion. We heard examples of people in distress being told that nothing could be done because "you have capacity, and it's your choice what you do." The reasons for this may sometimes be understandable,[7] and may represent system or training issues which could be addressed. However, service users will have to decide that being able to make their own decisions about admission is worth the risk of being refused treatment or being left to do something that is harmful to themselves or others. At the moment we are not convinced that most service users would think this way.

Test two – the Impact in Northern Ireland

The second confidence test should be an assessment of impact of the Northern Ireland legislation when it is implemented. We think it will be important to understand three key aspects:

1. Whether their legislation leads to an increase in formal detention (even though this would be via a capacity/best interests' framework):

2. How the Northern Ireland version of fusion legislation works in the criminal justice context.

3. Any evidence of an increase in suicide; and

4. The impact on those with learning disability/autism, in particular regarding their length of stay in hospital facilities.

Test three – whether the assessment of capacity is reliable enough to provide the sole basis for care and treatment

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[7] *For instance, this may be a reaction from overstretched staff (these examples often came from crisis services or A&E) with a very limited or non-existent choice of alternative services.*

The third confidence test is whether an assessment of decision-making capacity can bear the weight that fusion law would place upon it. The following are needed to help determine if this is the case:

1. A better understanding of how capacity is currently used within the MHA. If our recommendations are implemented, we will get a much better picture of this in practice for both admission and treatment.

2. Action to prevent misuse of mental capacity. We do not agree with the Committee on the Rights of Persons with Disabilities that mental capacity is simply an invalid concept in the context of delivering care and treatment[8] *– in part because we cannot see any acceptable alternative. But we do agree an assessment of someone's capacity can be misused. That risk might be increased if full fusion were introduced. Implementation of our other recommendations which introduce capacity elements into the MHA, (for instance in relation to Advance Choice Documents) will already require measures to be taken to secure against this risk, but it will be important to evaluate the impact of these measures before moving any further.*

3. Embedding of decision-making assessments in the cultures of the professionals involved, supported by infrastructure and training. There also needs to be an agreed way to resolve disputes when professionals don't agree on capacity. Again, we would expect this will develop if our recommendations are implemented; and

4. Research into how the legal test of decision-making capacity in the MCA can be translated into practice. This should include:

• the concept of "using and weighing;"

• the relationship with clinical concepts such as "insight;"

• the practical implications of the legal requirement for an "impairment or disturbance in the functioning of their mind or brain" to be the direct cause for someone's inability to make a decision. This research should be multi-

[8] *See further Annex entitled 'Treatment of involuntary placement/treatment and mental capacity by international human rights bodies'*

disciplinary, shaped by service users, and firmly linked to both practice and policymakers.[9]

Test four – that associated processes are adapted to support the change

The fourth confidence test is that key processes that would be needed to support fusion law are resilient enough. This includes 'supported decision-making' and 'enabling legal capacity.' The following are important building blocks which require development:

5. Support to find out a person's level of decision-making ability (e.g. communication, education), and to shift their decision-making inability to decision-making ability. For example, this might mean removing things that compromise their ability (e.g. other people, or the environment that they are in), or delivering specific interventions to help them.

6. Support to help participation in best interests' decision-making such as advocacy, and expression of and respect for wishes and preferences; and

7. Robust advance decision-making mechanisms capable of working in a 'fused' system. Work will also be required to set out how advance decision-making fits with the requirements of the CRPD.

Test five – public interest

The final confidence test is whether fusion law can take proper account of what is in the public interest, particularly when it comes to the risk of harm to others. We have considerable reservations as to whether the concept of 'best interests can work in this respect. We think at this stage that necessity and proportionality are likely to be more appropriate assessments.

Conclusions

Even if fusion currently looks like the most promising direction for future travel, things may well have moved on by the time our five tests can be delivered.

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[9] *An example of such research is that being carried out by the Wellcome-funded Mental Health and Justice Project, which supported our review through holding two policy labs in conjunction with the King's Policy Institute, leading to a report published in May 2018 on the future of the Mental Health Act (https://www.kcl.ac.uk/sspp/policy-institute/publications/the-future-of-the-mental-health-act.pdf.*

Some jurisdictions may choose to 'turn the clock back', perhaps by 'writing off' the ability of those with disabilities to make decisions. We could not tolerate that. On the other side of the spectrum, many countries are reforming both mental health and mental capacity legislation to be more in line with by CRPD and the work of the Committee on the Rights of Persons with Disabilities. How this works in practice and, more importantly, what difference it will make for service users and patients, remains an open question. We hope that Government will keep an open mind to the potential that we may, in due course, find new societally and morally acceptable ways in which to balance the multiple, competing, rights and interests of the people in our care.

For instance, legislation that asserts full legal capacity for all is, in practice, unlikely to make any substantive difference if it sits in a legal system that contains provision for the delivery of treatment in an emergency, especially if the concept of 'emergency' is broadly defined.

CONCLUSION

This report and our recommendations respond directly to the objectives set by the Prime Minister last year. We hope that readers of this report will find that we are making a real attempt to change things for the better. Given the range of differing views, and the complexity of both the law and the operational landscape, this has not been an easy task, and it is not likely that we have managed to give everybody precisely what they had hoped for. We do hope that everyone will find something that will make a meaningful and positive change for them.

We believe our recommendations will help make the Mental Health Act support our modern expectations of how people, particularly disabled people and people from ethnic minority communities, should be cared for. If implemented, patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs.

The Review asks the Government to commit to accepting these proposals, to making legislative changes once parliamentary time allows, and looks forward to its formal response."

Reducing racial disparity

98. I am unsure whether I can provide any further reasoning behind our proposals in relation to reducing racial disparity, which I believe speak for themselves. I direct the Inquiry to pages 58 to 60 and 163 to 173 of the Final Report **(WITN0155008)** for our recommendations which were the result of in-depth consideration of specific issues concerning different ethnic minority communities, focussing on those with black African and Caribbean heritage. We spent a significant proportion of our time throughout the Review considering these issues, working directly with service users, carers, communities and professionals. I further direct the Inquiry to pages 290 to 295 for a Final report **(WITN0155008)** (which I did not contribute to, although some other members of the Review Committee did) from the Mental Health Act Review African and Caribbean group which summarises stakeholders' experiences and their subsequent recommendations which featured heavily in our Review process. Given the collaborative effort of producing such a comprehensive review, I would find it difficult to explain our working on these particular recommendations, save to point to the Final Report itself.

Implementation of a statutory care plan

99. For the same reasons as set out above in relation to our recommendations for reducing racial inequality, I consider the Final Report itself to be the best explanation of our reasoning behind the recommendations made. I direct the Inquiry to our care planning and after-care recommendations at pages 142 to 148 of the Final Report **(WITN0155008)**.

Rights based approach

100. As with the two recommendations above, the best explanation of our reasoning behind the recommendations to shift to a more rights-based approach including advance choice documents and the use of a 'nominated person' rather than a nearest relative is at pages 22 to 24 and 70 to 91 of the Final Report **(WITN0155008)**.

101. I would also add that we were in no doubt that reform was needed to the legislation around nearest relative. I believe the concept of "nearest relative" was first outlined in the Mental Health Act 1959 act. But looking at it, it was very "Victorian" in its hierarchy, and out of keeping with modern thinking, culture and society. I was certainly aware from submissions and encounters during our engagement programme and follow up that there would be individual cases in which detained patients would make choices that would not be ideal – several parents were very clear on this. I accepted this but said that in the end that is the nature of choice – people can make decisions that are not optimal, and could and would cause distress to, for example, one or both parents (it usually was parents). I would explain that there would be checks and balances, and that social workers could apply to overrule the patient's decision when it was manifestly unwise. We remained committed, however, to modernising the criteria to reflect the profound changes in society over the last 70 or more years and I believe our recommendations reflect this.

Work since the Review

102. When the Final Report was published, I did a significant amount of activity in talks/briefings/media etc to explain our principal recommendations, and it was gratifying that in general the reactions were overwhelmingly positive. However, after that I resumed my clinical and academic career, which had been interrupted by the period chairing the Review. I was always of the opinion that this was no longer "my review" and that the torch had passed now back to DHSC and NHSE. Over the next two to three years, and before the tragic events in Nottingham, I was asked on two occasions to talk to ministers about removing autism and learning difficulties from the definition of 'mental disorder' in the MHA, which the Government was inclined to do, against our recommendation. I expressed my misgivings privately, as I thought doing this would most likely lead to people with autism and/or LD being more likely to be admitted to the criminal justice system when in crisis, and/or professionals would use the fact that those with autism and/or LD also very often have co-existing mental health comorbidities, such as depression or psychosis, to admit them under those labels, which would also be a regressive step. I was also on occasion briefed by the new Bill team, as an act of courtesy. My only public comments or appearance was in the evidence session to

the pre-legislative scrutiny committee. This was the only occasion in which I made my misgivings on the autism and learning difficulties issue in public. I should add that as far as I know, our recommendations on autism and learning difficulties are not in scope for the Nottingham Inquiry

103. However, after the Nottingham tragedy, I was asked to brief health ministers again, this time directly on our review and its relationship to those events (House of Lords, 13 November 2024, and another in DHSC with Baroness Merron at some point around this time (the date I cannot now locate). I also did a brief period of media, including the Today programme on the same topic. My main message was clear; the necessary powers to detain and treat VC against his will were available at the time, and that if and when our reforms are implemented, will still be present. It was my opinion that whatever it was that went wrong, it was not due to lack of powers, but the decision not to use those powers, and I expressed caution on not rushing to judgement that the answer was more legal powers but understanding why they had not been used.

104. I have been asked whether there is any evidence, subsequent to our Final Report, that restricted practices have been avoided when treating patients of African or Caribbean heritage in light of publicised concerns about their disproportionate use in the context of MHA reform. I am not aware of any evidence of this, nor have I heard anyone suggest there is, but I do not believe I am the best person to answer this question. I am not sure anyone would be able to answer this; how can anyone be influenced by a report that they likely had not read, was not an act of law, and in any case, does not say anywhere within that they should refrain from treating patients of African or Caribbean heritage.

Boosting community and crisis services to support the proposals

105. I think that the overall tone of our report is that reforming the MHA is necessary, but not sufficient, to improve care and move the dial. Every time I spoke in public I made this point, that I had learned from the many legal experts who were involved, and especially Sir Mark Hedley, one of my Vice Chairs, that actually legislation is rarely as powerful as non-legal experts think it is, and that change is a complex and long, drawn-out process. I also made the point that you do not need legislation to, for example, improve community care for those with severe autism or learning

difficulties, or increase crisis services and/or supported housing and so on but you do need funds. Throughout the report we made it clear that changes in the MHA would not of themselves transform hospital and community services.

106. I also pointed out that whilst spending on mental health services has increased during the period I have been in practice, in line with changes in society and the increasing importance given by the public to mental health issues, it remained the case that we are still the "Cinderella services", i.e., underfunded despite their importance. Whilst about 10% of the NHSE budget is spent on mental health, it is probably responsible for 20% or more of the burden of illness and morbidity.

107. The "Mental Health Investment Standard" **(NHSE0000928)**, introduced in 2015/2016, is a requirement set by NHSE for local health organisations to increase spending on mental health services each year, at least in line with as much as their overall funding increases. This did help in at least preventing things going backwards, but it did not mean a significant change in investment, especially capital. There has been a general feeling amongst the mental health community and charities that whilst there has been a major investment in talking therapies in the community via the Improving Access to Psychological Therapies (IAPTs) or NHS Talking Therapies as it is now known **(WITN0322009)** which is to be welcomed, this has little to no impact on SMI, which is excluded from IAPTs anyway, as is substance misuse. There are people far better placed to talk about this than myself, but I think there is a broad consensus that services for SMI, largely provided by Mental Health Trusts, has and continues to fall.

108. The latest 10-year plan was published several years after our review was concluded, but also just as I was resigning as Non-Executive Director of NHSE. It says very little about mental illness/disorder, but I believe DHSC are best placed to comment on its content.

Extending police powers

109. I have been asked about proposals within the Mental Health Bill about extending police powers of detention. I cannot speak to this issue which did not arise during our review.

Recommendations/further comments.

110. Although I have not been asked about this, I would like to draw the Inquiry's attention to page 119 of the Final Report **(WITN0155008)**, where we discuss the possible overuse of section 2:

> *"We think that section 2 should only be used where it is truly necessary to assess someone. Section 2 should not be used because it is perceived as the least restrictive option, and we believe our changes to section 3 mean that this argument no longer holds. We are recommending that the Code of Practice should be amended so that, where the AMHP is aware that a person has been subject to detention under section 3 within the last twelve months, an application for detention under section 2 can only be made where there has been a material change in the person's circumstances since they were previously detained under a section 3. We are also recommending that the Code of Practice makes it clear that section 3, rather than section 2 should be used when a person has already been subject to section 2 within the last twelve months".*

111. This has not been incorporated into the final proposals for the new Act, although to be fair it may be under consideration for the final Code of Practice. Given what is already in the public domain about the Nottingham tragedy, and the number of times VC was admitted for "assessment", I think the Inquiry should take a particular look at the above.

112. I am not sure I could offer any further advice on any improvements to multi-agency working to prevent similar dreadful outcomes as happened in Nottingham in the future, given the timing of our Review and that this was in any case outside of our TORs. As may be clear from our Final Report and my views above, I do not believe we need any further powers of detention to be made through legislation – we already have sufficient powers. We need to understand how and why these are used, and if not, why not, rather than legislate to increase them. I would however hope that it will be recognised that giving greater weight to the views of patients around their management/treatment (whilst recognising the very substantial caveats, checks and balances that remain in place) should improve compliance

with treatments, in line with the rest of medicine. Again, the relevance of this to the Inquiry I think speaks for itself. The more we recognise "the patient as individual", to quote our own choice of subheading, and the more we listen and respond to the task put to us by one of the service users on the core panel of the view, Kate King MBE, who I quoted at the start, the safer and better will be our services.

113. Finally, I began my response to the Rule 9 letter by quoting my opening remarks at the start of the Final Report. I would draw attention now to my Closing Remarks (fortunately shorter), which summarises my experience of chairing the Review, probably the most satisfying year of my professional life so far, and my thoughts for the future at pages 229 - 231 **(WITN0155008)** which I include below:

"PERSONAL REFLECTIONS

The test when seeking a chair for an independent review is to find someone who is not an expert in the topic. Anyone with too much knowledge would not be in a state of equipoise – in other words would already know what should be done. Not me. Once I completed my training, my clinical work has been in general hospital psychiatry, and my academic career has first been around unexplained symptoms and syndromes, and more recently our Armed Forces. Neither area brought me into contact with the issues or people at the heart of this Review.

This started to change four years ago when I became President of our Royal College, but even this did not compare to the transformation of the last 18 months – perhaps the most intense period of Continuous Professional Development one could devise.

Some of it has been tough. Listening to some of the stories and experiences of the patients and service users has been a salutary and chastening experience. At times all I could say was that I am sorry you had those experiences, and I hope that this Review will ensure this becomes a thing of the past.

But I have also had numerous positive experiences, and met an extraordinary range of people, professionals and service users alike.

And in the end I am not despairing, but hopeful. I recall visiting Look Ahead, a social housing organisation providing specialist support and care services for people with the most complex and severe of mental illnesses. I learnt about how they help those who have spent long periods of time in hospitals move towards more independent living, and the impact of austerity on some of the most vulnerable. I saw the close working relationship with their local Trust, and the unsolicited praise for several named psychiatrists for the support they give.

As I went to numerous professional gatherings of social workers and AMHPs I experienced their enthusiasm for their role, which convinced me that we should not touch the critical balance between the social and medical perspectives, or more accurately between health and social care, enshrined in the 1959 Act, but should strengthen those links. Like psychiatry, the police sometimes got a bad press from patients and carers, but I also heard numerous stories of individual acts of compassion and kindness, and met officers from the lowest to the highest rank committed to innovation and change. Reconnecting with colleagues old and new in my profession was a joy. Likewise, I have always had a sneaking admiration for the skills and wisdom of the judiciary, but a year of close interaction with those involved in mental health has shown me that this admiration is based on fact.

And then there were my three splendid Vice Chairs, and the twelve experts, professionals and experts by experience, who were persuaded like me, to give a day a week of their time to the Review for the duration. Yes that turned out to be the understatement of the year, but none of you complained, and all gave far more than anyone could have expected.

And another group with whom I interacted on a daily, and often nightly, basis, are the civil servants who made the Review possible, and provided me with all the support I needed. Their commitment to the cause of improving the experience of service users in our mental health system was remarkable. I enjoyed Gus O' Donnell's robust defence of the civil service and its values – and now I experienced it at close hand. When we say we have the best civil servants in the world we are speaking no more than the truth.

And there are other reasons for optimism. A revitalisation of community services that provide alternatives to detention for those with severe mental illness, and a new offer for those with learning disabilities and autism, are both very much on the cards. I am no Mystic Meg, but I expect some real change here, essential if we are to achieve the goals we have set ourselves. Legislation can only achieve so much - a reduction in compulsory admissions requires sustained investment in crisis services, and other innovative, often locally led, alternatives to detention. And I am far from alone in recognising that when compulsory detention is still necessary, it should provide both sanctuary and an environment conducive to improvement. I cannot over emphasise that the core of our recommendations must be taken alongside the forthcoming NHS Long Term Plan – improved crisis and community services are essential if our recommendations are to be effective.

I also can see that the enthusiasm felt by a younger generation for all things connected with mental health is starting to be reflected in career choices. Clinical psychology is oversubscribed, recruitment to psychiatry has started to pick up. There is a long way to go, especially for nursing and social work, without which our services will simply collapse. But a start has been made.

And finally, there are the service users. Largely unheard at the start of my career, now they are a major force for change and improvement. When I started the Review, I promised that service users would be at the heart of everything we would do. It's a cliché, but sometimes clichés can be true. The commitment of those who have experienced detention has been astonishing, and if some stories made uncomfortable hearing, this bred not bitterness, but instead a powerful desire for improvement. Service users took part in every one of the expert groups we created, and were an integral part of all decision making. There is hardly a recommendation that has not been either started by, or shaped by, their input. I am not a sentimental person, but I felt my eyes well up at the last meeting of our core service user and carer group as we discussed for the final time the shape of what you are about to read. I sincerely hope we have done them justice."

Statement of Truth

I believe the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Name: Sir Simon Wessely

Date: 04/12/25

Index to First Witness Statement of Professor Sir Simon Wessely

No.	Inquiry URN	Document Description
1	DHSC0000096	Fit for the future 10 Year Health Plan for England - executive summary
2	DHSC0000044	Implementing the Five Year Forward View for Mental Health
3	WITN0322002	Terms of Reference for the Independent Review of the Mental Health Act 1983
4	DHSC0000087	The Independent Mental Health Act Review Interim Report 01/05/2018
5	WITN0155008	Modernising the Mental Health Act_ Final Report of the Independent Review of the Mental Health Act 1983
6	WITN0322003	Coercion in mental health: a trial of the effectiveness of community treatment orders and an investigation of informal coercion in community mental health care
7	WITN0322004	Attitudes to Mental Illness 2023
8	WITN0322005	Independent Review of the Mental Health Act 1983 supporting document
9	WITN0322006	Mental Health Act Survey Response Analysis
10	WITN0322007	Mental Health Act Statistics, Annual Figures 2017-18 Summary Report
11	DHSC0000151	Draft Mental Health Bill
12	WITN0322008	Lady Hale Speech 24 June 2018, “Is it time for yet another Mental Health Act?”
13	NHSE0000928	Mental Health Investment Standard MHIS - Categories of mental health expenditure
14	WITN0322009	NHS Talking Therapies, for anxiety and depression