VoiceAbility

Submission of written evidence by VoiceAbility to the Joint Committee on the Draft Mental Health Bill

16 September 2022

About VoiceAbility

VoiceAbility is a registered charity in England and Wales (1076630) and Scotland (SC050036) and one of the UK's largest providers of advocacy and involvement services. We have been supporting people to have their say in decisions about their health, care, and wellbeing for over 40 years.

VoiceAbility supports people to be heard in decisions about their health, care, and wellbeing. We believe everyone has a right to:

- be heard and respected
- have the same choice, control, and freedom as any other person
- be safe from violence, discrimination, harm or abuse

VoiceAbility's Independent Mental Health Advocates (IMHAs) work in over twenty local authority areas in England and supported over 5,000 people in 2021/22 under the provisions of the Mental Health Act (MHA).

VoiceAbility has been supporting the MHA reform process through convening a national network of advocacy organisations and our work as a member of the VCSE Health and Wellbeing Alliance in partnership with Department of Health and Social Care and NHS England. Further information about our work on the MHA is available at: https://www.voiceability.org/about-us/what-we-think-influencing-policy/reform-of-the-mental-health-act-1

How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?

1. There are long-standing concerns around how the Mental Health Act (MHA) and Mental Capacity Act (MCA) are applied at the 'interface' between the two pieces of legislation[1] and some stakeholders have expressed fears this could become more problematic as the MHA is reformed in relation to people with a learning disability and autistic people.[2]

2. A recent report by the Kings Fund into clinical decision-making at the interface of the MHA and MCA found very varied practice which "raises the question about how the Acts are understood and applied individually, even before the question of how they are understood at the interface". It concluded that "the current status quo, however, is resulting in people being unlawfully deprived of their liberty and not afforded their appropriate rights".[3]

3. These problems and risks can best be mitigated by adopting the recommendation of the Law Commission that only the Mental Health Act should be used to deprive people of their liberty in psychiatric settings. The Commission's 2017 report into Mental Capacity and Deprivation of Liberty concluded that "the Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing, or providing medical treatment for, mental disorder within the meaning it is given by the Mental Health Act".[4]

4. The MHA is specifically intended for use in psychiatric in-patient settings and in a reformed MHA, relevant safeguards and provisions will include:

    - regular reviews of treatment and detention including access to assessment by an independent medical practitioner (SOAD)
    - ability to challenge detention and/or treatment before a First Tier Tribunal including regular automatic referral
    - access to a statutory Care (Education) and Treatment Review (C(E)TR) where relevant
    - opt-out advocacy services
    - section 117 aftercare which may help facilitate discharge and access to ongoing support to avoid re-admission

5. However, we also recognise there are examples where the Court of Protection has helped to secure better outcomes for people with a learning disability and autistic people in long-term detention. It would be beneficial to examine these cases more

[1] Reforming the Mental Health Act (publishing.service.gov.uk) p.61
[2] No loss of safeguards for people with autism or learning disability taken 'out' of the Mental Health Act | The Small Places (wordpress.com)
[3] Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005) (york.ac.uk) p.41
[4] Law Commission Mental Capacity and Deprivation of Liberty p.155

closely and consider more wide-ranging reforms to the role of the Mental Health Tribunal to enhance its ability to direct public bodies to facilitate hospital discharge.

6. Recommendation

i. The draft Mental Health Bill should specify that for the specific purposes of detention and treatment of people in psychiatric settings that only the MHA can be used.

To what extent is the approach of amending the existing Mental Health Act the right one? What are the advantages and disadvantages of approaches taken elsewhere in the UK?

7. We support an approach of amending the existing MHA as soon as possible whilst keeping the door open for more further reform in future. The MHA is outdated and the government's draft legislation has already taken five years to prepare since the Independent Review was originally commissioned. There is now some urgency in progressing these reforms to deliver benefits to those detained as soon as practically possible.

8. To inform current and future reform, including development of any new Code of Practice, it is beneficial to look at other approaches both within the UK and internationally. For example, the Mental Health and Well-Being Act 2022 in Victoria, Australia received Royal Assent on 6 September 2022 and is a useful source of immediate comparison. In particular, we recommend taking inspiration from the content and prominence of its 'Chapter 2 - Protection of Rights' which brings together provisions on advance preferences, access to advocacy, nominated support persons and second psychiatric opinions.[5] Within this Chapter, part 2.4 also creates a legal 'right to communicate' to protect communications between a person and their advocate and legal representative which would be a very useful addition to strengthen the draft Mental Health Bill. Unfortunately, not all mental healthcare services are pro-active in facilitating access to advocacy and creating an explicit right of communication would help ensure that people are able to access advocacy support and advocacy services are able to reach them more easily within the hospital environment.

9. International norms and expectations concerning mental health law are also shifting with the World Health Organisation (WHO) and the Office of the High Commissioner for Human Rights (OHCHR) developing guidance on mental health legislation and international human rights law that prioritises supported decision-making over substitute decision-making.[6] The WHO guidance provides useful context and ideas for considering where the Bill, and the accompanying Code of Practice in due course, can be further developed and improved.

[5] Mental Health and Wellbeing Act 2022 (legislation.vic.gov.au) p.47
[6] OHCHR | Call for inputs: Draft guidance on Mental Health, Human Rights, and Legislation published jointly by WHO and OHCHR

10. Recommendations

i. Chapter 2 of the Mental Health and Well-Being Act 2022 in Victoria, Australia should be used as a model in bringing together an individual's rights and protections in a prominent location in a reformed MHA.
ii. The Mental Health Bill should include a 'right to communicate' to protect patient's access to support services, including advocacy.
iii. The guidance on mental health law and human rights being developed by WHO and OHCHR should be used as a further source of inspiration for improvements to the Bill and drafting of the Code of Practice.

Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

11. As noted above, the draft Bill represents an incremental shift with the existing structure of the legislation largely retained and decision-making still resting primarily with the Responsible Clinician and, in relation to 'restricted' patients, the Secretary of State for Justice. However, we are concerned that some of the original proposals to increase patient autonomy in the Independent Review and the government's subsequent white paper have not been carried through into the draft Bill. Further efforts should be made to incorporate as many of the Independent Review's recommendations as possible.

12. Recommendation

i. Evaluate which of the Independent Review's recommendations have not been included in the draft Mental Health Bill and seek to include them.

How far does the draft Bill deliver on the principles set out in the 2018 Independent Review? Does it reflect developments since? Is the Government right not to include the principles in the draft Bill?

13. As an incremental reform, the draft Mental Health Bill can perhaps be viewed as partially meeting the four principles set out in the Independent Review although it is difficult to make a proper assessment at this early stage in the legislative process. As both the Independent Review[7] and the government's white paper[8] commented positively about the principles being added directly into the MHA, it is surprising they have not been included in the draft Bill and this would benefit from further interrogation. It is worth noting that the Mental Health and Wellbeing Act 2022 in Victoria, Australia does include a set of mental health and well-being principles at the beginning of the Act.[9]

[7] Independent Review of the Mental Health Act - GOV.UK (www.gov.uk) p.68
[8] Reforming the Mental Health Act (publishing.service.gov.uk) p.20
[9] Mental Health and Wellbeing Act 2022 (legislation.vic.gov.au) p.40

14. Recommendation

i. The draft Mental Health Bill should legislate for the principles to be incorporated in the MHA as recommended by the Independent Review.

To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?

15. A primary motivation in establishing the Independent Review of the MHA was the disproportionate detention of racialised minorities under the MHA. Whilst the causes of this are multi-faceted, we supported a letter co-ordinated by the National Survivor User Network in December 2021 calling on government to give additional consideration to how the draft Mental Health Bill and associated workstreams will reduce inequalities.[10] For example, the draft WHO guidance states that "legislation can help to shape culturally safe and appropriate responses by providing for the provision of culturally appropriate information, support and interpreter services, as well as more diverse recruitment practices and training for staff on culturally appropriate services and supports" and includes a list of areas that mental health law might cover.[11]

16. The government has also commissioned culturally-appropriate advocacy pilots and we would welcome further information on the next steps.

17. Recommendations

i. Investigate what further measures can be taken to address the disproportionate detention of racialised minorities under the MHA.
ii. DHSC to provide an update on the culturally-appropriate advocacy pilots and next steps.

What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

18. A lack of appropriate support in the community for people with a learning disability and autistic people, particularly in moments of stress or change, can lead to inappropriate admissions to mental health in-patient services. The unsuitable environment and in-patient services that are largely unable to meet their needs mean there is a lack of genuinely therapeutic care and support. The inappropriateness of the setting can lead to a worsening situation and increased distress with the person demonstrating traumatised behaviours. This in turn results in a vicious cycle of increasingly restrictive

[10] Open letter to Sajid Javid on institutional racism within Mental Health Act reform - NSUN website
[11] OHCHR | Call for inputs: Draft guidance on Mental Health, Human Rights, and Legislation published jointly by WHO and OHCHR p.74

practice and can lead to people being held in long-term isolation and in conditions that are inhumane with little meaningful social contact. This further worsens the situation and further increases trauma.[12]

19. Furthermore, the scandal of poor practice and abuse uncovered at Winterbourne View over ten years ago, and other places since, has prompted a succession of government initiatives to reduce the number of people with a learning disability and autistic people in mental health in-patient services, the latest being the Building the Right Support Action Plan published on 14 July 2022.[13]

20. It is within this context that we need to consider the proposed reforms to the Mental Health Act and how they might contribute to the overall goal of improving support in the community for people with a learning disability and autistic people and avoiding admission to mental health in-patient services.

21. Firstly, we strongly support the government's proposals to limit the scope to detain people with a learning disability or autistic people under the Mental Health Act (MHA). As noted earlier, there are concerns this might lead to greater use of an alternative legal framework (Mental Capacity Act (MCA)/Liberty Protection Safeguards (LPS)) and we propose the government legislates so that only the Mental Health Act can be used for the specific purposes of detention and treatment in psychiatric settings, as recommended by the Law Commission, to resolve this issue.

22. Secondly, we welcome the new duties on public bodies proposed in the draft Mental Health Bill in sections 125D (registers of people at risk of detention) and 125E (registers: duties relating to commissioning of services etc). However, we do not believe they go as far as the government originally proposed in the MHA white paper and therefore will need to be strengthened to achieve their intended outcome, particularly with regard to ensuring equivalent obligations on both the NHS and Local Authorities and co-operative working between them.

23. For example, the white paper stated "we propose to introduce a new duty on the NHS and Local Authorities to ensure an adequate supply of community services for people with a learning disability and autistic people."[14] 'Adequate supply' is the key phrase but it has not been replicated in the draft Bill. Instead, clause 125E places a duty on Integrated Care Boards to "have regard" to the information in the proposed support register and "seek to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of this Act". Similar duties would apply to local authorities but only in relation to their 'market function', with no mention of a local authority's commissioning or service delivery function. Again, we are concerned this falls short of legislating for an 'adequate supply' as originally proposed. We are also concerned that inclusion on the 'at risk' register does not provide individuals with any additional rights (for example, access to advocacy services) that could better support

[12] Out of sight – who cares?: Restraint, segregation and seclusion review - Care Quality Commission (cqc.org.uk)
[13] Building the right support for people with a learning disability and autistic people - GOV.UK (www.gov.uk)
[14] Reforming the Mental Health Act (publishing.service.gov.uk) p.13

them and provide additional safeguards to prevent a worsening of a situation and reduce the likelihood of detention or problematic interventions.

24. It is also welcome that Care (Education) and Treatment Reviews (C(E)TRS) will be placed on a statutory footing. The draft Bill specifies that under sections 125A(3b) and 125B(3b) the responsible commissioner, the patient's responsible clinician and the appropriate integrated care board should receive a copy of any C(E)TR report but does not provide the same rights of access to the patient and those advocating for them (for example, nominated person, family, independent advocate) and this should be remedied. We also have concerns that C(E)TRs in the community will be non-statutory and it is not clear what are the mechanisms for escalation, if the C(E)TR recommendations are not being implemented.

25. Thirdly, where there are concerns around excessive lengths of stay and/or high levels of restraint, seclusion and segregation there needs to be a strengthening of internal and external interventions to ensure more rapid progress towards hospital discharge. NHS data indicates that the average length of stay for people with a learning disability and autistic people in mental health in-patient services is five and a half years[15] compared with a median length of MHA detention of under 30 days (excluding those on CTOs).[16]

26. In terms of interventions within the health and care system, the right to a Senior Intervenor, or alternative form of intensive case/project management, could be added to the draft Mental Health Bill, particularly for those in long-term segregation or seclusion and/or those with long lengths of stay. Senior Intervenors are currently being trialled to work with people on a case-by-case basis to find solutions to barriers that may be preventing the individual from moving to less restrictive settings or into the community.[17] Piloting bespoke intensive case management was also one of the recommendations of a thematic review led by Baroness Hollins which published an interim report last year.[18] In terms of external interventions, we believe the role and powers of the Mental Health Tribunal should be expanded as we set out later in this submission in our response to the question on avenues for appeal.

27. Finally, the government should legislate for a nationally commissioned specialist advocacy service for people with a learning disability and autistic people in mental health in-patient services due to their particularly adverse experiences in hospital as outlined above. As we set out in a recently published paper,[19] to be effective in these circumstances, an advocacy service needs highly skilled staff with the time to provide more intensive support and working closely with family members. This requires capped caseloads, more training and professional support, an ability to work more closely with the person and their family on a long-term basis and working more easily across geographical and legal boundaries. This can only be delivered by a national commissioning model which would also help ensure the independence of the advocacy service, particularly in relation to independent or private hospitals where a disproportionate number of people with a learning disability and autistic people have

[15] Learning Disability Services Monthly Statistics, AT: July 2022, MHSDS: May 2022 Final - NHS Digital
[16] Mental Health Act Statistics, Annual Figures 2017-18: Summary Report (digital.nhs.uk) p.18
[17] NHS England » Reducing long term segregation and restrictive practice
[18] The Oversight Panel's interim conclusions and recommendations - GOV.UK (www.gov.uk)
[19] Advocacy-for-people-with-a-learning-disability-and-autistic-people.pdf (voiceability.org)

been placed and which often commission and make referrals to their own advocacy service. It would also provide greater national accountability for its quality and availability and there could be potential to extend its remit in future to also support people who are at risk of admission - including those on the proposed dynamic 'risk' or 'support' registers

28. Recommendations

i. Duties on public bodies should be strengthened to at least require an 'adequate supply' of community services for people with a learning disability and autistic people.
ii. People and those advocating for them (for example nominated person, family, independent advocate) should have the right to receive the C(E)TR report.
iii. Introduce more legal rights to internal and external interventions in the healthcare system to ensure more rapid progress towards hospital discharge, particularly where the person is subject to excessive lengths of stay and/or high levels of restraint, seclusion and segregation.
iv. Legislate for a nationally commissioned advocacy service for people with a learning disability and autistic people in mental health in-patient services.

What changes and additional support do you think will be needed to help professionals and the third sector implement the proposals effectively? Will additional staffing and resources be required?

29. Many of the legislative proposals contained in the draft Bill require additional resources to implement them and most will only come into effect through secondary legislation. It is therefore concerning that additional resources have not yet been committed by government thereby leaving a large degree of uncertainty over when the measures will come into effect. Although the impact assessment provides some information on costings and potential timings, the government should publish a separate implementation plan which can also be scrutinised by parliament and other stakeholders.

30. We welcome the recognition in the impact assessment accompanying the draft Bill that additional resources will be required to deliver opt-out advocacy for detained patients and to extend eligibility to voluntary patients. However, further work will be needed to ensure the estimated costings are as accurate as they can be, particularly in relation to the extension of advocacy to voluntary patients which seems under-resourced. It is also welcome that opt-out advocacy is scheduled for early rollout in the indicative implementation timetable.[20] Further consideration should be given to the potential benefits of bringing forward implementation of the extension of advocacy to voluntary patients to align with opt-out advocacy, rather than two years later as currently planned.

[20] Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk) p.14

31. Recommendations

i. Government should publish an implementation plan for the draft Mental Health Bill.
ii. As part of the implementation plan, further consideration should be given to the potential benefits of implementing opt-out advocacy and the extension of advocacy to voluntary patients at the same time.

How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?

32. We welcome the intention of the draft Bill to strengthen people's voice to have a greater say in their care and, as we proposed earlier, believe many of these mechanisms could be brought together in the MHA in a similar way to Chapter 2 - Protection of Rights in the Health & Wellbeing Act 2022 in Victoria, Australia. The inclusion of opt-out advocacy for detained patients and extension of advocacy to informal patients will ensure that many more people who are admitted to hospital for a mental illness will get support in exercising their rights and participating in decisions about their care and treatment. This could be further enhanced by extending opt-out advocacy to voluntary patients as well as detained patients.

33. However, the draft Bill does not make any substantial reforms to the role or powers of the Mental Health Tribunal which is a missed opportunity to strengthen the patient voice within the health and care system. At present, the Tribunal role is somewhat narrowly focused on reviewing a person's detention and whether they should continue to be detained or discharged. The government's white paper proposal for challenges to specific treatments[21] has not been carried through to the draft Bill and the powers to recommend after-care services (sections 38 and 39 of the draft Bill) fall short of the white paper proposal for Tribunal powers to 'direct services in the community'.[22]

34. We believe there is scope to expand the role and powers of the Tribunal so it can review an individual's care and treatment plans more generally and provide direction to public bodies where necessary. This should include the ability to review and enforce the outcomes of statutory C(E)TRs as there is currently no mechanism to escalate or challenge public bodies when recommendations from C(E)TRs are not being implemented. This may also require some amendment to how the Tribunal operates including access to appropriate expertise.

35. Recommendations

i. Extend opt-out advocacy to voluntary/informal patients.
ii. Expand the role and powers of the Mental Health Tribunal so it can undertake a more general review function and can compel public bodies where necessary.

[21] Reforming the Mental Health Act (publishing.service.gov.uk) p.46
[22] Reforming the Mental Health Act (publishing.service.gov.uk) p.32

What do you think of the proposed replacement of "nearest relative" with "nominated persons"? Do the proposals provide appropriate support for patients, families and nominated people?

36. We support the proposed replacement of "nearest relative" with a "nominated person" to enable people to choose an individual who they believe is best placed to support them. However, we were surprised that the draft Mental Health Bill specifically references Independent Mental Health Advocates (IMHAs) as being one of two groups of people who can legally witness the nomination and/or acceptance of the nomination.

37. As the Committee will be aware, IMHAs "support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment".[23] Therefore, whilst the IMHA may have a role in supporting people to exercise their rights in choosing their nominated person, we believe it is not consistent with the IMHA role for them to be responsible for witnessing the nomination and/or acceptance of the nomination.

38. For example, if there is a disagreement or dispute at some point about the selection of a nominated person, the IMHA should be available to support the person in resolving that problem rather than being partly the subject of the dispute if they have been involved in witnessing nomination/acceptance papers. It is important that IMHAs are not drawn into being official participants in this process but remain in the role of providing support to the individual in exercising their rights. We therefore recommend that IMHAs having a potential role as witness of this process should be removed from this part of the Draft Bill.

39. Recommendation

i. IMHAs should not be responsible for witnessing the nomination or acceptance of a Nominated Person; remove this from the Bill.

To what extent is the Government right in the way it has approached people taking advance decisions about their care?

40. The draft Bill's impact assessment predicts that Advance Choice Documents (ACDs) will be taken up by significant number of people and this will lead to potential savings through avoidance of hospital admission.[24] The modelling also assumes that "ACDs will be developed in the community, with the service user, following their discharge when the individual has the relevant capacity."[25] It also assumes that IMHAs will support people to produce ACDs.[26] However, people are only eligible for IMHA support if they are detained in hospital or on a Community Treatment Order (CTO). Therefore, IMHAs

[23] Mental Health Act 1983 Code of Practice (publishing.service.gov.uk) p.54
[24] Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk) p.97-98
[25] Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk) p.97
[26] Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk) p.19

would not be able to support people to produce ACDs in the community unless the MHA is amended to widen eligibility beyond the period of detention.

41. Recommendation

i. Further investigate how people will be supported to develop an ACD including the role of IMHAs and the potential need to widen eligibility for IMHA support to people in the community in the draft Mental Health Bill.

What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?

42. On 31 March 2021, around 30% of those detained under the MHA were forensic patients and this rises to nearly 40% of the approximately 2000 people with a learning disability or autistic people in mental health in-patient services. Any reform of the MHA, particularly one concerned with reducing racial disparities and improving outcomes for people with a learning disability and autistic people, therefore needs to be concerned with Part III of the MHA.

43. However, reforms to Part III of the MHA were not the principal focus of either the Independent Review or the government's white paper. There has not been a systemic review of how the forensic mental health system is working, something that Prof. Charlie Brooker and Prof. Jeremy Coid recently called for in a BMJ editorial,[27] and the reforms proposed by the Independent Review were relatively limited in scope and some have not been taken forward by government.

44. We believe a useful starting point is to reconsider the recommendations of both the Independent Review and also its expert topic group on the criminal justice system. For example, the Independent Review recommended that the powers of the Mental Health Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave from hospital or transfer to another hospital (as part of the pathway towards discharge). The government accepted this recommendation in relation to unrestricted patients (civil patients and forensic patients without restrictions) but not for restricted patients.[28] Furthermore, since restricted patients are eligible for section 117 after-care we see no reason why the Mental Health Tribunal should not also have powers to make recommendations on after-care in relation to restricted patients.

45. The Independent Review's expert topic group on the criminal justice system also recommended that the Tribunal should have powers to remove restrictions if satisfied they are no longer necessary to protect the public. In their view, the Tribunal should

[27] Mental health services are failing the criminal justice system | The BMJ
[28] Reforming the Mental Health Act (publishing.service.gov.uk) p.171

have the same powers as the Secretary of State and civil servants as these matters fall "squarely within the tribunal's area of expertise."[29]

46. Recommendation

i. Incorporate the recommendations of the Independent Review and its expert topic group on the criminal justice system, with a particular focus on expanding the powers of the Mental Health Tribunal in relation to restricted patients.

Are there any additions you would like to see to the draft Bill?

47. As the indicative timetable for implementing this legislative reform is prolonged, uncertain and dependent on allocation of resources, it is important that parliament is able to monitor and scrutinise progress. For example, the House of Commons Health Select Committee undertook a post-legislative inquiry after the 2007 reforms.[30]

48. Recommendation

i. Consider how parliament can evaluate and influence implementation of the MHA reforms.

[29] Independent Review of the Mental Health Act 1983: supporting documents (publishing.service.gov.uk) p.214
[30] 1st Report HC 584 (parliament.uk)

Summary of all recommendations

1. The draft Mental Health Bill should specify that for the specific purposes of detention and treatment of people in psychiatric settings that only the MHA can be used.

2. Chapter 2 of the Mental Health and Well-Being Act 2022 in Victoria, Australia should be used as a model in bringing together an individual's rights and protections in a prominent location in a reformed MHA.

3. The Mental Health Bill should include a 'right to communicate' to protect patient's access to support services, including advocacy.

4. The guidance on mental health law and human rights being developed by WHO and OHCHR should be used as a further source of inspiration for improvements to the Bill and drafting of the Code of Practice.

5. Evaluate which of the Independent Review's recommendations have not been included in the draft Mental Health Bill and seek to include them.

6. The draft Mental Health Bill should legislate for the principles to be incorporated in the MHA as recommended by the Independent Review.

7. Investigate what further measures can be taken to address the disproportionate detention of racialised minorities under the MHA.

8. DHSC to provide an update on the culturally-appropriate advocacy pilots and next steps.

9. Duties on public bodies should be strengthened to at least require an 'adequate supply' of community services for people with a learning disability and autistic people.

10. People and those advocating for them (for example nominated person, family, independent advocate) should have the right to receive the C(E)TR report.

11. Introduce more legal rights to internal and external interventions in the healthcare system to ensure more rapid progress towards hospital discharge, particularly where the person is subject to excessive lengths of stay and/or high levels of restraint, seclusion and segregation.

12. Legislate for a nationally commissioned advocacy service for people with a learning disability and autistic people in mental health in-patient services.

13. Government should publish an implementation plan for the draft Mental Health Bill.

14. As part of the implementation plan, further consideration should be given to the potential benefits of implementing opt-out advocacy and the extension of advocacy to voluntary patients at the same time.

15. Extend opt-out advocacy to voluntary/informal patients.

16. Expand the role and powers of the Mental Health Tribunal so it can undertake a more general review function and can compel public bodies where necessary.

17. IMHAs should not be responsible for witnessing the nomination or acceptance of a Nominated Person; remove this from the Bill.

18. Further investigate how people will be supported to develop an ACD including the role of IMHAs and the potential need to widen eligibility for IMHA support to people in the community in the draft Mental Health Bill.

19. Incorporate the recommendations of the Independent Review and its expert topic group on the criminal justice system, with a particular focus on expanding the powers of the Mental Health Tribunal in relation to restricted patients.

20. Consider how parliament can evaluate and influence implementation of the MHA reforms.