

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Wednesday 19 October 2022

Ordered by the House of Commons to be published on 19 October 2022.

Written evidence from witnesses:

- [MIND and Race on the Agenda \(MHB0070\)](#)
- [Professor Stephani Hatch, KCL et al \(MHB0064\)](#)

[Watch the meeting](#)

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

Questions 42-54

Witnesses: **Professor Stephani Hatch**, Professor of Sociology and Epidemiology, King's College London; **Dr Jacqui Dyer MBE**, Director, Black Thrive; Maurice Mcleod, Chief Executive, Race on the Agenda; **Beverley Stephens**, Community Engagement and Membership Manager, Catalyst 4 Change; **Lily Huggins**, Assistant Head of Operational Development, Gaddum.

Q42 The Chair: Welcome, everybody. This is the third session of the Joint Committee inquiry into the draft Mental Health Bill. This session will focus on addressing inequalities in the use of the Act. This was a key area and a key aim of the independent review chaired by Sir Simon Wessely. May I begin by asking each of you who are giving evidence to the inquiry today to introduce yourselves?

Maurice Mcleod: I am the outgoing chief exec at Race on the Agenda.

Dr Jacqui Dyer: I am one of the directors of Black Thrive Global. I was one of the co-chairs of the Mental Health Act review's African and Caribbean working group.

Professor Stephani Hatch: Good afternoon, everyone. I am professor of sociology and epidemiology at the Institute of Psychiatry, Psychology and Neuroscience at King's College London.

Beverley Stephens: Good afternoon, everyone. I am from Catalyst 4 Change, the West Midlands African and Caribbean hub, working around and within the West Midlands.

Lily Huggins: Good afternoon, everyone. I am very glad to be here. I am the assistant head of operational development for advocacy at Gaddum. Gaddum is a charity that provides

advocacy, carer support and therapy services in Greater Manchester. We have provided the statutory advocacy provision to the citizens of Manchester since 2015. We also provided the DHSC's culturally appropriate advocacy pilot, in partnership with our colleagues at African and Caribbean Mental Health Services.

Q43 Marsha De Cordova: Good afternoon, everybody. I also extend my thanks to you all for making the time to be here, in what I believe is a really important session for how we can address racial disparities, particularly among our black and ethnic minority communities. As you know, the Government and the independent review's goal was about reducing some of those disparities, particularly among black African and Caribbean communities. Do you believe that the proposed draft legislation goes far enough? Could anything else be added to the legislation to ensure that we reduce those inequalities in how the Act is applied?

Maurice Mcleod: I suppose it is not a surprise to hear me say that it does not go far enough. That is going to be my answer to most things about change in institutional stuff in Britain. I often think we do not go far enough. We have made four very clear recommendations with the draft proposals. The first is that anti-racism be enshrined in the Act as a guiding principle, making sure that all authorities have a duty to work at reducing disproportionality and discrimination.

We also think that the community treatment orders—CTOs—should end, because they do not work and they massively increase discrimination due to the subjective nature of them. You get the prejudice plus power dynamic, which always impacts on black communities, meaning that we are 10 times more likely to be on CTOs.

We are also calling for a right to assessment and treatment. I am sure I am talking to people who know this, but we often find that, when people of colour of marginalised communities, or whatever, seek medical support, they are not really listened to in the way they would like to be. They are not given the support they need at that point, and they end up re-entering the system at a later date by a much less comfortable route—via the criminal justice system or something like that. We believe that building in those rights would give patients—and, as is more often the case, their families—the ability to say, “No, we really do want treatment to start now”. As I think we all accept, the earlier we intervene, the better. It is more cost effective both for society and for the individual; the personal cost to them of going through a system by force is very different from one where they have been able to get the treatment they required.

The fourth thing we were calling for was a responsible person, someone whose specific role it is to draw up and implement plans to reduce racial inequality, similar to the role that has been introduced under Seni's law. It is really important for someone to own that task on a local level. Otherwise, we find that responsibility for doing this work gets passed from pillar to post, it is not really anyone's job, and it falls through the cracks. It is one reason why we are asking for that. So the short answer to your question is yes.

Maybe I should say something positive. There are bits in there that we feel would do some good. We are not completely going, “No, this is awful”, but if the question is whether it goes far enough, the answer will always be no, because very few things go far enough. Sorry, but that will always be my response.

Dr Jacqui Dyer: I agree with much of what Maurice has said. Often legislation does not go far enough when catering to people who are experiencing high levels of discrimination and disadvantage. In the context of the proposed legislation as it stands, there are opportunities to significantly improve the racialised experience. It was that level of detail which the African and Caribbean subgroup of the Mental Health Act advisory panel was attending to.

It is useful to remember what two out of the six key elements of the terms of reference for the review were. One was to attend to the rising levels of detention under the Act, which we all know for decades has been disproportionately implemented in relation to racialised groups; by that I mean black, Asian and minoritised groups. The other element of the terms of reference was to attend to the overrepresentation of people from black, Asian and minoritised groups within in-patient settings.

A couple of the recommendations attend specifically to that experience of disparities in the implementation of the Act and the treatment of racialised communities in mental health service provision. One is culturally appropriate advocacy, which the Government are leading on in creating culturally appropriate advocacy pilots. I believe one of the pilots is on the call, and another pilot was co-created in Lambeth by Black Thrive Lambeth. That was a culturally appropriate peer support and advocacy—CAPSA—service. It is infused with the principles of anti-racism and attending to the disparities of experience.

It has been really good in attending to that differential experience, and building trust and confidence with service users, carers, nominated persons and their networks and families by understanding and having somebody walking alongside them as they navigate the process when they are in crisis that might lead to detention under the Mental Health Act. I cannot emphasise enough how important that attention through a culturally appropriate lens is to dealing with the differential experience that comes from structures infused with systemic racism and structural inequities, and helping to rebalance the power dynamic in the best interests of a person when they are at their most vulnerable because of the loss of liberty they may experience. That is one component, which needs to be part of what goes around the advocacy element of the Act.

The other significant aligning part is the patient and carer race equality framework, which we are leading on in NHS England. I chair the steering group there for the development of that framework. As with the CAPSA service that is being developed in Lambeth, it is a co-produced framework, where service users, carers and other stakeholders are co-developing a race equity accountability framework, which acts as a service improvement mechanism both to hold mental health service provision to account and to support it in transforming services by improving access, experience and outcomes for racialised groups.

Maurice attended to some of the differential experience of the implementation of the Act and therefore the urgent requirement for such a mechanism. For example, community treatment orders are between eight and 10 times more likely for black communities than for their white counterparts. This is an ongoing pattern and trend that is still present today. In the Mental Health Act dashboard that has been created by NHS England, we can see nationally, regionally and locally by trust the disparities in the implementation of the Act for racialised groups. That is another key element of this legislation and the code of practice, which is really quite urgent.

The final one to mention at this point is the importance of the advance choice directives as another tool to empower service users and patients when they are at their most vulnerable, to help address the power imbalance, and to move the mental health service provision towards giving appropriate treatment according to need.

I want to emphasise the differential nature of some of the treatment. For example, we know that black, Asian and minority ethnic communities do not get access to psychological therapies when they are an in-patient or have been detained under the Mental Health Act. The emphasis is likely to be on some forms of medication rather than a range of options that are bespoke and tailored to meet the needs of the whole person and treat them with dignity and respect. The principles of dignity, respect and treatment that are infused in the proposed Mental Health Act are critical. I will leave it there for now, because there are other people I am sure you want to hear from.

Marsha De Cordova: Stephani, is there anything you would like to add that has not already been suggested by both Jacqui and Maurice?

Professor Stephani Hatch: We need to emphasise the need not only for structural change but for cultural change right across the board, not only with regards to the experience of service users, families and carers, but attending to the inequalities facing our mental health workforce. We really need more comprehensive and better-quality data and monitoring on mental health provision right across the system, including in social care. We need a greater emphasis on addressing known racial and ethnic inequalities at structural levels, in education, clinical placements and training, as well as in the design of new services and the redesign of existing services. I would like to add those two points.

Just to reiterate, we need something that goes a little further with a more explicit action plan approach, one that really does involve intervening at earlier phases, not just when someone is in contact with services. That access to psychological therapies must begin as an option prior to any first sign of mental health crisis. We would like to see that on offer, because time and time again from that data generated through a number of research studies we hear that medication is more likely to be offered than psychological therapies, despite the fact that we have such wide availability of IAPT—improving access to psychological therapies—treatments.

Beverley Stephens: I would echo all of that. It would be remiss of me not to say that the Act goes some way to seeing improvement. I agree with Jacqui that it is a real opportunity. We can, and we have to, go further.

Our communities, whether they be in-patients, carers or service users, have no trust in the system as it stands. Trust is at rock bottom. As Jacqui has just reported, we are working with the mental health organisation in the Midlands to look at the patient and carer race equality framework, which sits alongside the Act. It is going to be a way of pulling data and holding individuals and organisations to account. That is not yet happening across the whole country.

We need something that works alongside and in tandem with the Act. As it stands, I have no problem with the Act, and we will go through that, but the reality is that implementation will be a very different scenario.

Lily Huggins: I largely agree with everything the other panellists have said. There are a few areas that are welcomed, such as the removal of autism as a mental disorder and the replacement of nominated persons.

There are some functional elements in the legislation that could be amended to maximise impact. One that we touched on briefly is ensuring that the principles of the Mental Health Act are displayed more prominently. That goal of centring patients in decision-making is a signal to mental health providers as well. We touched on statutory ACDs—advanced care documents. Having advocacy provision to support people with the planning of their advanced care documents would be really effective. We would also like to see the expansion of advocacy entitlements to include people at risk of detention or open to community mental health trusts. That is also stepping into a more preventive model.

There is a larger conversation to be had about the removal of criminal justice routes to mental health services, replacing them with holistic crisis services and so on. The other area we would consider as an advocacy provider is that, if CTOs are going to be part of the legislation, which we agree they should not be, people on CTOs are part of an opt-out advocacy referral process, and that the notification from the responsible person to inform advocacy providers about people accessing their services is meaningful and clear. Those would be our additional amendments to that.

Q44 **Dr Rosena Allin-Khan:** I want to ask a very honest question, and I would really appreciate your candour at this time. I have worked in the space of mental health for many years, and I understand how much of the disparity experienced by and large by our black communities, but also by other minority groups, is in part down to existing structures in the mental health system and to wider, structural racism that exists in society. How much can be improved through what we can do with this Bill, and how much of the disparity and treatment that remain will be as a result of what we see ingrained in our societies? Can we do more to address that in the scope of this Bill?

Maurice Mcleod: You are right. As I said earlier, because of the way structural racism works and how it ingrains itself into every institution in our country, you cannot fix it on one issue without taking into account the others. We could do a brilliant job; I could write the Mental Health Act and make it exactly what an anti-racist might want it to be, but it still would not have all the tricks it needs because of the way it interacts with social care, housing, the criminal justice system and all the other elements of our society that still have a problem.

You are right: you cannot completely remove the problems that lead to the disproportionality that we are talking about. I am not sitting here going, “Oh my God, there’s no improvement”. I am not saying that at all, but we can make sure that those anti-racist principles are properly embedded, which is why we make the point about them being a principle throughout this draft.

As was said earlier, it is not just about the guidance. It is also about the culture that comes from that. As we know, that takes longer to embed and to work through, but if we have those two things working in tandem, we can make improvements. First off, we should keep in mind that the overarching aim is to acknowledge that there is a problem, which is sometimes a challenge. If, in everything we do, we are aware of that problem, we keep coming back to it, and we ask, “What is this thing we are doing here doing about disproportionality and the structures that we know impact on certain communities?”, we are at least going in the right

direction. I am not at all sitting here saying that this is not going in the right direction. It is, but I am always going to say that we should go further and do more. That is my role.

Professor Stephani Hatch: I just wanted to bring us back to a basic issue, which is that there has been a lack of acknowledgement of the exposure to racism and discrimination. For many of us, racism and discrimination experiences have a life course narrative, one that we experience first on going into the educational system and then right across social institutions.

We quite often hear, particularly in our qualitative research, the lived experience of engaging with mental health services in many different ways, and not one time someone asking about this very pervasive stressor and source of adversity, which not only occurs in your own experiences but has an impact on your mental health when witnessing racism and discrimination, as well as anticipating it. You avoid going into certain situations, taking up educational, training or work opportunities, or seeking help in the health services.

Our tackling inequalities and discrimination experiences study—TIDES—was based on a lot of national and local data in south-east London, which told us that these were very common experiences in mental health services, which could be addressed, and that we could focus in on the mechanisms through which these were taking place. We can start there and think about what training is being provided to mental health professionals, to both understand and deal with this in people's experiences.

I want to emphasise that this is also the experience among the workforce in mental health services. We really need to address that on both sides. Until we do, we will be faced with further regeneration and perpetuation of existing inequities.

Baroness Berridge: Could I just follow up on a specific issue here? The danger for us here is that we consider things in boxes—the ethnic minority experience and then LDA in another box. Do any of you have any experience of whether the disproportionality is showing itself through those who are detained and who have learning disabilities and autism? Much of the evidence has pointed to a risk of the overuse of the criminal justice system. Have you any experiences of that? About 2,000 people are detained at the moment in secure mental health units who are LDA and autism. How does that overlap with BAME?

Dr Jacqui Dyer: I am aware of that evidence and that the disparities of racialised groups with experience of LDA and autism is an ongoing issue. I am glad that you brought attention to that.

Q45 **Dr Dan Poulter:** Maurice, you mentioned that you cannot remove the issues that we have been hearing about from the wider context of society, but perhaps particularly the health and care system. What wider non-legislative changes to the health and social care system are needed to make the proposed changes in the draft Bill effective?

Maurice Mcleod: The obvious one is resource. The funds need to be there to do the things that we say we will do. We are looking for people to have more access to advocacy. We talk about that and about culturally specific advocacy. If the funds are not made available so that that can be delivered, and delivered well, without cutting corners, that will have a major negative impact on the efficacy of what is being suggested.

It often comes down to resources and prioritising what goes where. The other stuff is more cultural. In some ways, that might be harder to shift. One of the stated reasons why black people have had such bad outcomes when dealing with the mental health system is this perception of danger—someone’s perception when they look at somebody black, especially a guy. Sadly, there is a built-in perception that they are more of a threat. There is untold evidence on this: where police officers, for instance, are asked to describe someone they have just seen, they will often say a black guy is bigger and stronger than they actually are, because of structural racism, thousands of years of history and whatever. We can write books on that.

Often, in society, we will say that we need more freedom to look at individual cases, we need to be more subjective, we need to give the experts a chance to bring their expertise into a situation. That makes sense, but when there is a risk of that subjectivity bringing in those preconceptions about how black people may be, we find that that always has a skewed effect on the outcomes.

It is the thing I said earlier. Where you have power and the chance for prejudice mixed in, that is where structural racism has its really big impacts, because someone who has the power to affect your life is looking at you in a way that may not be fair and balanced, so the outcomes end up bad. That is the cultural stuff that you need to change. How that happens is a much longer process.

Dr Dan Poulter: Do any of our panellists want to talk more about the health and care system and what broader changes might be helpful in making the changes that are in the Bill more effective?

Beverley Stephens: We in the Midlands are looking at the power that Maurice talked about. That is a significant issue. I have sat with a carer, their loved one and a clinician and watched how the use of power by the clinician, whether or not it be unconscious, dismantles any hope that the family has of their loved one coming out of hospital or influencing a change in treatment.

In Birmingham, we are looking at how to bring about more co-design, co-production and involvement in system change, working with statutory organisations to lift the lid on some of this in a collegiate, non-adversarial way. Then we can dismantle some of the racist behaviours and working practices that often the organisation does not even know it is party to.

Dr Jacqui Dyer: In terms of the wider health and social care system, at the end of the day it is all interdependent. The mental health service provision operates at that level where people are in crisis; the Act applies when people are in crisis and at risk of harm to themselves or others. That particular system is unsustainable in terms of financial cost, where you are catering for people at the point of crisis and that is the only service provision available.

That has implications for what is done more widely in the health and social care system and what is done differently, both to intervene earlier and to prevent people ending up at that crisis point. We can change the structure from being top-heavy, like a pyramid, to one where people receive support and care in a culturally appropriate way much earlier in their journey. This means that there is less traffic into that more acute state, where the risk of having a

terrible experience is heightened for racialised communities—black, Asian and minority ethnic communities.

To what Beverley was saying, a way for health and social care systems to create different co-designed clinical care pathways along that spectrum is urgently needed. That is some of the work that we are attending to in South London and Maudsley mental health trust, where we are co-creating, between service users, carers, community members, the workforce and commissioners, alternative, culturally appropriate clinical care pathways.

I would just like to reignite something Maurice referred to about opportunities to infuse an anti-racist, anti-discriminatory, anti-oppressive approach in mental health service provision, recognising that the power to abuse is most pertinent in that context, as many of you will have seen with the recent Edenfield issue. We have to keep that front and centre, because while we were able to see visually, in the same way as we saw George Floyd's situation, what happened in Edenfield to people at their most vulnerable, and the abuse that took place in that setting, that has been going on for decades in relation to the black experience, particularly in secure mental health settings.

We have to change the trajectory, essentially, of people ending up in these detained spaces, and the cost to the public purse, by investing in earlier intervention and prevention. There is an opportunity for integrated care systems, integrated care boards and integrated care partnerships to work in a co-productive way with the communities and populations they are serving, particularly when there are high costs being paid for black bodies, racialised bodies, in detention or exclusion all day. We have to attend to this reality, as Stephani was talking about, by having much more attention to data, both qualitative and quantitative, and using it in an intelligent way to respond to what is, not what we imagine is.

Professor Stephani Hatch: I just wanted to emphasise the need for better monitoring and clearer mechanisms for patient and carer feedback. Some of this is currently in play with the patient and carer race equality framework. That needs to be more widely adopted across the system, as well as looking at the organisational competencies and making it very clear and transparent about where the accountability lies.

Lily Huggins: I would echo what the other panellists have said. We also need to look at resourcing and early intervention. Person-centred approaches need time and resource, have to be culturally appropriate, and need to be co-designed.

There is a range of training that would be suitable for health and social care providers on the use of the Mental Capacity Act versus the Mental Health Act, structural racism, culturally appropriate services and working with people with autism. This training has to be implemented in practice as well.

I would echo comments on training decision-makers in understanding power imbalances, different cultures and cultural presentations that are significant in clinical decisions. I would also echo an increase in preventive community and primary services, and advocacy access in regard to that.

One other area that is significant outside the legislative framework is appropriate settings so that when people are detained under the Act, where they are is suitable for them. It can be holistic, culturally appropriate and person-centred. We need to end dormitory wards. We

need to ensure that patients have access to phones and laptops to contact and connect to their community and advocates. We need suitable environments for people with autism and learning disabilities.

Dr Dan Poulter: On the wider health and care system, the Government have promised a health inequalities White Paper, which I think is now in doubt or could be scrapped. Is that piece of work important in looking at the sociocultural issues that need to be addressed as part of the wider health and care system?

Dr Jacqui Dyer: Yes. Adding to what Stephani emphasised, it is a good model to integrate into the wider health and social care agenda in terms of accountability, transparency and monitoring. Something similar to the patient and carer race equality framework could be spread throughout the health and social care system, using that health inequalities White Paper as a lever. PCREF, in a sense, could be embedded within the wider health and social care system via the health inequalities White Paper.

That is correct. We have to understand these issues systemically. Many of the health issues that arise are symptomatic of the wider systemic and structural inequalities and racism experienced by these communities—our families, neighbours and friends. Not to understanding that means thinking that attending to those disparities in one place lets everybody off the hook, when it is a systemic problem, with all components playing a role.

Dr Dan Poulter: Everyone has been nodding about the importance of the health inequalities White Paper emerging from the Government in this context.

Beverley Stephens: I do not know whether it is a good place to mention this. We have the mental health transformation programmes going on, certainly in my area, with the ICBs and the ICSs. It is a real opportunity, bringing in the PCREF and some work on dismantling poor systems. Here are other opportunities for the voluntary sector and community experts to work together in co-design and co-production.

There is a lot of good stuff going on and we need to knit that together across the system, working with the Mental Health Act at the same time.

Dr Dan Poulter: Jacqui mentioned, and it was mentioned in the evidence, the importance of data monitoring and reporting in this area. What data monitoring is really important, and what would you prioritise as something that needs to be done?

The Chair: This is really important, because if we understand how everything interconnects properly through digitisation, that can make a really significant difference.

Dr Jacqui Dyer: This is wonderful. Having improved responsibility for collection of the data, with an equalities lens, using all the protected characteristics, is critical across all components of the health and social care system. We are working on improving the implementation of the Mental Health Act by protected characteristics. That is also in relation to the Mental Health Units (Use of Force) Act, which has a bidirectional relationship with the implementation of the Act, lifting up the visibility of diverse experience from protected characteristics. In a

cross-government dimension, these health inequalities operate as a result of inequalities across the rest of the lived experience, in housing, employment, education, et cetera.

One key area that is so often off the table is the experience of access to welfare transfers, ie the data collected by the DWP. That has a significant role to play here. If many racialised communities are excluded from employment, education or other means to survive and thrive, they are reliant on welfare benefits and are having a differential experience there.

The ingredients are there to increase the risk of poor mental health. You cannot just attend to the implementation of the Act. You have to attend to different components of the system. Understanding that data better will enable us to better respond in intelligent ways, with interventions that support changing the trajectory of mental health, health disparities and other disparities.

The Chair: In that sense, this could be quite financially effective in the longer term, because you are talking about joining everything up. As an ex-Minister at the DWP, I know exactly what you are talking about when you talk about the need to connect people's whole life experiences.

Q46 **Baroness McIntosh of Hudnall:** Could I ask a very short question specifically on this point? This is really clear. Theory and practice need to be joined up, because the theory is very clear, but the practice appears to be quite a long way away from it. How far away is it, in your estimation, and what are the barriers?

Professor Stephani Hatch: I have a clear example of where we can make some immediate improvements. We have been doing work in the advancing mental health equalities task force, where I chair the data quality and research subgroup. I am working closely with NHS Digital on something very basic, which is the guidance on improving the collection of information on all protected characteristic for monitoring inequalities.

It is far from where we should be on a very basic level. I believe that the inequalities we have identified are grossly underestimated. The question earlier about the intersection of disability and learning difficulties, alongside race and ethnicity, is almost impossible to answer given the information available in the mental health services dataset in particular. There is lots of work to be done there. It is not only that dataset but IAPT data. These are national datasets that we rely heavily on. At a very basic level, we need better engagement and training for all individuals responsible for entering these data into records.

With regards to a wider population survey and understanding population mental health, we need more emphasis on an England-wide promotion of the upcoming data collection for the adult psychiatric morbidity survey. For a number of years, we have been lobbying to include an ethnicity boost, and we will finally have one in 2023. This is particularly important because we have not been able to disaggregate data of ethnic minoritised groups. The data collected that allowed us to do that was from nearly 20 years ago. We are really behind in understanding the heterogeneity of experience among these racial and ethnic minoritised groups in mental health and mental health services.

Finally, going back to that data linkage point, we need better utilisation of the anonymised mental health electronic health records, such as the CRIS system at the Maudsley Biomedical Research Centre that is funded by NIHR. There are others around the country, but,

importantly, they are linked to other datasets. At the Maudsley BRC, for example, we have a linkage between secondary mental health service data and DWP data that is held. We have linkages between primary care, secondary mental health care and hospital episodes statistics, and between CAMHS datasets and the national pupil database.

When we think about what needs to be included in this White Paper, it is not only what is existing; it is what questions have yet to be answered. Finally, could we please also attend to the difficulties in getting these linked datasets? They are crucial in moving us forward and there are a lot of existing barriers to making these happen.

The Chair: This is extremely helpful.

Q47 **Lord Bradley:** I am really interested in both the data collection and the integrated care boards and integrated care system agenda, which Jacqui and others have touched upon. In terms of data collection, one of the key pathways is between health and social care and the criminal justice system. Those linkages and that data, perhaps patient records collected at GP level, can be another vehicle to gather the information you are seeking.

It may be too early to say, but do you think that ICBs at a local level, in spite of not having White Papers around health and inequality agendas, are engaging with you on this agenda? Is the dedicated mental health person on the ICB board playing their role in ensuring this is at the forefront of their first round of commissioning arrangements, so that the mental health, learning disabilities, autism and criminal justice system voice is very loud at the start of the process?

Dr Jacqui Dyer: It is not yet loud enough in relation to the disparities, differential experience and mental health inequities experienced by racialised groups, as well as multiple morbidities and the criminal justice element. It has the opportunity to grapple with and be more attuned to that, but I do not see the structures as evolving as yet to attend to that very real challenge, particularly when you think about what is going down in areas where there are high populations of racialised groups and overrepresentations therein.

That conversation is not happening as rigorously as it needs to. I would like to see the PCREF and the race equity and accountability framework at that level of the ICB and the ICP. That would drive through attention to this agenda. It could transform how they operate at that regional level. You are on the right track there, but I am saying it is not as evolved as it needs to be at this moment.

Lord Bradley: Thanks very much. That is very helpful.

Q48 **Baroness Hollins:** I was thinking about the non-legislative changes that might make a difference and whether there are delayed discharges because of both a lack of understanding of the person who has arrived in hospital and the chronology of events that led to that, and then perhaps the discharge pathway not being clear. Perhaps there are some opportunities for data collection through the discharge pathway, which I am kind of exploring with another hat on, but I just wondered how it might relate to the experiences you are all talking about today.

Beverley Stephens: The data is highly important, but we also need places and services for people who are discharged to go to. I was recently involved in a workshop with some individuals in secure care. The whole conversation about their need and why they ended up revolving and coming back into care was often about the primary care services and the community services that are or are not available to them, and how communities and other infrastructure respond to them.

Although data is important, again, for me, it is always about aligning the two. You cannot do one without the other, or it will become very protracted and will take us many years more.

Dr Jacqui Dyer: I agree. We need qualitative and quantitative data to inform a more intelligent conversation about where to apply and commission resources in a way that serves the best interests of these vulnerable populations. The issue about discharge or Section 117 aftercare needs to be interrogated, because if the data is showing repeat admissions, particularly for people of racialised groups, it demonstrates an absence of appropriate services present within the community to hold, contain and support the person in their recovery and their life. It can be more bespoke and tailored to the reality of their chronology and life journey if we understand and respond better to structural racism and inequities.

Beverley touched on the lived experience, and I would like to bring in my own. It is good to talk abstractly, but it is also good to talk from a lived experience perspective. I do not know whether any of you know, but I have been a carer for three and a half decades. I have three siblings with severe mental illness. I just realised the other day that, for the past 30-odd years, I have been working through my lived experience in an interaction with the Mental Health Act since 1983.

I was like, “Wow, that is one long piece of journey”. I have not seen, for any of my siblings, any mental health service of a fruitful nature provision really responding to their needs, which, to cut a long story short, has led to my siblings not getting their needs met. I can clearly identify a system that has failed to look at them as a whole person, without the services in place to look after them. They have been reduced to medication.

My family, with no advocacy, is battling with mental health service provision not to give them such heavy doses of medication. That has been the battle. You are battling with these reductionist mental health models, in which all that you warrant is high levels of medication, in the absence of other service provision to support them. Two of my siblings have now passed at an early age: one at the age of 41, having spent 20 years with mental health service provision, and the other a few days after George Floyd, at the age of 54, having spent 35 years with mental health service provision. For me, the urgency of getting this right is palpable, because that has been my lived experience. It has impacted on my own mental health, because of my anxiety about whether mental health service provision will support my other sibling to live a long life or whether she will also die early.

That is partly to do with the mental health service provision not treating the person as a whole person—their mental health and their physical health issues. You see higher morbidity rates for people with severe mental illness and they die earlier than their counterparts. The physical health component within this equation also needs to be considered. The risks of death are real.

Baroness Berridge: Thank you so much, Jacqui, for grounding us in your experience, because I am about to ask a data question—sorry—of Stephani. Going back to what you said about data and what I asked previously about LDA and BAME, am I right in concluding from what you said that we would not be able to lift that data from the current datasets? I ask, because we are being asked to legislate. We are being asked to take LDA out of the Act, given the risks around the criminal justice system. Do we have the dataset to tell us, as legislators, which people currently in secure units are LDA and which are BAME? How do I assess that risk unless I know the population cohort that this legislation is about to affect?

Professor Stephani Hatch: I cannot remember the exact figures offhand, but the data on who is LDA will be far from complete. If we just take ethnicity, it is improving but it is also far from complete. There is also quite a bit of work looking at the accuracy of these data and how the ethnicity will change across datasets. That has to do with what I suggested earlier: the poor training and engagement for those who are entering the data.

Imagine this: even for ethnicity, as a basic question to enter into your health records, we still have those entering the data—mental health professionals and other administrative staff—saying that they feel uncomfortable asking the question. If they are not even comfortable asking, “What’s your ethnicity?”, imagine how comfortable they must be in documenting or understanding LDA or capturing disability as a protected characteristic. This is basic information, as I have said, that needs to be improved.

Maurice Mcleod: There are places where that data just is not available, for instance in mental health tribunals and sometimes when dealing with young people. This makes it incredibly hard. It is all very difficult when we are looking at how things are already, but if we are looking at new models—for instance, the ethnic minority health improvement projects—and new ways of trying to break down structural racism, without the data going in, how do we even know whether they are working? We have to be relentless in filling those gaps and making sure that stuff is available.

Baroness Berridge: You say that the data is not there for the tribunal. Do you mean for the composition of the actual tribunal—who the members are—or the people whose cases are coming to tribunal, or both?

Maurice Mcleod: I mean the people coming, so the cases of those who are coming and the outcomes.

Baroness Berridge: Okay. It is just another dataset that I have asked for and now I discover it does not exist.

Lily Huggins: Again, I would echo a lot of what the panellists are saying. I have been reflecting on what this looks like in practice, and I thought it would be helpful to give some of our experiences in providing advocacy. What we do see, and it has been discussed at previous committees, is an underdiagnosis of people with learning disabilities and autism. There is a lack of confidence in staff to accurately record this equalities data, both whether people have learning disabilities and autism, and how people identify in terms of their ethnic background.

We do see, and I am sure Stephani can speak much more eloquently to this than me, a bias by staff towards recording white British people. If a staff member sees someone that they perceive to be white British, they are more likely to record that person as white British. If they do not perceive that person to be white British, they are more likely to leave the box blank. This contributes to the lack of data that we have on people accessing our services.

It also comes from a lack of awareness from staff about why this is important, and a lack of confidence in having these conversations about people's ethnic background. Equalities monitoring is also perceived as an area that takes additional time, and we know from mental health staff that they do not have this time. They are underresourced and understaffed. One thing that gets pushed down the priority list, when staff are incredibly busy, is this effective data monitoring of inequality. I am not saying that that is good enough, but that is the reality of the pressures we are seeing in our mental health services.

Dr Jacqui Dyer: On the collection of data and the useful opportunity of the patient and carer race equality framework, we paid significant attention to the fact that high-quality data around the protected characteristics, including ethnicity, needs to be incorporated.

Part 1 of the framework is around leadership and governance, the legal and regulatory obligations around the Mental Health Act and the data therein, the Use of Force Act and the data therein, culturally appropriate advocacy and the data that arises from that, and the Equality Act and the public sector equality duty in terms of equality objectives. All of these are infused with bringing to the surface, in a transparent way, that data that we are referring to. That then serves as information to support you in service transformation, using your organisational competencies, which are within the PCREF framework.

Q49 Baroness McIntosh of Hudnall: This question is initially for you, Lily, because it is specifically about the pilot work you have been doing. Can you share any information you currently have about outcomes that would be helpful to us? I am going to tack on a few more questions that you can pick up, or other people can pick up for you.

The first is about the challenges of making culturally appropriate advocacy services widely available. You have a pilot and it will give you some information, but how can that be rolled out and what would be the challenges there? I think I know the answer to this question, but do you think the resources allocated in the impact assessment are sufficient? Finally, what would be the practical benefit, if any, of including culturally appropriate advocacy specifically in the draft Bill?

Pick off as much of that as you want to do, and we will pass the rest of it to other people, perhaps, to follow up.

Lily Huggins: Black Thrive is also a delivery partner in the culturally appropriate advocacy pilot for the DHSC. We delivered the DHSC's pilot service from November 2021 to June 2022. That was the duration of the pilot. It was about seven and a half months. We have submitted our report as written evidence, as well, for you to review afterwards.

The first thing we want to say about our pilot is that we delivered it in partnership. At Gaddum, we have been supporting and empowering people in a variety of ways for a long time. We have been providing the statutory IMHA service in Manchester. We teamed up with

our long-standing partners, African and Caribbean Mental Health Services. That organisation was founded in 1989 in response to the disproportionate number of young black people in Manchester being affected by the Act.

The partnership arrangement was, simply, that we would provide our expertise and our access to the in-patients that we are working with under IMHA, and African and Caribbean Mental Health Services would provide its expertise in culturally appropriate community advocacy. I am pleased to report we achieved significant positive outcomes with this service. We found that the majority of people reported that their advocate was able to meet their cultural needs; 64% to 83% reported that their advocate helped them have more say in their care and treatment; and 95% reported that, after accessing Gaddum's service, they had an increased propensity for self-advocacy.

We also found that a range of advocacy interventions were effective, but one-to-one was overall the most effective method. Those are some highlights for you. I can go into a few other details if you want.

Baroness McIntosh of Hudnall: You may have told us this and I may simply have forgotten, so forgive me. What is the size of the pilot you have conducted, in terms of the numbers of service users and of advocates? Were the advocates you brought into the process people whom you had to train, or were they previously trained and ready to go?

Lily Huggins: We worked with about 200 people through a range of methods. The advocates working on this project were a mix of qualified statutory independent mental health advocates—IMHAs—and community and cultural advocates employed by ACMHS. It was a skill-sharing experience and a collaborative approach.

The challenge with the pilot, with it being seven months, is that that is not sufficient time to train an advocate. Independent mental health advocates can take the level 4 qualification in independent advocacy, which usually takes a year or 18 months. We did not have time within this remit.

So that was our delivery model. We also made the decision that all the advocates on this pilot were people who identified as black, Asian or minority ethnic. They came from a range of professional backgrounds, but all of them could demonstrate that they provided culturally appropriate services. Would you like me to go on to the challenges? I think that was the next section of your question.

Baroness McIntosh of Hudnall: Yes. I will not interrupt again, I promise.

Lily Huggins: That is okay; it is important. I want to be clear, before I go into the challenges, that we have an abundance of good culturally appropriate advocates in our communities: friends, families and professionals. The big challenge we have is that it is not resourced. The advocates do not have the time and resource to adequately provide the advocacy that people are entitled to.

Jacqui shared her experience about being a carer and not being able to get support from advocates, either for herself or for her family. This is a significant area where advocacy needs to be funded. The culturally appropriate advocates that we have in our communities need

training in legislation and the role of statutory advocacy. We need to expand that understanding.

To be clear, in terms of statutory advocacy provision—IMHA—it is a relatively small number of people who serve in the areas. Consistent feedback that we get from our clients, even after we almost doubled our advocacy team with our culturally appropriate advocacy pilot, is that more people want more time with their advocate. To address the culturally appropriate needs of the individuals, to address systemic racism, to address these compounding issues that my colleagues have spoken about very eloquently, you need that time and commitment from an advocate.

There is also a perception that culturally appropriate advocacy does not require additional training. There is a perception that it is just the absence of being racist when, really, it is about being anti-racist, being culturally competent, being aware and being able to effectively address these issues. It takes time and genuine commitment in communities to reach this. It takes co-production. There is a lot more that goes into it than, perhaps, is perceived.

I know other panellists have discussed this, but advocacy services are often limited to their local authority areas, so continuity of care out of local authority area is an ongoing challenge. For a lot of our advocacy clients, it takes a long time to build that trust with an advocate. We do it in a lot of ways. One is that we are present on the wards, so they know that our service is there. When a patient moves, we have to move them out of area because of funding restrictions, so that is potentially a consideration.

Dr Jacqui Dyer: At Black Thrive Lambeth, we have experienced some of the challenges and successes of the pilot that Lily has outlined. They tally very well. I might emphasise the importance of robust training. We did, in Lambeth, a different training from what was offered, as well as that, so we could get to grips with what being discriminatory, anti-racist and anti-oppressive really looks like, and the different ways that it manifests itself in the patient's journey. We were emphasising that rights-based approach, but also, along the pathway, all the differential disparities that occur in the racialised experience, so that really surfaces.

Therefore, we get a better advocate response from that culturally appropriate lens because we are talking about the disparities that are experienced as a result of systemic racism, structural racism, oppression and discrimination. That is one element I want to build on and add to what Lily said.

Some of the outcomes are really amazing. If culturally appropriate advocacy is available prior to detention, we can operate to divert people from that pathway towards detention. Part of the review was about concern at the high levels of detention under the Mental Health Act. Culturally appropriate advocacy has the opportunity to divert people to other resources.

Of course, that needs resourcing in the way we discussed earlier, as a wider part of the health and social care system, but, nonetheless, that was what was also happening. Culturally appropriate peer support and people having alternative places to be, such as crisis houses or spaces of safety located in the communities, is critical.

The advocates who make up that workforce are also people who have lived experience of mental health and detention, and not only that, but a wide variety of people with a range of backgrounds.

We have also started seeing reduction of lengths of stay as a result of having advocacy to support people when they are detained. The challenges have been well articulated. Obviously, there is a resource issue as well.

Beverley Stephens: It is about illuminating the disparity in this area because, again, in the West Midlands and Birmingham we struggle for advocates. Quite often, service users and carers come to Catalyst 4 Change, for instance, for us to join them in a situation. This has just highlighted, listening to the excellent work that Gaddum is doing and that Jacqui is talking about, the disparity that is there. For me, this is an urgent need. Advocacy needs to be available to individuals across the pathway.

Lily Huggins: Exactly. Through the culturally appropriate advocacy pilot, we were able to informally work with people who were outside of the qualifying patient criteria for IMHA, including people who were at risk of detention. This is all preventive stuff. There were some fantastic outcomes in terms of being able to work with these groups and expand our advocacy provision. There are more details in the report.

Dr Jacqui Dyer: Finally, the other important use of advocates is as another source of data outside of that collected by the mental health minimum dataset. It is independent data that then contributes, under the PCREF, further intelligence to help improve services. It is critical. I remember somebody from the CQC saying that the most they learned about what was taking place in mental health hospitals during the Covid period was from the advocates.

Lily Huggins: I would agree with all of that.

The Chair: I gather you have given us a copy of the report, which is not yet published. Thank you very much, Lily.

Dr Jacqui Dyer: I hope that report is for all the pilots, so you should get that.

Q50 **Dr Ben Spencer:** Thank you so much for the evidence you have all given us so far. I know you have covered it in passing a few times, but I want to focus again on the provisions in the Bill to do what the review wants, what the Government want, what we all want: to reduce the number of people detained and the use of CTOs, particularly the disproportionality in people from black and minority ethnic backgrounds.

What we are talking about here are the detention criteria and the CTO changes in the Bill. Do you think they are going to achieve that purpose and, if not, what would you suggest is changed or tweaked?

Maurice Mcleod: On the CTOs, as I think I said earlier, our desire would be that they are removed completely. As I said, once you have that level of subjectivity and power, we fear that it is almost always going to be used in a disproportionate or discriminatory way, because we have not yet got to a place where those biases are not in society. The fact that they exist in society means that, when you give those powers to individuals, they are more likely to act in a biased way, because that is, sadly, ingrained in us. So we have concern about that.

We also feel that, more importantly, we are not seeing any evidence that CTOs do the job they are supposed to, which is to stop people from returning to hospital. We are not seeing, from evidence in other places where they are held, any implication that they actually do what they are intended to. As I just said, if they run the risk of embedding more discrimination, but are not even doing the task that it was hoped they would do, we would suggest other ways. We just do not think that they should be there at all.

So if you are asking, “Does it go far enough?”, we would say no, because they are still there. There are some moves to make them more accountable and shorter lasting. All of that sort of stuff is wonderful but, ultimately—this is not just the view of ROTA; this is with Mind as well, the mental health charity, which we have been working very closely with. We simply think that they are not really fixable. They should be taken away.

Dr Ben Spencer: Do you have any comments on the modified detention criteria?

Maurice Mcleod: No, I do not.

Dr Ben Spencer: That is nice and succinct.

Lily Huggins: The modified detention criteria go some way to reducing the number of people who will be detained. If that is not the pathway of care that people are receiving, they need to receive healthcare in other settings—primary, community and so on. To touch on CTOs, Gaddum is also of the view that they are not effective. There is considerable evidence on this. I believe there is a study ongoing at the University of Oxford, and there was one from Cambridge University in 2018. In practice, CTOs are inconsistently used and most would state that they do not use CTOs unless there are exceptional circumstances, anyway.

We can infer from the current statistics we have that minority racialised groups, and black people in particular, are perceived as needing additional restrictive measures by approved mental health professionals. Whether that language is “dangerous” or “risk of harm”, that perception is still there and needs additional inquiry. If CTOs continue to be included in the Bill, we would like to see referral to advocacy for people on CTOs that follows the opt-out system, because we know that, across the country, referrals for people on CTOs are incredibly low. One element of our culturally appropriate advocacy pilot was engagement, to try to get more people on CTOs access to advocacy, and it was incredibly challenging. We would like to firm up that right, if the CTOs are included.

Dr Ben Spencer: Lily, I might ask you a follow-up question on what you are saying and, apologies, I did not quite hear the start of your answer to me. One driver of the change in the detention criteria was that, because of the focus on risk and the biases that Maurice spoke of earlier, they are not used in a very cogent way and, in effect, disproportionately affect people from black and minority ethnic backgrounds. The changes were to try to adjust that and stop that happening. Do you see that or do you not?

Lily Huggins: It goes some way but, ultimately, as the panellists have discussed, we need to be addressing these wider systemic perceptions within our health and social care system, because any legislation, working within a system wherein there is structural racism and these perceptions, will be misapplied, unfortunately.

An area that we have not touched on here is the provision of primary early intervention community mental health services. What we know is that, for people who are black, Asian and minority ethnic, the mental health services in their areas tend to be less adequate. This is a contributing factor. Outside of the detention criteria in the legislation, there are bigger elements at hand that feed into it. By the time a person is being reviewed for detention, they have already experienced less adequate mental health provision.

Dr Dan Poulter: Lily, you are making almost a broader point, perhaps, about whether CTOs are effective or desirable in themselves, regardless of the issues we are actually talking about. We are talking here about the disproportionate use of CTOs, with black men in particular, and their inconsistency of use, but your points almost suggest that you would favour scrapping CTOs entirely because of that lack of consistency.

Lily Huggins: Yes, and the data shows that the readmission rates for people on CTOs are the same as people not on CTOs. I can send you some further data on this. I do not know whether the University of Oxford trial is ongoing or has recently wrapped, but the mechanism of a CTO to ensure that people are supported and monitored, and that their readmission is low, is not effective. You do not see any significant difference in the general population.

There is a perception, perhaps—again, I am an advocate; I am not an approved mental health professional—that they like to keep that CTO as an option. What we see, and I am sure the panellists can talk about this as well, is that CTOs are not effective, full stop, in what they do. Then, when they are applied, they are applied disproportionately to black people.

The perception that CTOs are disproportionately applied is shared by patient groups. Patients on wards know that black people on the wards are more likely to be placed on CTOs. There is a perception of this. Patients say to us, “We know that we’re going to be on this ward longer than white people on this ward”. I will leave it at that, and I can include more detail on that, if you want.

Dr Dan Poulter: With Baroness Buscombe’s indulgence, it would be very helpful to have that. You seem to be, effectively, saying that this is just a bad piece of law. That seems to be what you are suggesting: generally, the evidence suggests that CTOs are not good and do not work very well.

Lily Huggins: Yes, it is.

Dr Jacqui Dyer: I would like to have a different way of looking at the same point. In whose interest are the CTOs? Whose interest do they serve? If the evidence is showing that they are disproportionately applied to certain communities, what does that say about the CTO? That is one lens to look at it. There is an argument, for me, about why it is there.

If the criteria about the decision-making on a CTO are changing and the responsibility is on the clinician, or whoever wants to apply the CTO, to prove why the CTO needs to be applied, that takes us in a slightly different direction, rather than the service user or the patient having to prove why they should come off the CTO. Those detention criteria are slightly different.

However, the people who make the decision about somebody being on a CTO are still left with the same mindset as those who are enabling an overrepresentation of black bodies, which is 10 times the rate of their white counterparts on CTOs.



Dr Ben Spencer: Apologies if I have got the wrong end of the stick here. Your evidence on CTOs has been very powerful and clear. Going back to the detention criteria, it was my understanding that one of the real drivers for changing it was to try to reduce the disproportionality. Is it the case, then, from the people who are giving evidence, that you think it is probably not going to change that or you are neutral on it, or do you think it really will move the needle of the disproportionate application of the Mental Health Act?

That silence is an interesting response in itself.

Dr Jacqui Dyer: I am not fond of this one at all. I do not see the value of this particular lever because, whether or not there are reduced restrictions around it, the thinking to determine whether somebody is on a CTO will still be from the same mindset that leads to disproportionality at present. The disproportionality in a sense, for me, will still be present.

Going back to the earlier points, what is absent is appropriate and sufficiently resourced infrastructure, within a wider community mental health infrastructure, for prevention and early intervention, to support people when they are discharged and when they are in aftercare, so there is no need for this CTO, because people are getting their needs met.

Dr Ben Spencer: It might be useful for our written transcript of this that, when you were making those two points, pretty much everyone who is giving evidence was nodding along in support.

Q51 **Dr Rosena Allin-Khan:** Thank you, everyone. The independent review did not recommend the abolition of CTOs. The final review paper stated, “During the course of the review, we have become convinced that there are some service users for whom, despite our doubts, the CTO does play a constructive role. For these reasons, we do not propose their abolition at this stage”.

However, none of the organisations we have heard from, either represented today or before today, has supported the continuation of the use of CTOs. I would like to know for which groups and which people the reviewers could possibly think the CTO would play a constructive role, which would have been their reason for not abolishing them altogether.

Lily Huggins: I am not sure, but I imagine that the people who were asked about this were approved mental health professionals. I cannot talk on behalf of the whole advocacy sector, but advocates, as an independent body in this, are also generally of the view that CTOs should be removed.

Dr Jacqui Dyer: I would agree on the position of professionals rather than service users, patients and carers.

Dr Rosena Allin-Khan: The EHRC suggested potentially wording it as “a new duty in the Bill to require local mental health trusts to explain overall rates of use of CTOs and take action to address disparities”, and recommended an increase of transparency and accountability. I would like to know what possibility there is for us in this Bill to remove them altogether. If we cannot, what can we do to really crack down on the

disproportionate use? Black people are 10 times more likely to be placed on one than their white counterparts. We have heard everything today, we have heard everything previously, and we know that the advocacy sector is against it, so what are our options?

Beverley Stephens: If you are going to continue using them, there needs to be greater transparency in how they are finally agreed. They cannot be agreed with one clinician. For me, it would need to be, as in the acute sector, some sort of multidisciplinary approach, because I feel strongly that it is a power tool that the clinician uses. Again, I am going to be gentle and say “unconsciously”, with unconscious bias, but I am not always sure, from the experiences I have had when I have sat with a clinician and the service user.

Lily Huggins: One way of looking at this is to ask when a CTO would be applied. It would be applied when it is the least restrictive option for the individual. That is, in principle, what the purpose of it is. I imagine an example of where CTOs are deemed to be effective being when someone can leave hospital, which is more restrictive, to be in the community, supported on a CTO.

Perhaps we need to be looking at the fact that these discharge placements are not suitable and have to be reinforced with a CTO, but wraparound support in terms of mental health provision is not adequate in its standing that there has to be a coercive measure and that the CTO has to be implemented. That would be my suggestion—the greater the community support, the less need for the CTO. It would be surplus to requirements.

Dr Rosena Allin-Khan: My original point still stands. What power do we have as a committee, given everything that we are hearing, to say, “Actually, we don’t like them”?

The Chair: That is something for us to then develop in our thinking. We can also put the question to those—

Dr Rosena Allin-Khan: Forgive my ignorance. I am just asking.

The Chair: No, it is all extremely helpful, but we can work on that as a committee as we continue with our deliberations. This is all extremely helpful.

Dr Jacqui Dyer: On that point, it is in your remit to consider your view on that, and we would look for it to be favourable in that direction.

If it is continued in the way, shape or form that is proposed, it needs to be made explicit and transparent, as part of the data collection within part 1 of the PCREF, how the Mental Health Act is implemented according to protected characteristics, including ethnicity, and what that racialised lens of the CTO looks like. Under Sections 2, 3 and 4, and all the sections including Section 117, what does this look like in terms of each of the protected characteristics?

That data will be transparent and public facing to the communities and the populations that are being served, so that lens is there in terms of accountability about what is happening, and the appropriate challenge can happen from communities and the VCS: “Well, that data’s not

changing. How are you going to work with those to help change that?” That is one route, but my preference is that that data is not there in relation to CTOs, because we have other systems in place that will cater for the needs of communities.

Q52 Baroness Berridge: We have heard that statutory advance choice documents, which were in the review but are not currently in the draft Bill, would improve patient choices and outcomes, particularly for minority groups. Do you think that they should be statutory and, if yes, why?

Dr Jacqui Dyer: I do. I do not even understand why they were removed, to be quite frank, because this is about rebalancing the choice and autonomy of service users and patients. If we take away this other route of rebalancing the power differential between them and the services, it is extremely disempowering and does not align with what I understand around human rights, dignity and respect, which are principles that I am sure we are trying to infuse within this Act. I do not understand the arguments as to why this would not be present.

Baroness Berridge: You said that you did not understand why they are not there. You are the only person, I believe, who was on the review co-chairing a group. There were lots of non-legislative recommendations, which are very important. You see the review, which goes to the White Paper response, and now we have a draft Bill that, on its face, besides CTOs, does not really talk about the issues from the beginning that began this process. Can you give us some insight into how we ended up with, basically, very few clear legislative options in the Bill?

Dr Jacqui Dyer: I am not privy to the whole of that process that led from what we proposed as a review to the final proposal. I would be advocating for elements such as this around rights, choice, dignity and respect to be present in the Bill. This is one really powerful manifestation of that, which should be included within the legislation. I do not understand any alternative argument to that.

Baroness Berridge: Does anybody have a different view from Jacqui or do you all think they should be in the Bill?

Lily Huggins: I agree that they should be in the Bill. It would support people, and especially those with more complex needs, if they had an advocate to support them to make their advanced care document as well.

Beverley Stephens: For me, that is a no-brainer. I cannot understand, like Jacqui, why—

Baroness Berridge: We are going to hear from the review people, and maybe that has helped us to know what to ask them.

The Chair: Maurice, you mentioned the use of advance choice documents or joint crisis plans in your written evidence as being cost effective for black and ethnic minority groups. Could you just expand on this?

Maurice Mcleod: Our thinking, along with Mind, is that, if a patient has these ACDs, they are much more likely to be thinking in advance. They are much more likely to get early intervention. They are much more likely to, I hope, get the resources, support and whatever they might need as they go along the process and therefore much less likely, I hope, to enter

the mental health service through the criminal justice system or through other unpleasant means.

It encourages early intervention as well, but there is something more about empowering the individual to feel like they are having more of a say, to feel like they are going to be listened to, and to know that, when their records are looked at, their views will be taken into account.

The Chair: So they are part of the process.

Maurice Mcleod: Absolutely, yes, making sure that they have agency.

Dr Jacqui Dyer: That is right. We must not lose track, in creating those advance choice documents, of how important it is for advocacy, particularly culturally appropriate advocacy, to support that individual to be able to access. We have to put some of the component parts together, because creating an advance choice document with your clinician is not within the system.

An independent advocate supporting you to create your advance choice document is something that is intrinsically empowering in the way that Maurice states, and is especially important when you think about racialised communities' experience of disparities, being reduced to medication, essentially, and the lack of access to psychological therapy.

Q53 Dr Ben Spencer: Before we finish off, I just wanted to ask the panel about a slightly different topic. We have heard a lot about the Mental Health Act and how that can be and has been disproportionately applied to people from black, minority and ethnic backgrounds. Is there any evidence that the Mental Capacity Act also suffers from that same problem? Is there a concern about the use of the Mental Capacity Act in that regard?

Lily Huggins: There are many other people who could probably talk about this much more eloquently. From what we experience through our services, the purposes of these two Acts are quite different. Under the Mental Capacity Act, you have specific decisions being made when you are being deprived of your liberty in your best interests. The majority of people impacted by the Mental Capacity Act are older people, because it is related to age-related illnesses such as dementia. I am speaking generally, of course.

One of the challenges with the Mental Health Act, as I think a few people would agree, is that, in not all but many cases, it is harder to appeal the Mental Health Act. You can be moved under the Mental Health Act. The place you are resident can be moved under Section 3. That is not the case under DoLS. There are different powers within these Acts, in that they serve defined purposes. It is not something that we are currently aware of.

However, that is not to say that people who are subject to the Mental Capacity Act and going through best interest meetings, best interest decisions and so on do not experience racism or barriers, or do not have a need for culturally appropriate advocacy, but it is not something perhaps as significant that we have seen in practice.

The Chair: Maurice, did you want to come in?

Maurice Mcleod: It is only to admit my complete ignorance of the capacity Act, so no.

Baroness McIntosh of Hudnall: I just wanted to go back to the advance choice document issue. The theory behind this—and you can see evidence of it in other areas—is that you make your choices at a time when you are not in crisis. In this respect, it has some read-across to the Mental Capacity Act, because the provision of LPAs is not the same, but there is a similarity in that you make provision for what you want to have happen when you lose capacity to make that decision for yourself.

So my question to you about ACDs is this. If somebody has made an advance choice and there is a document, who knows about the document? Who has access to it? The nature of crisis is that it happens when you are not expecting it, at an inconvenient time, or when the people you would like to be able to see are not available or you are not in the right place. How do you ensure that advance choice documents are accessed appropriately, at a moment when somebody may wish to see them implemented, but is not personally in a position to ensure that they are? Does that make sense?

Well, that stopped everybody in their tracks. If there is not an answer, please write to us.

Dr Jacqui Dyer: Surely, if as part of the process of implementing the Mental Health Act you are required to consider, bring into the equation and the decision-making process, and pay optimal attention to the advance choice directive, it is a requirement.

Baroness McIntosh of Hudnall: I completely understand the theory of it. I am really talking about practicality. I am talking about what happens in the moment and how you ensure that the decision you have made can be implemented when you may not be dealing with, as it were, the co-creators of that document, who might be your own clinician or advocate. This issue is about how people get access to data.

Dr Jacqui Dyer: It is about the health records and the records that follow the client. It is about that data and information being present on their—

Baroness McIntosh of Hudnall: What I am saying is that it is not always so.

Dr Jacqui Dyer: Yes, you are right.

Beverley Stephens: We have not talked very much about the role of a carer or parent of an adult. Jacqui eloquently gave her story and her role with lived experience. The role of that individual who is caring for someone has a significant part in this aspect as well. Quite often, they experience isolation when they ask questions about their loved one. They are clouded by confidentiality, where they are not able to gain information, and yet they will possibly be looking after that individual after they have come out of hospital and ongoing, as they go on their psychiatric journey.

This is an area where we should be considering the carer role—a mother, a father or a sibling—around how they can support the advanced decision process for that individual.

Dr Jacqui Dyer: That is right. There is an evolution of that in terms of the nominated person, because the family member might be the source of the issue. The nominated person is critical, and you have identified the range of people who that could be—and so is the advocate in

supporting the nominated person, as is the individual, in making sure that the advance choice document is implemented. It needs to be a wraparound from various elements to make sure that that is what is following the patient journey.

The Chair: The point you have just made, Beverley and Jacqui, segues quite well to the last question, which is on workforce diversity.

Q54 **Dr Dan Poulter:** Workforce diversity has also been identified, and a number of you have touched upon that, as a key area in improving culturally appropriate support. How do you feel that the legislation specifically could support increased workforce diversity?

Maurice Mcleod: Workforce issues and workforce diversity are a challenge across everything. One of the things that would make things easier is removing some of the barriers for people from minority communities and maybe different incomes entering the system. In 2017, the number of student nurses entering higher education dropped by 11%, which was when bursaries were dropped—so there were things there to make it easier for people from different economic backgrounds to get into the system. If those are being removed, you are creating a challenge there.

It is more than just money, though. It is more than just cash. The same things that lead to other occupations not being as diverse as they could be in terms of workforce will come into place here, if you are not actively trying to break down some of the normal recruiting practices and making sure that you are not simply recruiting in your own image or replicating institutions.

A lot of that stuff feels easy to say but hard to deliver, which is why a lot of these problems are quite intransigent. They are quite stiff and hard to move on. If you want people from diverse backgrounds to enter any profession, you remove the barriers to them entering that profession.

Professor Stephani Hatch: Diversity is the bare minimum. We need to be focusing more on inclusion as a practice beyond that, making that a part of this and, specifically, defining clear actions and accountability for addressing, as was just said, the known barriers in the workforce pipeline. Many of these begin at the education and training stage. What we see very clearly in some of the areas most affected is not just focusing on increasing diversity.

I will give the example and the evidence from the workforce race equality standard, where the London trusts, which are the most ethnically diverse, perform the worst on many indicators. Where there are high levels of diversity but low levels of inclusion, you get your worst outcomes, not only for the workforce but for the service users in terms of patient care.

Diversity is just the beginning step. Some of the important work in this area is about taking really strong stands around anti-racist practice in relation to changing codes of practice.

My group is currently doing work with the chief nursing officer, the deputy chief nursing officer, the chief midwifery officer and the Nursing and Midwifery Council, as well as the NHS Confederation, on exactly that, with the code of practice, for example, being an important demonstration of public and government commitment, as well as leadership at all levels. It would be great to see, with nursing and midwifery leading the way, other

professions moving in this direction, so that there is something on which people can be held to account.

Dr Jacqui Dyer: I fully agree with what Stephani and Maurice have already said. When we are talking about the workforce here, we are talking about a whole range of mental health disciplines that range from psychiatry to social work, nurses, occupational therapists and peer support workers—the whole shebang. There is a whole diversity of what makes up the mental health workforce.

We have that data broken down by protected characteristics of each of those professions, the career pathways and opportunities, and what those look like in terms of diversity. We need to change those trajectories, so that, when we are talking about barriers, there is equity of access to all those careers, and progression and opportunities in those disciplines, in order to create a diverse workforce that, at every level, reflects the demography of the populations that it is serving. That complements what Stephani and Maurice were already saying.

If the experience is of racism, bullying and harassment of the workforce through the hierarchy of the way that the workforce operates, often operating within a human resource element, and their experiences of line management or supervision being really quite poor and oppressive, that affects the appetite of diverse communities to come and join the workforce. Then there is a whole issue about recruitment and retention of a diverse workforce, because of these terrible experiences that are really well known and have never really been attended to.

Another element that is really important is about attending to the curriculum for each of these mental health disciplines. Professions need to be quick to operate in an anti-discriminatory, anti-oppressive and anti-racist manner, and that should be a professional code of conduct. Without that being embedded in everybody's professional practice, what emerges are situations such as we experienced at Edenfield, where there is seemingly an idea that it is okay to behave in those really terrible, wicked ways. I do not know how else to say it.

Some of these workstreams are emerging in the way that Stephani described via Health Education England, but I would emphasise how important it is to have a diverse, inclusive but also well-equipped, workforce to operate in an anti-racist way.

Lily Huggins: One element that we could include in the Bill and that would have a positive impact on workforce inclusion is the inclusion of culturally appropriate advocacy. It is effective in addressing the inequalities of the application of the Act, but also signifies a commitment to cultural competence and inclusion. It gives a statutory basis for organisations to work to a higher standard.

Another area that we have not been able to discuss in detail—it has gone so quickly—is retention of staff. Ensuring a diverse and inclusive workplace is enabled by adequately resourced services. We need a commitment to ensure that the expansion of rights and duties under this legislation is matched with appropriate resourcing, because we do not want our mental health workforce to be in a position where they have additional responsibilities but no resources to enact all the positive elements that may come from this Bill.

The Chair: Can I say a huge thank you to all five of you? We have now been in session for over two hours, which was rather more than we asked you to come for, so



we are hugely grateful. It has been an amazing session. You have all been very open, frank and straightforward in your answers. It has been unbelievably helpful to us in our deliberations on this enormously important Bill. Thank you to all of you online and thank you, Maurice, here in the room.