

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Tuesday 11 October 2022

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Written evidence from witnesses:

- [Centre for Mental Health \(MHB0012\)](#)
- [Alexis Quinn and Jennifer Kilcoyne \(MHB0068\)](#)
- [MIND \(MHB0070\)](#)
- [National Survivor User Network \(NSUN\) \(MHB0074\)](#)
- [Rethink Mental Illness \(MHB0076\)](#)

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Members present: Baroness Buscombe (The Chair); Dr Rosena Allin-Khan; Baroness Barker; Baroness Berridge; Lord Bradley; Marsha De Cordova; Jonathan Gullis; Baroness Hollins; Baroness McIntosh of Hudnall; Dr Dan Poulter; Dr Ben Spencer; Sir Charles Walker.

Questions 1-28

Panel 1

Witnesses: **Sophie Corlett**, Director of External Relations, Mind; **Andy Bell**, Deputy Chief Executive, Centre for Mental Health; **Mary Sadid**, Policy Manager, National Survivor User Network; **Lucy Schonegevel**, Associate Director, Policy and Practice, Rethink Mental Illness.

Q1 The Chair: This is the first session of the Joint Committee’s inquiry into the Draft Mental Health Bill. It is intended to give an overview of the key issues as they impact patients. The first panel covers some of the larger or more influential mental health charities, while the second addresses the proposed changes for those with autism. I will begin by asking each of the panel to introduce yourselves very briefly to say who you represent and what your role is.

Lucy Schonegevel: I am the associate director for policy and practice at Rethink Mental Illness. Rethink is a charity that supports people who are severely affected by mental illness through service provision, information and advice, and campaigning. We have been involved in the Mental Health Act independent review, chairing topic panels and so on. We have also been commissioned by the Department of Health and Social Care to carry out the

consultation on the White Paper with people with lived experience of detention who are currently detained under the Mental Health Act. I would like to represent their views here today.

Mary Sadid: I am the policy manager at the National Survivor User Network, also known as NSUN. We are a membership organisation for individuals with lived experience of mental ill health, distress or trauma, and user-led groups.

Sophie Corlett: I am director of external relations at Mind and our work is based on a lot of feedback from people who have been detained over the years of all ages.

Andy Bell: I am deputy chief executive at Centre for Mental Health. We are an independent organisation dedicated to eradicating inequalities in mental health. We do that predominantly through research.

The Chair: Before we begin the session by asking you questions, could I please ask my colleagues in the House of Lords to declare their relevant interests, if they have any?

Baroness Barker: I sit on an advisory panel for Rethink. It is an unpaid post.

Baroness Hollins: I am chair of an oversight panel that reviews independently chaired care education treatment reviews for people with learning disabilities and autism who are detained in long-term segregation.

Lord Bradley: I am chair of council at the University of Salford, honorary special adviser to the University of Manchester, chair of the MaST and BTG LIFT companies, trustee of the Centre for Mental Health, trustee of the Prison Reform Trust, chair of the non-custodial partnership advisory group for the NHS, and chair of the independent advisory group on self-harm in the women's prison estate for HMPPS.

Q2 **The Chair:** I will ask a question, others may ask a first question, and then there will be possible supplementaries. We have a lot to get through in a short space of time, so if you agree with what someone else on the panel has said, perhaps just say you agree and we will see how we go.

In summary, what do you think of the changes the Government have proposed in the draft Bill?

Lucy Schonegevel: We are hugely supportive of the amendments to the Mental Health Act and the draft Bill. There are a number of changes that we welcome, and we know that people living with mental illness and people who are currently detained under the Mental Health Act welcome them, including the opt-out advocacy, the nominated person, the ability to put in statutory treatment and care plans, and the change in detention criteria.

But we also think that it needs to go further in a number of areas. In particular there are issues such as addressing racial inequalities and advance choice documents, and a few other areas that I am sure will come up.

The Chair: I will take the top line from all of you, and then perhaps we will go a little deeper. Also, thank you all for submitting very comprehensive written evidence, which is very helpful to us.

Mary Sadid: We broadly agree with what Lucy has set out there on the positive changes, but we also have concerns that it does not go far enough. We are concerned about the implementation period and how long it will take for some of these reforms to come into practice.

We are concerned that without adequate resourcing and without monitoring and evaluation at key points in the implementation stage we will not see significant change and, for many people who are detained, that their experiences will not change until many years into the process. There is also a risk that we will lose traction and will on some of these reforms.

We definitely think that it does not go far enough on racial inequity. We think it is important that we remember that the Mental Health Act is an instrument that regulates coercion, and that we try to do our best to push forward any changes that minimise coercion.

Sophie Corlett: I would agree with all that. It is important to shift some of the balance of power for people when they go. We know that by definition the Mental Health Act is a coercive piece of legislation, but some of the areas where people's power or choice is taken away are not necessary. We are hopeful that the elements in the legislation might change some of that and give people some agency back, support people to recover faster and make sure that things like Edenfield are not the norm, that the balance of power can change. That needs to go alongside some extra changes that people have talked about, as well as an investment in changes in culture and staffing—those other things that are not in the Act but need to go alongside it.

Andy Bell: There is no doubt that the draft Bill takes us in the right direction in modernising the Mental Health Act and bringing many of the proposals that were in the independent review into legislation. It is disappointing that not all the elements of the independent review are in there and that some have been dropped. I am sure we will come to those. Alongside the things that other people have mentioned, I welcome the provisions to speed up transfers from prison to hospital and to get people out of prison when they need urgent treatment under the Mental Health Act.

The Chair: Thank you. Marsha has a question on the UN Convention on the Rights of Persons with Disabilities.

Q3 **Marsha De Cordova:** Some user-led groups have said that the draft Bill is not compliant with the UNCRPD and have called for a complete overhaul of the legislation. Mary, what would be your view on this?

Mary Sadid: User-led groups have differing opinions on the CRPD. That is not necessarily a consensus position but something that is often referenced. We found that the independent review did not engage with the spirit of the CRPD. Often, the CRPD is taken as shorthand for the abolition of detention and then people fail to engage with the spirit and the scholarship around the CRPD.

Where there is consensus in user-led spaces is that it is pushing towards a rights-based approach. We do think that engaging with the spirit and engaging with a rights-based

approach would have been beneficial to the independent review and obviously the draft Bill, but that is not something we have seen happen.

Dr Ben Spencer: Is it, in your view, compatible to have legislation that, as you put it, regulates detention and treatment that is compatible with the UNCRPD, or by definition will there always be an incompatibility?

Mary Sadid: That is quite a difficult question, because there are different interpretations of what the various articles mean. I think getting into the question of compatibility can lead very easily to the dismissal of some of the issues raised by the CRPD. Our position is that it is important to engage with the ideas, the thinking and the user-led voices that have generated this work, instead of coming to the binary of whether it is compatible or not, because there are lots of ideas about the rights of people who are detained that are important to engage with. If we come down to this binary question, we lose a lot of that nuance.

Q4 Dr Rosena Allin-Khan: The Government have said that the principles outlined in the Wessely review underpin the whole draft Bill. To what extent do you agree with this?

Lucy Schonegevel: We strongly believe in the principles that underpin this Bill and we would urge that they are on the front of the Act. It is so important when trust is so low among service users and staff. We are at the stage where we have had “Panorama” and “Dispatches” showing the opposite of what these principles are trying to do being put into practice in too many places around the country, and we hear from service users that they actively try to avoid going into hospital to receive care.

If you set out this amended Mental Health Act with the principles on the front of the Bill—principles that have been co-produced with people with lived experience and that set out in plain language what the aims and objectives of the Bill are there to achieve, setting the culture that should run through everyone’s experience of care—that would be far more likely to lead to therapeutic benefit, to people trusting the process, and to recovery, which is what we are trying to achieve here.

Sophie Corlett: I totally agree with all of that, in order to see those four principles carried out. There are still some things that we would want to see in the Bill. For patient autonomy, we would like to see a right of advocacy when you make your advanced decision. There are a number of different areas. In particular, we would like to see patient autonomy as an individual right spelled out a bit more so that it can much more easily address racial inequalities and make sure that that is dealt with, because that is obviously a problem that is institutionalised and embedded across the system.

We would not only like to see that explicitly spelled out in the principle but we would like some actions behind it to follow up, a responsibility to reduce that over time. We have a number of suggestions. If you look at those principles individually, there are some tweaks and changes that you could make, which would make the Bill speak more strongly to each of them.

Mary Sadid: We support the principles, but we want to make the distinction that these principles are not the same as a set of rights for someone who is subject to the Act, and it is important to remember that. In some of our engagement work on the independent review and

the subsequent drafts, we found that people raised concerns about things like therapeutic benefit and the potential misapplication of therapeutic benefit. Although we think there are lots of positives in these principles, it is also important to remember unintended consequences.

Q5 Dr Rosena Allin-Khan: This question has in part been answered, but do you want the principles included in the Bill itself? I think, Lucy, you said that you would like it front and centre. If so, what practical benefit do you think this would have?

Andy Bell: I agree with colleagues that it would be helpful for the principles to be on the front of the Bill. We know that at the moment there are principles in the code of practice but not a huge amount of attention is paid to them, so putting them right at the top of the actual legislation would be helpful. It is about whether the legislation backs up those principles, as colleagues have said, and that the spirit of those principles is understood when decisions are being made, because ultimately this is often about decisions being made at a very difficult time in someone's life. Often in the midst of a crisis you need guiding principles that are clear and up front to help you make a decision that is fair to that person and does what they need, and of course continues to be used. This is about decisions that go on after someone has been detained throughout their time while this piece of legislation is being used, which, as colleagues have said, is a coercive piece of legislation.

Q6 Baroness McIntosh of Hudnall: Can I pull that thread out a little bit, to be devil's advocate? You talk about the principles being embodied in regs, which has been the usual practice in the past. What is the impediment to that being a basis upon which clinicians or other people can take the sort of decisions or protect their individual patients in the way you think having the principles on the face of the Bill would actually do?

Andy Bell: Partly it is the invisibility, and at the moment the principles that underpin them are probably less focused than the ones suggested in the Wessely review. So they are broader, almost contrary to one another. They are largely invisible in the goodness knows how big a document they are contained in. Inevitably, there is that pressure to focus on other issues—I am sure we will come on to talk about risk and safety, for example—that mean that sometimes the application and the principles go missing when decisions are being made.

Baroness McIntosh of Hudnall: Just to be clear, you feel that they do not have sufficient prominence in regulations.

Andy Bell: Absolutely.

Q7 Baroness Berridge: If I could roll it back slightly on the point of principle, obviously people are also detained under the Mental Capacity Act, so would you have gone back to the beginning? In Northern Ireland they are trying to fuse everything and put it together as one piece of legislation. Given a choice, do you think we have missed an opportunity here to start again and rewrite it, or was it right, because of the situation for service users, to amend what we have at the moment?

Lucy Schonegevel: As far as I understand, that question was off the table when the 2018 review happened. I know other colleagues were really involved in it. Given time and the fact that people are receiving substandard care in hospitals at the moment and that detention rates

are increasing so much so quickly, we need to look at what we can do now, which is making these very important amendments to the Mental Health Act but making sure that there is that sufficient interface with the Mental Capacity Act. We have a number of suggestions around timing and making sure that there is sufficient training when both are rolled out, to make sure that you are not just talking about the Mental Health Act without making sure that staff and service users and so on know about the Mental Capacity Act as well.

Obviously the Mental Capacity Act has principles on the front of the Bill, so having the same on the Mental Health Act I think would also make sure that there is that parity and again that real understanding of what the Bill is running through everything.

Sophie Corlett: The review recommended, and we would recommend, that over a longer period we look at whether there should be some fusion legislation. There is an urgency about mental health legislation, and there are quite difficult things to work out around fusion legislation—Northern Ireland is still struggling with that some years on now—and we cannot afford to wait for that work to be done before we make changes to what is happening now for people detained now or people to be detained in the near future. For us, the urgency is about changing the Mental Health Act.

Q8 **Dr Ben Spencer:** Could you give a couple of examples of the difficult areas when it comes to using a capacity or best interests-based approach to the Mental Health Act?

Sophie Corlett: I am not the best expert on that, but a few of us were involved in the working group linked to the work on the Mental Health Act and it was one of the things that we looked at very early on. Capacity, making decisions when you do not have capacity, the protections that you get and the protections under the Mental Health Act are quite different from the protections under the Mental Capacity Act, and the question is how you would marry those things together in a way that worked. Northern Ireland has done a good job but it has not been implemented yet, as far as I understand.

There appear to be practical difficulties, so we did not spend the time doing that. We were going to spend the time on the Mental Health Act, but we have experts back at Mind who are much more expert on that, and we could certainly write to you about that.

Baroness Berridge: Can I explore a bit more about this issue? As far as I understand the Act and the Mental Capacity Act, we are potentially ending up with three different tests here. We will have a new test into the civil system, we will have the same existing test of the Mental Health Act for those who are coming through the criminal justice system, and potentially another test if you are under the MCA. You have talked about the urgency, but have you, as part of the working group in the review, thought through how this will deal with the urgency of the issue that you are talking about?

Lucy Schonegevel: We think that mental illness needs advocacy services, but I am definitely not the expert, so it is worth speaking to some advocates as part of this process. When I spoke to them, the key thing that came out was the timing. With the Mental Capacity Act and the Bill coming up, the concern among some advocates was that they would not necessarily be able to give the best advice on the rights that people detained under the Mental Health Act should be receiving, and they said that a big part of that was the timing.

Essentially it should come down to the least restrictive option, but because these processes are not running concurrently, there will be a huge amount of confusion among the advocacy services that we provide about how to advise their clients.

Q9 Dr Ben Spencer: When you speak to people who have experience of using services about future options, do they prefer a system that is more functional or one that is more status-based, as the Mental Health Act currently is?

A follow-up question for Mary, going back to the UNCRPD: in your view, is functional or status-based legislation is more compatible with the UNCRPD?

Mary Sadid: The UNCRPD is not my area of expertise. I can communicate with you via email from someone who is better informed. People do not necessarily articulate their views and their experiences into this function or status category. In talking and listening to people we hear lots of different views that do not neatly fit into these boxes. Part of that is understanding that good mental healthcare looks different for different groups, and different groups have different needs. That can often be met in community context. But I am not best equipped to answer the question about function versus status.

The Chair: Let us come on to the issue of detention and treatment.

Q10 Baroness Barker: From your opening statements, it is quite clear that you are all supportive of the reforms as far as they go; they are limited because they apply only to civil patients and not to forensic patients. To what extent do you think the changes will lead to a decrease in the number of people being detained? How do you think the harm and therapeutic benefit tests will work in practice?

Sophie Corlett: I am happy to start on the number of detentions. As we know, the number of detentions has been going up, and our view and our understanding of how people recover and how people end up having shorter stays or staying well and not needing to go in is that it is about having good mental healthcare outside of hospital, and that they are willing to engage with it because they see it as positive or they are able to engage with because it is available. It is also about having good care when they are in hospital, about having choice and autonomy and a feeling of their dignity being given back to them. Often none of those things are available to people, so detentions go up. Some of the things in the legislation at the moment will support that.

We know that advance choice documents are the best evidence base for reducing detentions—crisis care planning, as it has been mainly called to date. Crisis care planning can reduce detentions by 25%, and, encouragingly, it can reduce detentions even more for some of the groups who are more likely to be detained, such as black people. Those sorts of things could be powerful.

For us, something key that is missing in the Bill as drafted is a mandatory offer of an advance choice document, and that needs to be on the face of the Bill. The Scottish legislation has an advance choice document, but it is not on the face of the Bill, and they now see that as a mistake.

There are things that are already in the legislation and that could be put in the Bill that could reduce detentions. As I said at the beginning, we also need to see easier early access to support outside. We need to see better conditions inside, which is a building issue, a staffing

issue. There are other things that need to be in place. There is evidence that advanced choice documents should work and there are other things here that help to give people back their dignity, their control. We know that those things are important for people's recovery.

Baroness Barker: As the Bill currently stands, do you see any unintended consequences happening as a result of the change to the criteria?

Sophie Corlett: No.

Andy Bell: We hope not.

Sophie Corlett: I do not see any that are unintended.

Lucy Schonegevel: There is one thing that we can foresee. We do a lot of work on community mental healthcare, and the community mental health transformation that is under way; we are a year in to a three-year transformation programme, which is long overdue. It is completely needed—absolutely essential, as Sophie has been saying—as part of reducing detentions. If you are changing the detention criteria, meaning that fewer people will be detained but they are at a crisis point, that makes it even more essential that community mental healthcare is provided. That will be an increased demand over and above what was set out in the long-term plan and the funding that was set out for that. That needed to be looked at urgently.

Andy Bell: It is worth identifying the two key bits that you mentioned, Baroness Barker: the focus on harm being significant, and harm being imminent. Again, we move away from the notion of risk. All the evidence we have seen shows that being able to predetermine someone's risk is worse than unscientific; it is educated guesswork. It is important that when we are talking about harm that takes us to a different and potentially better place where we can take away some of the potential for subjective and potentially discriminatory decision-making in the system. There is something very helpful about the focus on harm and, again, the focus on therapeutic benefit.

Again, how that is determined will be quite important. None the less, there is the potential for there to be something worthwhile happening to somebody who is in hospital deprived of their liberty. Of course, crucially, this is not just at the point of detention; this is throughout someone's time. It is not just about fewer people being detained; it is about fewer people being detained for less time, and the same would apply for community treatment orders—fewer people having to go on to those provisions and hopefully for less time.

There is something quite powerful about these two changes. Clearly there is some debate about Part 3. In particular, there is a very strong argument for therapeutic benefit being in Part 3, because again, keeping someone in hospital without any therapeutic benefit feels like a very strange thing to do.

Baroness Berridge: Just on the unintended consequences, do you agree with the Bill not applying the same test to the categories of patients here, because one of the funnels for disproportionality is obviously, in terms of ethnic minorities, coming from the criminal justice system. If the test works, and we hope it works in the way you say, why would we not apply it to all people who are ill regardless of whether they are in prison or not?

Andy Bell: We need to work this through. It is difficult to come up with a definitive answer. I think there is an argument for it. As I understand it, because the principle of least restriction has been brought to this, the notion is if the choice is between being in prison or being in hospital, being in hospital is a less restrictive environment. Whereas if you are not in the prison system obviously it is a choice between being at home or in the community versus being in hospital, and clearly home is less restrictive.

So there is an argument for applying it differently but we are very mindful that what we are looking at is potentially two very different systems for the civil and criminal parts of the Act. As indeed has been the case in Scotland for a very long time. It is certainly important that we think about what that means and the consequences of that change and whether again, if something is good for civil sections of the Act, the burden of proof ought to be if they can be applied in the criminal sections as well, being mindful that there are different circumstances.

One thing we are very disappointed about is that the Government did not take the independent review's recommendation around tribunals making decisions when someone is under part 3. That does feel like a missed opportunity.

Lord Bradley: Is that a view shared by all of you?

Andy Bell: Yes.

Q11 **Baroness McIntosh of Hudnall:** All four of you in your opening statements stressed that you were very keen on these reforms coming forward. You also talked about them needing to be done speedily and therefore not addressing things that will impede the speed. Given what Lucy just said about the mental health services that stand behind the crisis service, which is the application of the Mental Health Act, do you think—I am trying not to ask this question in a loaded way—that speed of implementation of the reforms in this Bill should be implemented over the improvement of availability of, as it were, primary care mental health services?

Lucy Schonegevel: I can answer very quickly my view on it. We are a year and a half into the transformation of community mental health care. I am presuming once the Bill makes its passage through Parliament that will be another year; hopefully as quickly as possible. But the long-term plan set out the aim for 2023, which was to have transformed community mental health services around the country that wrap care around people, not just clinical care but also employment support, financial support, housing, all the things that we know affect people's mental health that the NHS cannot provide alone. We know, because Rethink has been working with a number of ICSs locally, that there are some incredibly transformations that are so far along already that I would be very surprised if we were not already seeing people receiving that care in the community that we know is needed.

That process is already under way but there will always be people who will need to be detained under the Mental Health Act and will always need in-patient care. So we need to make sure that those rights are there as well and again, going back to the principles, that everyone is aware that those are the principles that are there, that then match the support that should be being developed in the community, although I appreciate it will be different in different ICSs around the country.

Baroness McIntosh of Hudnall: That is an extraordinarily optimistic view—

Lucy Schonegevel: It is very optimistic.

Baroness McIntosh of Hudnall: —given what we are constantly being told about the availability of mental health services in the community and in primary care. Is the view that Lucy has just expressed shared by all of you? Do you have things you want to add?

Sophie Corlett: I think it is a mixed picture across the country but, even if you took the most pessimistic view, because of the importance of reducing the number of people detained and because of the possibility of doing that—and I go back to advance choice documents—at the moment we are spending 50% of the Bill on 2% of the patients because each in-patient stay costs upwards of £18,000. So if you can reduce it just by 10% you will be saving £90 million a year; I think I have my numbers right. That will allow you to do more in the community.

Whatever we can do to drive down the number of detentions, why would we not? Because that gives us the opportunity to give people care when they need it earlier; it allows us to invest in keeping people well. It is exactly allowing us to do what we want and it is not by funding things up front, it is about dealing with it. It is seldom that you can solve the problem when people are falling into the water but this is something that can be done when people fall into the water, bringing them out quicker and preventing them falling in again, which then would enable us to fund some of the more preventive early intervention stuff, which is where things need to change.

The Chair: Let us move on now to the issue specifically about inequalities. If I can start with Rosena please.

Q12 **Dr Rosena Allin-Khan:** For me this is one of the key elements of the whole review. Obviously the independent review was established with a strong focus on reducing racial inequality. We know that black people are four times more likely than white people to be detained under the Act and over 10 times more likely to be given a CTO. How far do you think this will achieve the goal of reducing inequalities and is there anything that should be added to the draft legislation that would go further to reduce inequality in the application of the Act? Please be brutally honest. We have a real once-in-a-generation opportunity to try to get this right. I think we have an imperative to do so.

Lucy Schonegevel: I could not agree more with that. A huge amount of work was done in the independent review to try to identify the solutions that were needed. The draft Bill does not go far enough. We would want to see the principles on the front of the Bill and, as Sophie outlined earlier, the principle of personalised support extended to specifically mention personalisation for racialised communities. We think that would set the tone again, showing the importance of this step change that is needed in support for people from racialised communities, in terms of NHS, police, obviously service users—huge amounts of trust need to be built here, it is at rock bottom—to help people trust the services that are there to supposedly make them better. We think the principles are a significant part of that.

Advance choice documents again are one of the elements of the independent review that have been proven to reduce detentions among black communities, so that is an important part that needs to be on the face of the Bill and in legislation.

Dr Rosena Allin-Khan: Does anybody have anything else that they would like to see in here?

Andy Bell: On the positive side, what some of the changes, particularly around the detention criteria, could allow—again, all about interpretation and how it is used—for less subjective decision-making and I think the only explanation we have for the disproportionate use of coercion among racialised communities is perceptions of dangerousness. There is not a good explanation. Taking away that subjectivity, having more people involved in decisions, having more checks through tribunals, having better access to advocacy, taking the edges off CTOs, will all, theoretically, if done well, help to take away some of that disparity in the way decisions are made and systems work. I do not think it is a guarantee.

We know that there has to be much wider system change. It is important that the Patient Carer Race Equality Framework the review recommended, and which has now started, is seen through, is done for as long as it needs to be done, and is done at the right level of ambition and does not become a training programme.

One thing that could be put in the Bill would be to ensure culturally appropriate advocacy is available and, crucially, that advocacy is available to people on CTOs because at the moment that is very rarely the case.

Sophie Corlett: Did you say advocacy when people are doing their advanced choice documents?

Andy Bell: I did not, so you should definitely say that.

Sophie Corlett: Advocacy when people are doing their advance choice document, because you might do it while you are in hospital at the end of one period of detention, in which case you would have a right to advocacy there, but you might do it when you are out in the community. Being able to express your views at that time and to think that through and have somebody to support you to do that would be important.

The other thing is we would also like to see the abolition of CTOs because there is no evidence that they work to reduce detentions and because, as you have pointed out, that is where the greatest inequality lies.

The other thing that we would like to see is that there is a role that has been introduced through Seni's Law around restraints, which is the role of a responsible person whose job it is to see the reduction of the use of restraint. An additional responsibility that could be given to that person would be to see the reduction of inequality within the hospital and just to spend time looking at what is going on and where the issues are in that particular hospital, whether it is a training issue, whatever it is, and driving those things down. Then reporting on that publicly would be useful.

Dr Rosena Allin-Khan: Obviously this all happens in the timeframe that it happens but for everybody else living in the community it will be business as usual, they will

not know about this. Do you think there would be a positive benefit to adding into the legislation that people were told of their right for advocacy and told of their right for culturally specific advocacy at the time? We all know it is not always in people's interests to tell people, "Hold on a minute, before anything happens further you have a right to advocacy". Would that be something positive?

Sophie Corlett: Yes, we would like to see people having basically an opt out on advocacy. Your advocate should show up and then you have a right to send them away. That is how it should be. Because at the moment you have a right to advocacy but then you do not think about it, so you do not ask for it.

Dr Rosena Allin-Khan: No one will tell you can get it.

Sophie Corlett: Yes, or they have told you at a point when you were really ill and you have not remembered that. We also think people should have advocates.

Dr Rosena Allin-Khan: A very important element, the opt out.

Sophie Corlett: There are informal patients as well, and that is important for children because a lot of children are informal patients because their parents consented. So effectively, from their point of view, their voice is not heard in the system. We would want to see advocates across the in-patient system.

Q13 **Marsha De Cordova:** Thanks for this because it has been helpful. In your opinions, unless the Bill does explicitly include provisions around culturally appropriate advocacy and ensuring that there are the opt-out clauses and so forth and the principles, will the Bill go on to achieve its desired outcome of reducing disparities and inequalities?

Mary Sadid: We are not convinced as an organisation that the Bill will make significant inroads into reducing disparities and inequalities without the scaffolding and the support of all the recommendations that were in the independent review and additional monitoring and evaluation to understand what these look like in practice and people's experiences. We know, for example, that racialised groups are more likely to experience restrictive practice. They are more likely to be offered medication over psychological therapies. We need to also be monitoring these outcomes and seeing how they are changing.

We wrote to the then Secretary of State for Health, Sajid Javid, as part of the mental health alliance, and we basically outlined that we wanted the Secretary of State to acknowledge institutional racism in the Mental Health Act and to commit to publishing annually rates of detentions of racialised people and a commitment to reduce these rates.

We think we should be seeing data transparently communicated of commitments across the Mental Health Act that pertain to racialised groups. But one issue around detention is that a reduction in detention does not mean an improvement in outcomes. We hear from our members all the time issues around accessing any kind of service. They might be too sick for community care but not deemed sick enough for crisis care or they may experience something that they call gatekeeping. We think that any reduction in detention also needs to see an investment in community services and a real understanding of how people's

experiences are changing on the ground. Without that, a reduction in detention rate alone is not enough to understand.

Andy Bell: I completely agree with that. Sorry, the point has gone out of my head, it will come back; apologies.

Sophie Corlett: I will come in then because I was going to back up what Mary was saying. One of the things that we would like to see in the legislation is a right to assessment and treatment outside of hospital because that is one of the things that people struggle with. They have tried to get care support, they know that they are unwell but they have not been able to get that. Then what they do end up getting is detention. People are keen to get one thing, they end up getting something that they did not want. That right would be important.

The things that we know would drive down inequalities are advance choice documents, which we have talked about a lot—we are very keen that that should be much more embedded in the legislation—and the removal of CTOs because that is where the worst disproportionality exists. That point about transparency and the data is important and the responsible person, similar to Seni’s law, or attaching it to that post, would be an opportunity for every trust to have explicit information for every hospital to be looking at how you drive down those inequalities.

Q14 **Baroness Berridge:** One of the points the Government have made about the disparity is we will increase the use of the tribunals. Can you give us some insight into that, particularly obviously for ethnic minority communities? Do they have the confidence in the tribunal, in terms of its culture and composition, that this solution the Government have given within the Bill will help to reduce the inequalities?

Sophie Corlett: One thing we would like to see that has not been put in is the tribunals having some powers over care and treatment. Mary has already mentioned that once detained, there are issues particularly for black men around higher dosages and being much more likely to be given medication than other sorts of treatment. At the moment there is nowhere you can take that into the tribunal. We think it would redress that power imbalance that exists even more for black people if the tribunal was able to look at those as well. That is a big missed opportunity for us.

Lucy Schonegevel: When we spoke to service users and people from different communities, they said they found the tribunal process confusing and hard to access. There was a real concern around that among people who are currently detained and previously detained. That is where advocates come in, who are so important, and that is where they do not get access to advocacy or culturally appropriate advocacy such as they would under the legislation. That is where we need to focus and I agree with the idea that tribunals should be able to address decisions about treatment as well.

The place we want to get to is people should not take these to tribunals and their choices are respected, their advance choice documents are taken into consideration and their nominated person is consulted as well so we do not get to that stage where people have to go to tribunals. But if it is there, advocates should be there to support.

Baroness Berridge: You are putting a lot of weight on the advanced choice documents, but as I understand it, they can be overruled. It is different from a



physical decision about your health care. Is there something around there that maybe we could put too much weight, although it would help, on advanced choice documents because they can be overruled, even when you have capacity? It is a very different situation from when you decline treatment for a physical illness.

Sophie Corlett: It can be overruled, but the tribunal is able to look at that and say why was it overruled. Was there a good reason or was there no good reason? I know one thing people have worried about with advance choice documents is people will ask for things that are not available or impossible to have and that has not been the experience. Many of the things people ask for are not about their hospital stay at all. They are about what will happen back at home. Who will look after their dog? Knowing that sort of thing is being looked after to your wishes is really important for people: feeling secure about that.

There are the big things that people might not want to have: a particular treatment. There are also distinctions. People might say, “I do not get on with this drug. I get on better with this drug.” There is no particular reason why that should not happen except we know in many cases people just say, “This is the one I always prescribe, so I will give it”. Whereas why not give the person a choice? Those are the things where people feel much more confident. They will also feel much more confident that they are going into a situation where they may not have capacity to get this message across but that has already been made available and many clinicians will be happy to say, “I do know what this person wants and here it is.”

The Chair: We are covering some of this a little more in later questions as well. We are now turning to community treatment orders.

Q15 **Dr Ben Spencer:** I have a few questions on CTOs. Sophie, you have already made your position on that quite clear in support of abolishing them. Before I go into a deep dive on that, can I check with the rest of the panel? Is that a view shared by the rest of the panel in terms of supporting scrapping CTOs? Mary, you are nodding.

Lucy Schonegevel: We think they need significant change and they need to be reviewed after five years. The draft legislation does not go far enough in the changes that are needed. We speak to service users who say that they have been helpful, feeling safe coming out of hospital and then being able to restart their life in the community. They have been helpful but they need significant overhaul.

Andy Bell: My instinct has always been that they are a coercive measure that I would like to be without. It is very difficult when you hear people with lived experience talking about the benefits they received from them in a very small number of cases to hold that line. It is incredibly difficult and, as colleagues have said, they have proliferated. If we are talking about unintended consequences, if you look at the numbers of people the Government said CTOs would apply to when the 2007 Act was being made, and you look at the vastly greater numbers who have experienced these coercive powers, it makes you question them and I would take the view that if they do continue, they need to be very severely curtailed.

Baroness Barker: Following on from that point that Andy made, why do you think they have been so widely misused, or maybe that is too strong?

Andy Bell: When we did the independent review and I was supporting the working group I had a look at this and it was tremendously difficult. I struggled with it a lot. What became evident was that research on CTOs is very limited and what there is suggests very little benefit. Trying to understand why, it became apparent that when you talk to practitioners, they tell you either they never use CTOs or they use CTOs really well but everyone else overuses them. This I have heard consistently. It is always other people who are overusing them and it is very inappropriate, but for my group of patients we really need them. That is the language we have heard on a number of occasions.

The only way of looking at it is if you give people a power that enables them to discharge someone from hospital and feel a bit more comfortable about that decision, that notion that they can maintain a coercive power over that individual is something they feel comfortable with and, in some cases, it gives people some structure. We have seen from survey results and what little research is out there, that for some people it is helpful. It is an incentive to recover and gives people that framework. But for others, it is deeply punitive, deeply coercive, deeply patronising, and obsessed with medication compliance rather than recovering in a meaningful way. Particularly, some of the conditions that are placed on people seem quite extraordinary. Sorry, that is a much longer answer than you wanted.

Baroness Barker: It is very helpful. In 2007, people who were advocating CTOs cherry-picked their way round various different jurisdictions and brought in the hybrid stuff that we have here. Regarding the lack of research here, is there any other research elsewhere in the world about the use of CTOs, and in particular any system of CTOs that has led to a reduction in detention?

Andy Bell: I am not aware of any research anywhere in the world that shows that happens. There may be, and hopefully new research is appearing, but the last time I looked I did not see anything that particularly showed there was a preferential approach to it in one place or another. There is some worry that in some jurisdictions where CTOs or their equivalents proliferate, it almost becomes a way of accessing a service, and that is a very dangerous place unless you have a CTO. If you have rationed service, the people on the CTO get the help and that is a terrible place and we must not conflate the use of coercion with access to support.

Dr Ben Spencer: To be clear on that, is there any research you are aware of that shows that CTOs do what they say in reducing readmission or helping long-term outcomes of patients?

Sophie Corlett: There is a lot of research in the UK that shows they do not work in reducing detention. The work that Professor Tom Burns has done over a number of years, and we can send you the links to that, shows they do not reduce detentions.

Dr Ben Spencer: Where is the support for them coming from? The Government and the independent review both wanted a reduction in CTOs. You are saying from your sectors you keenly feel CTOs need to be reviewed or reduced or scrapped. Where is the overwhelming support coming from that is maintaining them as an item on the menu of choices for treatment?

Sophie Corlett: As one of the people advocating their reduction, I cannot tell you where that comes from.

Lucy Schonegevel: The only thing I hear is this risk-averse decision-making.

Q16 **Dr Ben Spencer:** My final question is this. In terms of the consequences of the MM case, when you look at supervised conditional discharges, which are sort of forensic CTO—I will probably be told off for using that analogy but there are some similarities—what do you think about the proposals for allowing deprivation of liberties in the community through the mechanism proposed in the draft Bill, building on the MM case?

Sophie Corlett: We are really concerned about that because it feels like another potential CTO position where you set something up for a group of people and it balloons into something that then affects a lot more people. Definitely it would be helpful to have something for that small group of people but at Mind we do not think that is the solution because it feels like it would be too easy for a lot of people to end up going into it.

Dr Ben Spencer: What would you do?

Sophie Corlett: We would want to look at it much more closely. Is there more that could be done with Leave or other sorts of things? Putting people into limbo between the two systems seems to have been the difficulty with CTOs. For us, we would remove CTOs and use Leave, possibly, as a way of supporting people to get back into the community and use that more. Maybe there is a way of doing that, but we have not looked at that in detail at the moment.

Dr Ben Spencer: Even if that section 17 is something that is used for months and months and perhaps years at a time, would that still be palatable for you? I appreciate you have not looked at it in detail.

Sophie Corlett: I do not know. Maybe, yes, there might be different ways but I would not want to commit particularly.

Q17 **Sir Charles Walker:** Andy, you mentioned the 2017 review of Mental Health Act. I was in the committee down the corridor looking at that. You touched on CTO inflation and there were warnings in 2007 that there would be overuse. Can you give us an idea of the inflation and what sort of numbers? Remind me as I cannot remember what we were talking about in 2007.

Sophie Corlett: It was 450. That is what my note says: 450 is what was suggested at the time altogether, at any one time. Now we are more likely 4,000 to 5,000.

Andy Bell: I wanted to come in briefly on the conditional discharge because it is an important power. The other elements to this are there may be some instances where it is the least restrictive alternative, again if we apply the principles, rather than someone being kept in secure services for years and years, which is what happens to people. That does not mean it needs to proliferate, but it potentially creates a regulatory framework and for some people the benefit of CTOs is you have all that protection that you do not have if you are in a de facto position where coercion is being used as a threat but without that structure around it. That is the reality for some people.

The Chair: Very helpful, thank you. We have already covered as much as we are able in the time, because we have very little time left to cover several questions,



advanced choice documents, unless there is something else anybody wants to add on those. We can move on to a question about mental health tribunals from Lady McIntosh. We have already dealt with that.

Q18 **Baroness McIntosh of Hudnall:** We have, and I noted, Lucy, you said that you thought treatment should be included in the powers of the tribunal and it is not. Can you expand that view a little bit for us and tell us whether you think there are other changes that could be made that might give the tribunals useful powers they do not currently have but will also address some concerns the Government have, without forcing you to repeat things you have already said?

Lucy Schonegevel: A few of us believe that tribunals should have the power to look at treatment decisions. Going back to the vision and where we want to get to, we want to get to a point where people do not need to go to tribunal unless there is something that needs unlocking in the system. Ideally, and this is why advanced choice documents are so important, we want all these different factors, the nominated person, the advanced choice document, the care and support plan, the individual's wishes if they have capacity, and the clinician, really importantly, or the second opinion doctor, whoever it might be, then make the decision about those treatments so that that is the prevention. That means that people are receiving the care and support they need.

At the moment we are very far from that. We are in a position where we hear far more often than not that people do not feel part of their care and treatment. They do not feel like they are receiving the treatment that they would want, that it is therapeutic. We hear all the time that people would want different sorts of therapy. The main access of care they get is in some cases medication when they want therapy. They want access to outside space, they want mindfulness, physical activity, all these different factors that can help support someone to recover. Yet, the treatment plan they are told about is very specifically about medication they may not want and may have had an adverse reaction to. They all factor into this trauma that has led to them needing to be detained under the Mental Health Act in the first place.

We are very far from this position we want to get to, so having tribunals as part of the Act, ideally we get to a place where we do not have to use them but we need a stepping stone to get there, because the culture within mental health hospitals is very far from that at the moment, so a tribunal that is able to look at treatment will be that safeguard and that push to make sure that culture is changed so people are involved in decisions about their treatment.

Baroness McIntosh of Hudnall: Can I ask you to be clear about mental health tribunals being involved in decisions about treatment?

Lucy Schonegevel: I mean as a recourse.

Baroness McIntosh of Hudnall: I understand not as a primary source of decisions about them, but if the tribunal is in a position to comment or opine on the impact treatment has had or on the fact that somebody is in front of the tribunal in the first place, what extent do you think that power should have and what should be the outcome? What should they be able to do that they are not currently able to do or would not be under the provisions of these changes?

Lucy Schonegevel: To be able to look at the evidence in front of them. Again, this is why advanced choice documents are so important.

Baroness McIntosh of Hudnall: And then what?

Lucy Schonegevel: To then be able to look at all the factors in front of them to make a decision about future treatment, to factor into the future advanced care and what they are currently on, if it is a continuation of treatment, medication or whatever they are receiving.

Baroness McIntosh of Hudnall: I am not trying to catch you out at all. I wanted you to say or not say is what you just said: that they should be in a position to, in effect, mandate a different treatment regime. If that is the case, that is a very substantial change, so I am interested to know what other people feel about that.

Sophie Corlett: We would agree. They would not do that just on the basis of the advanced choice document. They would also be taking information from the clinician. We want to see that when people overrule the advanced choice document or any other capacitance choice that somebody has made, to have to say why. If the reasons are good, the tribunal will find in favour of the decision that has been made, but it is making sure those decisions are made more public.

Our view is if clinicians are required to say more about the decisions they are making and explain those more, there will be fewer tribunals. One thing people really dislike is having their choices overruled and not really knowing why. If there are more discussions and that is more open, hopefully there would be fewer tribunals but also the decision a tribunal might make to go with the patient's view of what is needed makes more sense.

One of the other things we would like to see as part of that is to go back to the original beneficial treatment principle and say, is the treatment that is being given having a benefit? That should also be part of that process. Is treatment that somebody is receiving contributing towards their recovery and their eventual discharge? We need to bring that into the mix and make sure treatment is being provided and not just a therapeutic environment, which, as we know, is one of the problems. It happens for a lot of people at the moment that they are in hospital but they are not getting any treatment other than nursing care.

The Chair: Can I intervene because we are running out of time to cover implementation, which is fairly critical? Andy, did you want to add to that or are you happy to move on?

Andy Bell: I will be really quick—two seconds. The proposed statutory care and treatment plan is really important here. It should, with the individual's and family's involvement, make sure that while you are under this power, there is something active happening. It is part of the care plan and the tribunal can review that. It is an example of where this is a package, not a menu.

The Chair: That is really helpful. Lady Hollins will touch on the issue of nominated persons and then we move to implementation.

Q19 **Baroness Hollins:** We all support nominated persons. Is there anything that could be

there to strengthen their role?

Lucy Schonegevel: The ability to choose the number of nominated persons—so, two—particularly in the case of young carers or older adults caring for children who have other factors that might mean they are not available at any one time.

Sophie Corlett: We are concerned about under-18s and there being no statutory test for competence, how possible it will be for them to choose their nominated persons. That is because it goes back to the Mental Capacity Act and where that does and does not work for under-18s.

The Chair: All nodding heads in agreement. Thank you. Let us move on to the issue of implementation.

Q20 **Lord Bradley:** The current pressure on the mental health service is well documented. Do you think the resources and timescales allowed for the implementation will be sufficient to achieve the goals of the Bill?

Andy Bell: It is really difficult. We want this to be done well, so it is important that it happens. As colleagues have said, there are promises of extra funding coming to mental health services in the next two to three years; we need to see that extended up until the end of the long-term plan that was supposed to be a 10-year plan. It is important that funding comes to mental health services and that mental health services are going to change. What has not been said is that mental health services cannot carry on doing the same things, particularly if they are to meet the needs of people from racialised communities, so we need a change in the offer as well as just simply more, more, more.

The difficult part of this, as if the rest is not difficult, is that legislation can help to ensure resources are placed into the mental health system appropriately, in a way that other incentives cannot. We know previously that when Governments have invested in mental health, sometimes when that investment stops and a push from the centre stops, the money seeps out into other areas of health care. What potentially changes to the law can do is ensure you have that resource locked in because there is a requirement to provide it, which is where the Welsh mental health measure could have some benefit.

It is an interaction: seeing one before the other or the other before one, is very difficult. But if we have a clear pathway to implement these changes, and they come with funding that allows for them to happen, we can have a system that uses public money very much better to achieve better outcomes for people.

Lord Bradley: You are all nodding on that. To dig down a little bit, because I know time is really limited, looking at the optimism I share around the ICB and ICS opportunities they have to transform, I am pleased to hear that primary mental health care is on the way in some places. What role do you think they could have in transformation on the interface between health and justice where you need investment for alternative capacity and provision, for example on the 28-day transfer from prison to hospital or banning the use of prison and police custody for places of safety? That only works if there has been that investment in the alternative provision, for example, crisis care units outside A&E departments, and then you start to get that transformation and change. Where do you think we are along that

pathway that will enable this Bill to be implemented in the timescale that would be appropriate?

Sophie Corlett: Some of these things you have to just get started on and what Andy said was right. You cannot put one before the other, we just have to get started on all of them and they will fall more into place as we go along. If there was infinite money you would fund everything and then you would change it, but even while you did that you would leave people in the current system adrift while you invested in everything. You just need to start and the proposals about implementation plan, we think some of those things could happen quicker. Compulsory care and treatment plans do not have to wait until 2027-28 or 2028-29. There are things you could potentially do faster but waiting for A to be in place before you do B is a recipe for infinite delay.

The Chair: You were talking about how you embed in the legislation the issue of kickstarting the implementation. Do you have some examples of what we could put into the legislation?

Andy Bell: It is very difficult to put it in the legislation, I know. My point is if there is a statutory requirement on, let us say, an integrated care system to have, for example, support for autistic people and people with learning disabilities outside hospital, that may create an incentive to ensure that money is spent as intended and does not go into other areas of health care.

On the health and justice point, we now have liaison and diversion services in every part of the country, which is an important presence in the system. Where we have a gap is in services for people who no longer need to be in a secure hospital. Getting more people into hospital from prison and getting people into hospital from prison quicker is great and really important because people should not be stuck for months in a prison cell waiting to be moved to a hospital bed. But you need services in the community to move people on to, and that is where we need to see the investment. As colleagues have already said, some of the worst racial disparities are in the secure system so we need those services to get people out of hospital when they no longer need to be there.

Sophie Corlett: We would introduce a right to assessment and treatment for people outside hospital. You might say you do not have that in the physical health world, but you do not have coercive treatment in the physical health world so there would be a balance there and that would push ICSs to think much more equitably about investment in mental health services, so there would be something there. You would not have to exert your right but if you wanted to have treatment you needed, there would be a right to that assessment, a right to that treatment and potentially that would mean you would not need detention later down the line. That would then force the issue then for those making and planning funding decisions.

The Chair: A final question is on priorities for implementation: you are all saying it is not right to prioritise, in a sense.

Lucy Schonegevel: Yes. It has to come as a package otherwise we are not going to achieve the aim of reducing detentions.

Q21 **Dr Rosena Allin-Khan:** Are there any additional resources that you think are needed

in order to properly implement this? If so, what are they?

Lucy Schonegevel: Absolutely. There is the advocacy. Opt in/opt out advocacy means that we need thousands more advocates, which is a funding issue, but it is also workforce. With these directives come innovation. We are piloting some trainee roles for advocates. That brings in people who are very interested in working in mental health, we train them up and then they become fully qualified advocates. It is things like that. It is things like places of safety. The directive is that police cells absolutely should not be places of safety because they are not.

That is when the innovation happens, where you think about rebranding ambulances, which could then look like places of safety and things like that. That is where there are these pockets of innovation and interesting things that are happening around the country and will continue to happen, which NHS England will draw upon and share best practice. We will play our part in that as well, but it has to come from the legislation.

Sophie Corlett: The other thing that I would add would be buildings. There are things within the legislation that would need to be funded in order to happen, training or whatever, but the buildings that people are working in do not support good practice. Some of them are literally just falling down, so that is an issue. Buildings may have noisy, clanging, heavy doors that make people feel like they are in prison and make it very difficult for people to recover and feel that they are in a supportive environment. There are basic things like lines of sight, which are very difficult—it is all of those things.

The Chair: That is incredibly helpful. This has been a very intense but very worthwhile report session. Thank you very much indeed for your time; it is hugely appreciated by all of us. I will now suspend this public session for just a few minutes, probably five or six minutes, and I thank you again for your time.

Panel 2

Witnesses: **Alexis Quinn**, Manager, Restraint Reduction Network; **Dr Jennifer Kilcoyne**, Clinical Director for Centre for Perfect Care, Mersey Care NHS Foundation Trust and Director for National HOPE(S) NHSE Collaborative.

Q22 **The Chair:** Thank you, everyone. This is the second panel of the first session of the Joint Committee's inquiry into the Draft Mental Health Bill. In this session, I will turn straight away to our two witnesses. We have Alexis Quinn and Dr Jennifer Kilcoyne. Thank you very much indeed for coming. I will ask you to say your names and then Lady Hollins will ask the first question.

Dr Jennifer Kilcoyne: I am Jennifer Kilcoyne.

Alexis Quinn: I am Alexis Quinn.

Q23 **Baroness Hollins:** Thank you very much for being here today. I know you both because I have worked with you on the question of long-term segregation and its use for people with autism and learning disabilities who are detained under the mental health legislation.

You have said that you think that autism and learning disabilities are not sufficient



criteria and should not be used to detain people, but you are very worried that if they are taken out of the Bill in the way proposed this could make things worse; there could be some unintended consequences. What needs to happen to make sure that those unintended consequences do not happen? Alexis, if people were not going to be detained as they are at the moment under the Mental Health Act, what would need to happen to make sure that all the warnings about what could go wrong will not happen?

Alexis Quinn: Is it helpful to explain what could go wrong?

Baroness Hollins: Yes, please do.

Alexis Quinn: I think this will impact people with higher and lower support needs equally. For me, as somebody with lower support needs, I think that there is a big increased risk of suicide. As we know, autistic people are nine times more likely to die by suicide, and the average life expectancy is 54. With community provision, currently there just are not the support structures there for people who experience even moderate distress. You have to wait years for counselling and often when you get any sort of psychological support it is not tailored for autistic people; then you get offered six sessions. That is the first problem. Often autistic people need support very quickly and the system is not responsive.

There is a likelihood of being given another mental health diagnosis. I was given six diagnoses when I was in hospital and it took pretty much the whole three and a half years to get rid of those, then I ended up with autism at the end. There is confusion about symptoms, so I think there needs to be some training for psychiatrists to understand different presentations. That is a potential solution.

I think the Mental Capacity Act is more likely to be used for people with higher support needs, but for somebody like me there is very little chance—no chance, probably—that I could be detained under that Act. What Jennifer and I have experienced from different sides is the forensic pathway, which will apply to both groups of autistic people.

When I was in in-patient settings, if there was a meltdown in the hospital, the staff would often call the police or get the police involved. The reason for that was just to accrue a forensic record so that they could justify a forensic pathway for me, to get me out of acute units or to get me out of PICU and to put me in secure settings; it is a different funding stream, I believe. That is definitely a pattern that I have experienced, which happens to people. Would you agree, Jennifer?

Dr Jennifer Kilcoyne: Yes, I would agree with that. I work with a lot of people who are in long-term segregation who are autistic and have learning disabilities, and children and young people. Over the last few years there has definitely been a focus on trying to criminalise that behaviour. When autistic people are very distressed, they might damage property or things like that, quite often services now are moving to prosecute them. That is an issue that we are very concerned about, that if people are not afforded some protections under the Mental Health Act, they are just being increasingly criminalised and end up in prison. Those are some of our concerns.

Equally, within services, in my work I find that there is a very large number of people who are autistic who are in long-term segregation when you look across the country. Quite often

services are putting people in long-term segregation because their sensory needs are not being met in hospital because they are going into mainstream hospitals where people are not trained in understanding autism. Even though there is a kind of mandate that you need to be trained—and moving forward, we are hoping with the Oliver McGowan training that that will improve—quite often clinical teams are like, “Well, we don’t have time for that. Most of our other patients are not autistic, so we don’t have time to develop individualised care for this particular person”. What they tend to do is put people in long-term segregation, away from other people. That is one unintended consequence of taking it out of the Act.

We are worried about what safeguards there are—and there are plenty of faults with the safeguards currently with people being admitted to hospital—and that without robust community support, people will be criminalised and end up in prison—like your experience.

Alexis Quinn: I am probably the least likely person that you could imagine to have ended up in an in-patient unit. I was a teacher; I swam for Great Britain. I had been teaching eight years before I ended up in an in-patient hospital and I ended up in long-term segregation. This is a very real fear. Certainly, we know from the Penrose hypothesis that inverse relationship between in-patient beds: for every 100 psychiatric beds closed, there are 36 more prisoners. I live in fear, to be quite honest, that I will have a meltdown in the street and the whole process could start again because at the moment—and this is what we need to stop, Lady Hollins—is that the system responds in the same way.

Nothing has changed since I escaped five years ago, so if I had a meltdown on my way home, the system will respond in the same way. If I cannot be detained under the Mental Health Act and the Section 2 runs out, where do I go? In hospital, because it is very stressful in there, if you are locked in a room with just a mattress on the floor and you are fed your food on the floor, you get a bit upset about that. You might bang on the door, and if you break the door, then they call the police. Do you see what I am saying? This is normal human behaviour. I was a teacher. This is normal human behaviour; you do not like to be locked up. What would happen to me? Right now, from the options that we have talked about already today, I think it is prison. I would be criminalised and I just do not think it is preferable to the Mental Health Act. Although, yes, in principle it should be taken out, unless we know that people are not going to be criminalised, I think that that is more life-limiting. It is more life-limiting for me to have a criminal record, as a law-abiding citizen otherwise, with a university degree, a master’s degree and I have written books. Do you see what I am saying? This is not okay.

Baroness Hollins: Alexis, this is even though the average stay for an autistic patient or a patient with a learning disability is something like six years compared with a month for somebody else. You pointed to the fact that when treatments were offered they were not the right treatments. Is that part of the issue, the fact that you were a traumatised autistic person but you did not get a trauma-informed treatment?

Alexis Quinn: No, I did not get any of the right treatments. That is the thing and the pathway remains the same. We are taking it out because it cannot be treated and we want to reduce the number of autistic people who are detained for no reason. I am totally for that, but for that to work, for people not to then be detained in other settings or detained under the Mental Capacity Act, we have to change what we are doing in the community and how we support people. We are not there yet.

Dr Jennifer Kilcoyne: In services, autistic people are not getting even the very basic care sometimes around having a SALT assessment, to understand their communication needs and having sensory assessments. I work with people, as I mentioned, in long-term segregation so you would think that teams would be focused on getting their care absolutely right because they are in long-term segregation, which is a highly restrictive practice, but even then, because of pressures on services, they are not getting those very basic things that will really help. Understanding somebody's sensory needs, understanding their communication, communicating with them and making reasonable adjustments in how you talk to them about their care and treatment and focusing on what is meaningful for them is not happening currently within the system.

We were discussing this focus on the community and how we get those very robust community support systems. There are some examples out there. There is the Durham crash pads service, which is a flat where people can go if they are struggling and their placement is at risk. There is also some intensive support for young people in Ealing. We think there need to be safe spaces in the community for when people are experiencing difficulties, because we do know that hospital is a really difficult place for autistic people and that it makes them worse.

In principle, we fully agree, absolutely, but what we are concerned about is those unintended consequences without the right community support. We need to think about how we mandate that community support and how we get people to put that infrastructure in place. We fear that without it there is such a gap that people will end up in prison.

Baroness McIntosh of Hudnall: Alexis, you have described your own experience. First, you have described yourself as somebody who is lower level—I cannot remember what the phrase was.

Alexis Quinn: Lower support needs.

Baroness McIntosh of Hudnall: Lower support needs. You have described your own pathway into being a teacher and having a very successful academic career. I think what is very hard for people who do not fully understand the difference between autism and mental illness is to understand what kind of treatment would have helped somebody like you in those earlier days before you got to the point where you needed to be helped because you were in crisis and then you got the wrong kind of help. Does that make sense?

Alexis Quinn: Yes.

Baroness McIntosh of Hudnall: Could you explain that to us a little bit?

Alexis Quinn: Yes, sure. Basically, my brother died and I had a baby at the same time. The health visitor was not very helpful, so that was the first problem. They do not understand autism very well.

Baroness McIntosh of Hudnall: Is it all right to interrupt you just for a moment? By that time did you have an autistic diagnosis or did you not?

Alexis Quinn: No. That is the first problem for women especially, but just to skip forward a bit, I was living in a hospital for three and a half years and it took two years until I saw a specialist autism psychiatrist—by accident. That is how I ended up going on the right pathway. This is what I am saying about psychiatrists, they just did not understand, and because I can sometimes speak articulately, they just assumed that it was all very volitional, do you know what I mean? That is a problem.

At the time, I had a baby and my brother died and I was having a very clear autistic grief reaction. Now that I look back at it, it was really quite obvious, and it just was not supported. I needed some immediate psychology, an immediate speech and language assessment, an immediate sensory assessment and maybe a safe space. If you do not get those things straight away, if we delay getting those things, then the deterioration is very fast. It took two weeks for me to be where I was dangerous, for sure, in the community, so then you would need a safe crash space to get some very intensive support, maybe for a week or two. If those things were in place, then I could maybe have gone home.

This probably would not have cost very much, but what ended up happening was, as Baroness Hollins said, I got stuck in the system for three and a half years. I ended up then getting detained for another year, at which point I just decided to escape. I was going to a medium-secure unit, so if I had not done that, I would probably still be in the system now. I feel very strongly about this because if I was not able to be on a Section 3, what would happen? Unless we can sort the community out and we stop the system taking that pathway, we should not take it out unless you guys are sure.

Dr Rosena Allin-Khan: Oh my goodness, thank you, Alexis. I have so many things going around in my head, but just a couple of things I wanted to say. You spoke about women. My friend sent me a letter after she received an ADHD/ASD diagnosis. She is a woman around 30, she is a secondary school teacher and she was told that she had a 36-month wait for an assessment, so exactly what you are saying is ringing true, probably worse than ever now.

I want to ask you—and please forgive my ignorance—what an autistic grief response looks like and whether or not there is something we can consider here. Where there are people that have a diagnosis, if they are in crisis, going through a bereavement or going through something very traumatic, given the fact that there is a known response, is there something we can do to ensure that they go down a pathway where their GP or their psychiatrist or whoever takes care of them, whatever their supports needs are, can trigger this pathway that means they get that quick and timely help?

Alexis Quinn: The first question was about what it looks like. For me, it looked like a very heightened sensory awareness, so I saw things very brightly, everything was super noisy and I felt like my skin was on fire. Just having had a baby, people thought that I had psychosis, so I entered the system with a question mark of psychosis. I had never had any history of mental illness, I had never had any trauma before that, maybe a bit of bullying at school because I was a bit weird, but apart from that. I entered the system like that and of course as soon as those doors shut, the sensory problem got really big.

I describe it like a balloon, it is very, very full, and it would just take a little something, like a member of staff speaking to me, and I would just have a massive meltdown, so then it looked like personality disorder and it looked like I was being emotionally unstable. That is how I got stuck. I was at this unit and then this autism psychiatrist witnessed a meltdown. She just happened to be on shift that night when I randomly had a meltdown. I am so lucky. That is the only reason that everything kind of changed.

Even though things got better, people then understood and I had a narrative to understand what was going on and I could calm down a bit, as Baroness Hollins points out, the system is very inappropriate to detain autistic people. Having said that, I really would rather be in a hospital than in prison. I was destroying property, I was aggressive and violent, but you have to understand it was in response to it being unbearable that my body could not tolerate the sensory environment and that kind of environment. I was having restraint, seclusion, restraint, seclusion all day long every day, until I was in long-term segregation, until they detained me again and I was like, “No, enough is enough”. You think: at what point along that road could the Mental Health Act have made a difference?

Dr Rosena Allin-Khan: Also your baby—because we have to be mindful that yours is not going to be an unusual case, sadly, particularly as women remain hugely undiagnosed.

Alexis Quinn: I have written a book, *Doctor*, about autism and pregnancy.

Dr Rosena Allin-Khan: I am going to have to read that because it sounds incredible.

Alexis Quinn: I have a lot of mums who are autistic contacting me. Some of them have been in in-patient units and what is happening to those mums is that social services are coming in and wanting to get involved, so this is the problem, yes.

Dr Rosena Allin-Khan: Exactly, that is why I am asking. What happened to you?

Alexis Quinn: They tried to take the baby.

Dr Rosena Allin-Khan: Yes, that is what I imagine would have happened.

Alexis Quinn: But we have been living together now for six years since I escaped the system without any problem, and I am working full-time. I was back teaching full-time within six weeks of leaving the UK, so I landed and within six weeks of leaving the UK I was back working. The reason that is important is because it shows that with the right support and with the right environment, this will not happen to people. What I want to make clear is there is not the right support and right environment in this country at the moment. It is not here, so we will be setting people up to fail if we do not do something.

Dr Rosena Allin-Khan: Where did you go?

Alexis Quinn: I went to Africa. The point is that it was cheaper, so I could buy what I needed, so I thought all that through, through the night, and here nobody can do that because it is too expensive.

Q24 **Baroness Hollins:** Your experience of being bereaved, because your brother died, is a very common precipitant for autistic people and for people with learning disabilities when they are admitted to hospital—incredibly common—but often the staff admitting them have not asked the question and do not know that they are bereaved. What is the solution? What needs to be in place to recognise that bereavement is a common precipitant and that something needs to be there to support people when they are bereaved?

Alexis Quinn: I think that psychiatrists should get some training that is more in-depth than the Oliver McGowan training. It needs to be much more in-depth, it needs to be much more specific and the distinctions need to be made clearly between sensory-driven behaviour and something like personality disorder or psychosis. A lot of the time when I used to abscond I would get picked up by the police and taken to A&E, so maybe there needs to be some distress training in A&E services to divert people away from A&E. That Section 136 pathway for police—police need to know. Sorry, Jennifer.

Dr Jennifer Kilcoyne: No, that is all right. I was just going to say, distress training has been piloted in Scotland, where they have trained police and the ambulance service, and it has had a very good impact on reducing A&E admissions. What you would need to do is include some autism-specific aspects in that so that then people are aware of things such as sensory overload and communication issues. That has had a very positive impact because the police at the moment have very limited training on autism. I think there is one person in the country that does some training on autism for the police. There are some improvements in relation to how people come into services to prevent that admission through A&E. I think we were going to talk as well about—

Alexis Quinn: The blue flag. I think a blue flag would be very helpful. When I was detained in York, there was a red flag put on the police system so that any time I absconded and was picked up by the police, they handled it very differently and brought me back. It would be helpful if a blue flag was made available for all emergency services so that they can understand that person's specific needs—that is really quite doable—so that it maybe links to advance decision documents in emergency situations. That could potentially be very powerful.

The Chair: That is very helpful. Any more questions from anyone?

Sir Charles Walker: Alexis, one of the questions we have in front of us—because clever people write our questions for us—is, “Where in the mental health system is the most work needed to improve understanding of learning disabilities and autism?” It would seem to me, from your experience, you were taken when you were having a meltdown and put in an environment that guaranteed you would have more meltdowns and be under more pressure, like turning a ratchet on you every day, just getting that reaction and making you feel more unhappy daily.

Dr Kilcoyne, maybe I have this wrong, but it strikes me that there just needs to be—and I say “just”—better awareness for autism in the system and that there is just a lack of awareness and understanding. If there was that better awareness and understanding, it would not be a chance intervention that perhaps saved your life, Alexis, it would have been recognised earlier on in the process what support you needed.

Alexis Quinn: I think the problem is in the community. Obviously, it is an inappropriate environment in hospital. I do not think anyone is disputing that. The problem is it is a very coercive, harsh measure. You say I got picked up. I was handcuffed, my legs were tied together and I was put in a cage. This is an aggressive, violent attack on autistic people who are in a crisis situation. I do not think it is just to do with understanding, it is to do with the massive power structures. I know VoiceAbility has just put out a national advocacy strategy, which is fantastic. There need to be more peer workers. I am not necessarily talking about advocates now, but peer workers who are supporting in tribunals so that we are levelling up that power imbalance, because as soon as you create that pressure, an autistic person will react against that. I do not think it is just about understanding, but of course that is part of it.

Dr Jennifer Kilcoyne: Once people are in services, there is a significant need in relation to improving understanding and improving environments. A lot of in-patient wards are not suitable for autistic people because of all the other noises or the lighting, everything else, so it is about having flexible environments in our hospitals as well. I do think it is a training issue. What we were talking about is if Alexis had had some intensive support at home that would have been very helpful. We spoke yesterday about circles of support. I know that these are used with offenders who might be very disconnected from communities, but often autistic people and people with learning disabilities are in a very similar disconnected position. So, we wondered whether something like circles of support for autistic people and people with learning disabilities in the community, where they would have some volunteers around them to support them when they are struggling and have consistent long-term relationships with them, that would be helpful as a framework moving forward. That has had quite a lot of success in the offending populations.

Sir Charles Walker: One more question. I am just trying to develop my thinking on this. What does struggling look like? What would be the indicator that someone is struggling that would initiate the circles of support?

Alexis Quinn: Ideally, it needs to happen before that. It needs to be in place before. It would be difficult for it to be a reactive measure, but I guess a heightened sensory awareness is a massive indicator. When you are asking for help, you should not have to beg for help and then wait six to 18 months to get it. That is a huge problem. It needs to be immediate. If it is going to stop people getting detained under the Mental Capacity Act, dying by suicide and all those other things, it has to be immediate and at the moment there is no immediate thing.

Ideally, this would all be in place already. It should be in place now. I feel that by the time this Bill goes through we are not going to have made any progress at all and people are going to be dying in prison or under the capacity Act.

Q25 **Dr Ben Spencer:** Thank you, Alexis, for your evidence. It is good to hear that you and your family are doing well now.

My question is, in terms of the evidence you have given today, how much would you say is specific to people who are living with autism and how much would you say is general points that could apply to other disorders; for example, personality disorder or psychosis in terms of your experience going through care? How much would you say is autism-specific where you think things need to be changed, or how much would you say it affects other people living with other conditions too?

Alexis Quinn: I think the power structures affect everybody. Like the gentleman was saying earlier about coercive measures—those affect everybody. Nobody likes to be taken to a hospital, but I think it disproportionately impacts autistic people and people with a learning disability—very, very much disproportionately impacts.

I had a very good, secure upbringing, I have been very successful—all of those things and yet I could have been a decade in the system.

Dr Jennifer Kilcoyne: If you look at, for example, long-term segregation, so restrictive measures, autistic people are disproportionately affected by that in services. In patient care in general there are some very specific things around autistic people in terms of—

Alexis Quinn: Restrictive practices are unbelievable.

Dr Jennifer Kilcoyne: —restrictive practices, not meeting their needs and often the system is built on people doing things differently in response to your feedback, and that is not always how autistic people would see it. They might stick to what they want to do. They might have special interests. They might have lots of sensory needs that are not being met. They might have communication issues. They might not understand some of the processes. They might take things very literally. There are lots of things stacked against them when they go into services.

Dr Ben Spencer: Could I unpack that a little bit if you do not mind? Of course, lots of people with lots of different conditions have good upbringings and education and background and so on, so I do not think it is necessarily exclusive to people with autistic spectrum disorders, and I know you were not meaning that, Alexis. Is there something more specific, first, about the impact? I would like to unpack the impact on people with autism in terms of going through the care pathway, specifically about the nature of the condition that makes it more problematic.

Alexis Quinn: Yes. Basically, when I get into the service and the door shuts and you are in an absolute sensory nightmare, that is very specific to autistic people. It is loud. It is chaotic. There are lots of lights. It is busy. It is moving all the time. There are alarms going off. There are people all over the place. There are staff changing over. There are patients coming and going. That creates an overload. You can hold that overload for only so long without the ability to sensory modulate.

All of your activities are taken away from you and you cannot go out. I used to sensory modulate by running or walking or swimming but because I could not do that—and often the garden was shut because it is a blanket restriction because it opens for only 15 minutes an hour—I would then have a meltdown, and then the meltdown would be met with six to 10 men holding me down, injecting me in the bum with a sedative, usually with two antipsychotics. Then I would be picked up like a battery ram and taken to seclusion and I

would be there for about four hours, and then I would come out and wait for it all to happen again. There would be all the sensory stuff again. I would have no opportunity to modulate. I did not have my activities. It was a cycle.

This does not happen to other populations. This is very autism-specific. Not only that, when people are communicating with you, they are not doing it in a way that you can really understand. It is not specific to the communication that you need.

Dr Ben Spencer: My other question is in terms of the long-term segregation. Do you have figures in terms of people who were in short term versus long-term segregation and how that breaks down by primary diagnosis?

Dr Jennifer Kilcoyne: I do have figures. I do not have them with me but I do have figures on that. I can provide those to you.

The National Mental Health Data Set talks about diagnosis and length of time in segregation. There is quite a lot of evidence that indicates people who were autistic are disproportionately affected as well. The only data that we do not have is very robust data on children and young people, which is a shame. We do not have robust data on that in terms of the NHS.

Sir Charles Walker: Alexis, you said that you could be coming home from work and have a meltdown and you ended up being handcuffed, having your legs bound, carried like a battering ram. If you were on your way home from work and had a meltdown, what would be an appropriate intervention to talk to someone with autism? Do you see what I mean? If you were writing the book on it—you have probably written a book on it—what would the right intervention look like to de-escalate the situation?

Alexis Quinn: People would need to move away, which is the opposite of human nature. It is to go to. People would need to move away. Give me some space. Maybe one person could come and sit with me and say, “It is okay”, just be reassuring. It is kind of the opposite.

Sir Charles Walker: As opposed to eight people—well meaning, probably—shouting at you at the same time.

Alexis Quinn: Exactly. If you are having an overload, you want to reduce the sensory input. You do not want to go to. When the police come or when mental health nurses come, there are lots of them all talking at you because they are not understanding the communication. They are not understanding that that creates more sensory input. Then, if they touch you and your skin—like my response is it feels like burning. If they put their hand on you it feels like fire, so of course I am going to thrash and that makes it look like I am being aggressive.

Sir Charles Walker: Let us assume these are well-meaning people.

Alexis Quinn: They were all well-meaning people, by the way.

Sir Charles Walker: Yes, they are trying to read a situation.

Alexis Quinn: Yes.



Sir Charles Walker: When you are having a meltdown, are you in a situation to let them know what works for you or what does not work? Would there be a way of having something on your person that would indicate, is that—

Alexis Quinn: I used to wear a wristband that you just flip over, so people could know. In York they could find that flag and that was very helpful. However, it needs to be during the overload. By the time of meltdown it is far too late. That is it; you just have to let it take its course. That could take hours in a mental health unit because of the lights, because of the noise, because of the other alarms going off; whereas at home it does not take very long. Sorry.

The Chair: No, it is fine. I do not want to interrupt you, Alexis. There are just a couple more questions if you are happy to take them when you finish on that point.

Alexis Quinn: Yes, I have finished. Thank you.

The Chair: Thank you. Lady Barker and then Lady Berridge.

Q26 **Baroness Barker:** Thank you very much. I have sat on quite a number of these committees, including the initial ones on the Mental Capacity Act. I vividly remember, when the Mental Capacity Act was in draft, being told about a person who had learning disabilities who was sectioned under the Mental Health Act. In fact, it turned out that the person had a thorn in their ear, which had gone septic over a long period, and they could not articulate what was the matter.

At the time that the mental capacity legislation was coming—and I say this because what has happened to you has happened when the Mental Capacity Act, revised, and the Mental Health legislation are both there—the argument that was put was, “The Mental Capacity Act is going to be very much based on best interests and, therefore, it will be better for people who have learning disabilities or autism”. The counterargument was, “Well, the problem with the Mental Capacity Act is it does not have that much by way of safeguarding and review and tribunals. That is better under the Mental Health Act”.

The part of your story that is missing, I suppose, is: how did you manage to get out? Were people reviewing what was happening to you under the Mental Health Act? I absolutely take your point that it is better not to be in jail and to be subject to mental health legislation as a sort of second best, but does all of this not speak to the fact that those two bits of legislation—the Mental Capacity Act and Mental Health Act—are both failing people with autism and learning disabilities?

Alexis Quinn: Yes. What is the question, sorry?

Baroness Barker: My question is: if the Mental Capacity Act was stronger would it be okay to take autism and learning disabilities out of the Mental Health Act?

Alexis Quinn: It would help if the Mental Capacity Act was stronger but I think it would suit a certain population. What we need to think about is certain populations. I am of a certain population, a certain type of person who is more likely to take a criminal justice route, and there will be people who have autism and a diagnosis of learning disability who might be

more likely to take a Mental Capacity Act route. Therefore, I think we have to think about all of the populations.

I had lots of solicitors and lots of tribunals. I was always trying to get out of it, but one of the problems, which I do not know if it is okay to mention, is about inclusive communication in tribunals and in Mental Health Act assessments. I never really understood them and I had lots of tribunals and lots of Mental Health Act assessments, but there were no adjustments made to the way that people communicated with me. That was especially true in Mental Health Act assessments.

For example, people would say, “You meet the threshold for detention. Would you like to be admitted informally?” Well, I did not want to go to hospital so, “I would not like to be admitted informally, thank you very much”. What that meant was, which I did not understand, that I was then going to be detained. It took me a long time to figure that out. That is the sort of thing. That implicit messaging is not happening.

This is why Jennifer and I were thinking it would be a good idea, when people that we know are autistic, when they are admitted that they have a speech and language assessment and they have a sensory assessment, but specifically the speech and language assessment so that it can make recommendations for communication for people in tribunals and for assessment, and that could stay with a person, maybe with their advance decisions.

The Chair: Lady Berridge, we have just touched on advocacy but if you would like to—

Q27 **Baroness Berridge:** Yes. Is there more that the draft Bill can do to help people with learning disabilities or autism to access safeguards and/or advocacy?

Dr Jennifer Kilcoyne: As was mentioned, I work with people in long-term segregation and it is very positive at the moment because people have access to the C(E)TR processes as well. There is a real lack of advocacy. When I have done reviews, when I have worked with people, very rarely do they have access to good advocacy.

A lot of the time it is the general staff shortages, but sometimes advocacy is not that strong in challenging some of the medical models as well and fighting for people’s rights and the safeguards that they need.

Alexis Quinn: Yes, sometimes you feel like they are part of the staff team. You have a conversation with them and then they will go and tell the staff. I was in 12 different hospitals. I may get a relationship with an advocate but then I move hospital and I no longer have that advocate because they are funded from somewhere else. There has to be a national strategy, I think.

Dr Jennifer Kilcoyne: It is quite fragmented. People find it hard to access and you might have built a relationship with someone and lots of people are very traumatised in the system, so it takes them a while to build those relationships.

I have worked in mental health for 25 years, and I have not felt that there were very empowered advocates acting on people’s behalf in terms of the safeguards. There are some, but I would not say that there is a consistent picture at all, and it is very fragmented. To rely on that, we are not at that stage where it is a real powerful force for change.

Alexis Quinn: Peer workers who are in the community—I work at the Restraint Reduction Network and we are running a project that buddies somebody who has been discharged who is now in the community with somebody in hospital. We had a piece of feedback last week that said that this is the most unique relationship that they have ever had. They do not feel any pressure. I am not talking about peer support workers who are members of staff. I am talking about somebody completely independent. That has made a huge difference for that person in helping them to transition very soon into the community, so I think that would be helpful.

Also, having a nurse or teams of staff—teams like the HOPE(S)—who are with a person and can go with them to the hospital to create that link, or in a safe space and then move home, that would make a massive difference as well, but I do not know if that is beyond the scope of what we are talking about here.

The Chair: That is very helpful. Thank you. Rosena.

Q28 **Dr Rosena Allin-Khan:** I want to ask a quick question. It might sound like a stupid question but, given the fact that so much more is done digitally now and the issue with moving—like 12 different hospitals—for a person with autism would it be less advantageous to have the same advocate but do things digitally as well? Would that be difficult?

Alexis Quinn: That would be a useful option. What worries me about that is that sometimes it can then be removed. People rely on that and you never actually see a person. You never build that connection.

Dr Rosena Allin-Khan: If you had a relationship with someone and dealt with that person.

Alexis Quinn: Definitely, yes.

Dr Rosena Allin-Khan: One of the major issues we have now is out of area replacements. Sometimes people will move 200 miles away. Then to try to create that, particularly if we are talking about our BME community, you might not find someone who is an Asian woman or a black man 300 miles away from home. We have had people being sent over 300 miles away from where they live. If there was someone who they had built a relationship with, if there was the capacity to have them continue as the advocate on Zoom or Teams, would that help?

Dr Jennifer Kilcoyne: That has happened in the service that I work with: someone has had an advocate in Birmingham and we are in Liverpool and they continue that relationship over the iPad virtually.

Dr Rosena Allin-Khan: Which is something we could look at.

The Chair: Yes, which makes sense for everyone because then you are sitting in a familiar environment where you are then having immediate contact with a familiar person. Yes, that is amazingly helpful.

Alexis Quinn: Could I say something else?

The Chair: Yes, please do.

Alexis Quinn: I was just wondering, if you are going to go ahead with this, whether you could make a duty to record and monitor where people go, so if they are not going to hospital under the Mental Health Act can we monitor how many are detained under the capacity Act and, also, do we have the ability to measure the number of autistic people and people with learning disabilities in the prison population, for example? Could there be a duty to do that?

The Chair: Yes.

Alexis Quinn: Also, one other thing, if we could delay the change until the community was a bit better, if you are going to go ahead with it.

The Chair: As we heard in the previous part of the session, the idea that we do everything sort of big bang just would not work.

Alexis, and Dr Jennifer Kilcoyne, thank you both so much. This has been enormously helpful. Thank you for speaking in stark terms, too. Thank you very much. The session is now ended. Thank you.