

## Recent reports on mental health and learning disabilities provision

Three significant reports have been published in the last week with a focus on mental health and learning disabilities, but with relevance to all NHS foundation trusts and trusts. This overview briefing provides a summary of each and NHS Providers' view. The reports are:

- **The Government's Green Paper on mental health: failing a generation** – a joint report by the Health and Social Care Select Committee and the Education Select Committee
- **The Learning Disabilities Mortality Review (LeDeR) Programme** – the annual report by the Healthcare Quality Improvement Partnership, on behalf of NHS England
- **The interim report of the Independent Review of the Mental Health Act** – the review being chaired by Professor Sir Simon Wessely and commissioned by the Department of Health and Social Care

## The Government's Green Paper on mental health: failing a generation

### Key points

#### Introduction

- The Health and Care and Education Select Committees welcomed the publication and direction of travel of the Government's Green Paper on *Transforming Children and Young People's Mental Health Provision*. However, the headline of the Committees' report on the Green Paper is that it "lacks ambition and will provide no help to the majority of those children who desperately need it". The Government is seen, by the inquiry's witnesses, to be "tinkering" rather than undertaking the "seismic shift" required in provision.
- The Committees found little attention to the factors affecting children's mental health and the need for prevention or early intervention. The committee recommends the Government includes the early years in its plans.
- The Green Paper's narrow scope fails to take several vulnerable groups into account and more needs to be done to integrate preventative approaches with these groups.
- The funding for the Green Paper's proposals is not guaranteed and is contingent on an unspecified level of success and adequate funding being made available beyond 2020/21.
- The Government effectively limited the scope of the Green paper by restricting the terms of the evidence review. The lack of access to the review hampered effective scrutiny of proposals.

## Implementation and success

- Hundreds of thousands of children and young people will be unable to benefit from the strategy due to the long timeframes involved in implementing the proposals and with possibly worsened provision if staff leave to join trailblazer areas elsewhere. Moreover, the Government should not attempt to ensure short-term, rather than long-term, success by choosing only high performing areas for the trailblazers.
- The suggested speed of delivery will leave hundreds of thousands of children with no improvements in provision for several years. Rolling out the plans to only “a fifth to a quarter of the country by 2022/23” is not ambitious enough.
- More widespread implementation and iterative learning methods to inform best practice across is recommended.
- The Government should reconsider how it chooses to review progress and extend the period of time to monitor progress of trailblazer areas beyond the 2020/21 Spending Review.

## Funding

- Stakeholders raised concerns that existing funding for children and young people’s mental health services was failing to be delivered at the local level. NHS Providers is quoted as telling the committee that “money earmarked for Future In Mind spending is being diluted”.
- There is a risk that the delivery of the proposals will be stunted by the amount of funding currently allocated.
- The Committees were concerned about the unspecified opportunity cost of proposals on Departmental programmes, which represents a diversion of existing, rather than new, resources. The Government should publish details of the source of funding for the policies outlined.
- NHS England should commit to a mandatory child and adolescent mental health investment standard.
- Appropriate resources must be made available to ensure the implementation of the four-week waiting time target does not have any unintended adverse consequences on those accessing CAMHS services by making the threshold for accessing services even higher.
- There should be more co-commissioning between adult and child mental health services for the whole family, especially in perinatal mental health support.

## Integration

- Concerns were raised by witnesses that despite the importance of a “person-centered” approach to provision, children and young people had not been placed at the heart of the strategy. The Green Paper does not join up with other relevant policies and is a missed opportunity to address fragmented and, in places, poor services. The Government should demonstrate how it will join up fragmented services in order to children and young people at the centre.
- The Green Paper outlined a ‘three pillar’ strategy: a Designated Senior Lead for Mental Health in every school and college, new Mental Health Support Teams linked to groups of schools and colleges, and trials of a four-week waiting time for access to Child and Adolescent Mental Health Services (CAMHS).

However such proposals are made on top of an existing complex and fragmented health and education systems.

## Transition to adult mental health services and vulnerable groups

- The Committees were disappointed that there are no substantive plans to deal with the transition from CAMHS to adult mental health services. The Government should commit to a full assessment of the current transition arrangements between child and adult mental health services. The committee heard that a better age for young people to transition to adult mental health services should be 25, and the lack of action on transition was a failure of ambition.
- Despite clear evidence of particular need amongst vulnerable groups of young people, the Government has not recommended policy interventions to ensure support is available. The Green Paper does not refer to social mobility despite the witnesses saying there was a correlation between social disadvantage and higher rates of prevalence of mental health.
- Mental health support for children in and between care is patchy and disjointed. While the Green Paper recognises the high rate of mental health prevalence amongst looked-after children, the proposals won't meet their needs and may exacerbate them. They should be granted priority access to mental health assessments, the government should outline proposals as to how they will access mental health services. Social workers are not referenced in the proposals, despite their wider service links and connection with looked-after children.
- The Committees were disappointed that it heard addressing health inequalities would dilute the Green Paper's focus on the partnership between schools and the Department for Health and Social Care.
- The Government should ensure support is provided for those likely to need it. It should set out how it will reduce health inequality in the mental health of young people. Funding for mental health support should be targeted into areas of social disadvantage and inequality.

## Workforce

- Proposals – such as for new Mental Health Support Teams which would have a significant remit– can't be delivered effectively if the workforce doesn't have capacity and capability to deliver. Stakeholders highlighted that given current pressures on the CAMHS workforce, proposals may jeopardise the care of children with the most severe needs. The Government must take account of, and mitigate against, stretched resources and workforce pressures.
- Health Education England should set out how it will address questions raised about the impact of the Green Paper's proposals on the CAMHS workforce in its upcoming workforce strategy, due for publication in July 2018.
- The Green Paper proposes using the current educational workforce to deliver the Designated Senior Lead for Mental Health role, but the Committees were not convinced that existing significant and complex pressures on schools and staff have been acknowledged in proposals. Information on current levels of the pastoral care and mental health support workforce, provided by schools and colleges, should be documented and kept under review.

- Trailblazer areas may add an additional, fragmented understanding of 'local' on top of the complex local health, commissioning and local authority landscape. They will need clear collaboration links and legal frameworks to work effectively across a variety of disparate and mismatched authorities, as well as clear lines of accountability for further monitoring and evaluation purposes.

## Data , monitoring and accountability

- The assumptions underpinning the Green Paper have been based on out-of-date prevalence data. There are widespread expectations the level of demand will have been underestimated. The publication of new prevalence data is welcome, but a seven-year survey is not sufficient. Government should outline how it will ensure prevalence data is sufficiently robust, and regular follow-up studies in the impact of the Green Paper proposals on the nature and prevalence of demand should take place.
- Effective evaluation of the efficacy of proposals demands a clear picture of the current level of mental health services provided by schools and colleges, how much has been cut, and how that provision is balanced with NHS resources and demands.
- The required data sharing frameworks must be in place as the Green Paper's proposals are rolled out to best support collaboration and implementation.
- The Committees were informed that Mental Health Support Teams would be clinically supervised by CAMHS, employed by the NHS and "working for clusters of schools". However, stakeholders were concerned about the lack of clarity on local-level responsibility and accountability, and the need for rigorous and well-understood monitoring and evaluation methods.

## Further recommendations

The Committees also recommended that:

- The Government should undertake a consultation on the mental health impact of exam pressure and commission independent research on the potential impact on narrowing of the school curriculum.
- The Department for Education's review into exclusions should focus focuses on the increase in pupils being excluded with mental health needs and how their mental health needs are being met.
- Social media education should be part of PHSE, which itself should be compulsory in all maintained and academy schools.
- The evidence review should be published alongside the response to the committees' report.
- A further education sectoral approach in implementation should be utilised amongst other approaches.
- The government should set out how it plans to make the Designated Senior Lead for Mental Health an attractive role and what it will do in the event of a low-take up.

The full report is available here: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/news/green-paper-on-mental-health-report-published-17-19/>

## NHS Providers' view

### Urgent steps needed to address child mental health

Responding to the report on the government's green paper on child mental health by the education and health and social care select committees, the deputy chief executive of NHS Providers, Saffron Cordery, said:

"We welcome the select committees' strongly worded critique. Their report highlights the scale and urgency of the challenges surrounding children's mental health. Trust leaders tell us demand for mental health care is growing rapidly, particularly for Child and Adolescent Mental Health services (CAMHS). It is important to acknowledge that progress has been made in some important areas, notably in perinatal mental health. Trusts are doing all they can to provide the best possible care with the resources available. But it is extremely worrying that MPs on these highly respected committees have found the government's strategy on child mental health falls so far short of what is required."

## The Learning Disabilities Mortality Review (LeDeR) Programme

### Key points

#### Introduction

- The persistence of health inequalities between different population groups has been well documented... Today, people with learning disabilities die, on average, 15-20 years sooner than people in the general population.
- The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
- The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.
- The programme has developed a review process for the deaths of people with learning disabilities... At the completion of the review, an action planning process identifies any service improvements.
- By the end of November 2017, all but two of the 39 LeDeR Steering Groups were operational. Key processes to deliver mortality reviews of people with learning disabilities have been established, and over 1,000 local reviewers have been trained in the LeDeR methodology.
- The programme has developed a robust quality assurance process to ensure that training is of the highest standard, is fit for purpose and ultimately delivers high quality reviews.
- The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors:
  - large numbers of deaths being notified before full capacity was in place locally to review them
  - the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review
  - trained reviewers having sufficient time away from their other duties to be able to complete a mortality review

- the process not being formally mandated.
- The programme team has been resolving these challenges in a number of ways:
  - including the use of Key Performance Indicators;
  - the appointment of Regional Coordinators to work with local Steering Groups;
  - additional funding from NHS England to support local recovery plans;
  - the commissioning of NHS Sustainable Improvement to help address and support a reduction in the number of un-reviewed deaths, and develop a more streamlined process for the delivery of mortality reviews.

### Deaths notified to the programme

- 1,311 deaths were notified to the LeDeR programme (1 July 2016 – 30 November 2017)
- A Learning Disability Nurse was the most frequent role notifying a death.
- Key information about those who died includes:
  - Over half were males (57%)
  - Most were single (96%)
  - Most were white (93%)
  - Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
  - Approximately one in ten (9%) usually lived alone
  - Approximately one in ten (9%) had been in an out-of-area placement
- The proportion of people with learning disabilities who died in hospital was greater (64%) than the proportion of hospital deaths in the general population (47%).
- Younger people with learning disabilities were more likely to die in hospital than older people.
- People with profound or multiple disabilities had a median age at death of 41 years; those with mild or moderate learning disabilities had a median age at death of 63 years.
- Less than half of deaths notified to the LeDeR programme a cause of death.
- Almost a third of the deaths (31%) had an underlying cause related to diseases of the respiratory system.

### Learning points

- By November 2017, 103 reviews have been completed and approved by the LeDeR quality assurance programme.
- In 13 cases (13%) people's health had been adversely affected by one or more of the following:
  - delays in care or treatment
  - gaps in service provision
  - organisational dysfunction
  - or neglect or abuse
- Examples are given to demonstrate this

- The deaths of 13 people received a full multi-agency review. Three of these met the criteria for Priority Themed Review.

### Summary of recommendations based on completed local reviews of deaths in 2016-2017

Recommendation		Responsible agency
1.	Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.	Commissioners
2.	Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.	NHS England
3.	Health Action Plans, developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).	NHS England Commissioners Providers
4.	All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.	Commissioners
5.	Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.	Providers
6.	Mandatory learning disability awareness training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families.	Commissioners Providers
7.	There should be a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment.	NHS England
8.	Local services strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.	Commissioners Providers
9.	A strategic approach is required nationally for the training of those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.	NHS England

The full report is available here: [https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-annual-report-2017/#.WvKiAH\\_\\_qHs](https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-annual-report-2017/#.WvKiAH__qHs)

## NHS Providers' view

### Learning for health sector over care of people with learning disabilities

The head of policy at NHS Providers, Amber Jabbal said:

“There are still too many people with learning disabilities who aren’t receiving the care they need and should expect from the health and care system. All providers understand the need to ensure that they are making the right adjustments to meet the needs of people with learning disabilities and ensure they are picked up early enough within a care setting. Delays in access to appropriate care and not having staff with the correct training and awareness of the needs of people with learning disabilities are impacting on quality of care. This report makes a series of useful recommendations for acute and mental health trusts to act upon. Sharing best practice and learning from incidents is a vital part of improving the experience of people with learning disabilities. It is clear that there is learning for the sector as a whole. The health and care sector must work together to provide a more joined-up approach for people with learning disabilities.”

## The interim report of the Independent Review of the Mental Health Act

### Key points

- The independent review of the Mental Health Act 1983 (MHA) was commissioned by the government in October 2017. The terms of reference ask for recommendations for improvement in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system. The review looks at both legislation and practice.
- The interim report summarises work so far and the priority issues that have emerged for further examination. An overview of these issues can be found in appendix 1.
- In addition to the goals set by the terms of reference, the review team has developed a set of more detailed goals to guide its work. The overarching aim is to make the MHA work better for everyone. To that end, the detailed goals are:
  - Service users and carers being treated with dignity and respect
  - Greater autonomy for people subject to mental health legislation
  - Greater access to services for those that need them
  - Making the least restrictive option appropriate to a person’s circumstances the default option
  - Improved service user and carer wellbeing
  - Service users and carers supported to be fully involved in treatment as possible
  - Reduced disparities between groups with protected characteristics
  - Greater focus on rights-based approaches
  - Reduced harm and improved safety for all
  - Professionals better able to deliver their expertise



- The review has engaged extensively, with a priority on people affected by the MHA. It has also commissioned academic literature reviews and new data analysis.
- In response to asking whether service users agreed or disagreed that being detained has been the best approach for their mental health needs, views were split. For some, they were positive or largely positive that it was the right course of action which potentially saved their lives. Others did not believe it was the right approach for them.
- The review has heard multiple reports from service users of serious issues about the manner in which they were previously detained under the MHA and the circumstances of their stay in hospital. This includes many people who accept that detention was necessary. There have been frequently reports of practices and procedures which fell short of respecting their dignity.
- Improvements cannot be achieved by legislation alone – changes to the MHA must be underpinned by improvements to mental health services.
- Examination of local and national data around rising detention rates found the rise reflects more individuals being detained overall, rather than some people being detained more often. To address this, the review will consider whole-system approaches that seek to reduce the need for detention, including health and care services alongside other partners like the police. It recognises multi-agency approaches as vital in supporting discharge, and will consider how to improve care planning and the system of aftercare for service users who have been detained.
- To better enable a person's wishes, the review will look at reforming advance planning, rules for involving families and carers, and Community Treatment Orders. Reforms to improve the standard, availability and role of advocacy, and other opportunities to improve safeguards – such as tribunals and managers' hearings, and requirements for consent – will be considered.
- Experiences of people from black African and Caribbean heritage are particularly poor and they are detained more than any other group. Too often this can result in police becoming involved at times of crisis.
- The review has heard concerns about inappropriate use of the MHA in relation to people with a learning disability or autism, potentially linked to lack of appropriate alternative provision in the community. In relation to children and young people, the review will examine issues of parental involvement and decision-making in particular.
- The review has heard that the interaction between the MHA and the criminal justice system can be improved. Service users are left too long in prisons when they should be in hospital. Decision making about restricted patients is often lengthy.
- The review wants to rescue the notion of the 'informal patient' who is not subject to legislation. As well as tackling rising detention rates, we intend to consider what should, and should not, amount to a 'deprivation of liberty' at the interface of the MHA and the Mental Capacity Act. This builds on the government's acknowledgement of the urgent need to reform Deprivation of Liberty Safeguards (DoLS).
- The final report of the review is due to be published in autumn 2018.

The full report is available here: <https://www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report>

## NHS Providers' view

This interim report makes it clear that there is a need to look at a wide range of options for reforming the Act, but helpfully acknowledges that the Act cannot be considered in isolation from the operational and practical context in which it operates. Mental health services are facing major staffing shortages, are struggling to cope with rapidly rising demand and, despite increases in national funding for mental health, they continue to face a severe funding squeeze. We welcome the review and its focus on not only legislative change but also on improving the quality of mental health services.

## Appendix 1

### Issues identified by the Mental Health Act interim report for further consideration

#### BEFORE DETENTION

##### Addressing rising numbers of detention under the Mental Health Act

- What interventions could reduce use of the MHA and compulsory admissions, such as but not limited to, joint crisis plans, models of street triage and high fidelity home treatment and crisis resolution teams
- Opportunities to take a 'whole system' view of this issue. We will seek examples of where local areas have sought to reduce compulsory admissions in order to learn from what has worked and what has not
- Both legislative and non-legislative ways of encouraging or mandating closer interagency working between services
- Opportunities to improve risk and safety assessment

##### Decisions to detain under the Mental Health Act, and renewals

- Whether current risk thresholds under the MHA are the right ones, and if not, what they should be
- How the MHA can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal
- Whether the appropriate treatment requirement is adequate to ensure a person really is receiving clinically effective help while being detained
- Whether sections 2 and 3 of the MHA should be combined or reconfigured, with an initial shorter period for assessment and treatment

##### Interface with the Mental Capacity Act

- Whether and how legislation could enable the return of informality to the delivery of mental health care and treatment in hospital
- Whether there are recommendations that can be made prior to the end of the review to solve the urgent problems identified to date, in particular the dramatically rising numbers subject to DoLS/the MHA
- The specific legislative issues identified as falling for consideration by the review in the government's response to the Law Commission proposals
- The definition of deprivation of liberty given by the Supreme Court in Cheshire West, whilst taking account of the parallel inquiry of the Joint Committee on Human Rights into liberty and security, and the government's response to the Law Commission's proposals

##### Police Role

- How recent legislative changes to sections 135 and 136 are changing service approaches and whether it is right to bring an end to having a police cell designated as a place of safety. If so, what safeguards and resources are needed to do this safely?
- Why people who are arrested under the criminal law are staying in police cells for too long after an approved mental health professional has decided that the person needs to be admitted to hospital,

and what can be done to address this

- Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this
- The practicalities and benefits of NHS England taking over the commissioning of health services in police custody, as has been recommended in both the Angiolini and Bradley reports
- Equality issues, particularly police interactions with people from BAME communities under the MHA

## DURING DETENTION

### Dignity and respect of the service user

- The issues identified in our ongoing service user engagement including our survey and other sources
- Learning from successful initiatives to improve care for the service user
- Opportunities to improve systems for identifying and addressing poor or abusive care as well as changing regulatory systems and safeguards
- Opportunities to improve redress for service users and carers
- The possibility and impact of introducing guiding principles onto the MHA itself, in particular considering the principles currently in the Code of Practice

### Autonomy of the patient

Consent to treatment and treatment without consent:

- Whether service users have enough say in MHA decisions, and if not, how this could be increased or other safeguards provided
- Whether a person's mental capacity and decision-making ability should play a role in detention and/or treatment under the MHA, and at what points
- The potential for unintended consequences from different approaches to reform

### Advance planning

- How the existing legal framework under Part 4 of the MHA and MHA Code of Practice can be better implemented to strengthen advance planning
- Whether additional legislative reforms are needed

### Procedural safeguards

Treatment safeguards:

- The appropriate route to securing safeguards for patients in the initial period of detention, whether that be under sections 2 and 3 of the MHA as they stand, or under a reconfigured version of these sections
- The appropriate route to securing safeguards for patients thereafter and revising the current urgent or emergency treatment exemptions
- Whether service users should be able to appeal to the Tribunal against compulsory treatment decisions. If so, in what circumstances and with what conditions

### Tribunals and managers' hearings

- How to ensure that the Tribunal provides an effective and proportionate safeguard for patients subject to the MHA
- The role that hospital manager hearings should play in the future
- How Tribunals sit amongst other safeguards inside and outside the MHA including other parts of the

judicial system

- Whether the Tribunal should provide the sole channel to challenge being subject to the provisions of the MHA and if so, a patient should be allowed to apply more than once in the statutory period if there is a change in circumstance

#### Advocacy

- How to ensure that the Tribunal provides an effective and proportionate safeguard for patients subject to the MHA
- The role that hospital manager hearings should play in the future
- How Tribunals sit amongst other safeguards inside and outside the MHA including other parts of the judicial system
- Whether the Tribunal should provide the sole channel to challenge being subject to the provisions of the MHA and if so, whether a service user should be allowed to apply more than once in the statutory period if there is a change in circumstance

#### Family and carer involvement

'Nearest relative' legal role:

- Reforming the nearest relative provision to allow individuals to nominate a person of their choice to fulfil this role. This will also consider how this could apply for children and young people.
- Granting the nominated person a statutory role in treatment decisions and whether this could mirror the principles of the Power of Attorney and Deputyship provisions in the MCA
- Appropriate safeguards in relation to the appointment and discharge of nominated persons, including where the relevant person user lacks capacity
- Other mechanisms through which the carers, families, and friends of people who are detained can be supported to be involved in care of the person they support

Confidentiality and access to information:

- Non-legislative approaches to deliver a better balance between protecting confidentiality and appropriate disclosure
- How any replacement of the nearest relative provision can be used to improve appropriate access to and sharing of information
- The framework that needs to be in place for the authorisation of sharing information and the resolution of disputes

#### Use of restraint and seclusion

- The practice of restraint and seclusion in relation to a person's detention, and the options available to strengthen the principle of least restrictive practices
- We will monitor closely the ongoing legislative and policy developments in this area, and consider if and where it is appropriate for us to make further recommendations

## LEAVING HOSPITAL

### Community Treatment Orders

- How CTOs are experienced by individuals and their families

- Why people from BAME communities, in particular black African and Caribbean men, are much more likely to be given CTOs and with what outcomes
- The disparity of views about the effectiveness of CTOs
- Whether some groups of people do derive benefits from CTOs, and in what circumstances
- The implications of either reforming or replacing CTOs

## Discharge and aftercare

### Section 117 aftercare:

- The need to clarify what aftercare means within the modern health and social care system, so that it supports independence and recovery
- The case for reforming eligibility for aftercare to improve equity of access
- Resolving some of the complex arrangements across health and social care, especially regarding funding and ordinary residence.
- The need to modernise section 117 aftercare in relation to the provisions of the Care Act

### Care planning and support in the community:

- The opportunity to bring the requirements of the CPA, the Care Act, the Children Act, NHS Continuing Health Care (as well as other legal provisions) and section 117 care planning together in a coordinated way
- Opportunities to drive greater collaboration between bodies involved in preparing and delivering care plans, which may include new statutory duties
- How to incorporate opportunities identified in our consideration of advance planning (in section 7.6 above) to any proposed reforms

## ISSUES FOR PARTICULAR GROUPS

### Black, Asian and minority ethnicities

- The experiences of BAME people of being detained and treated under the MHA, with a particular focus on people of black African and Caribbean descent and including interactions with primary care, social care and criminal justice systems
- Why some BAME groups have worse outcomes, including but not limited to being more likely to relapse when they left hospital
- Whether specific changes to the MHA or the Code of Practice including the ways they are implemented could help to improve disparities in detention rates and experiences of compulsion
- Possible extension of the approaches used by NHS Workforce Race Equality Standard to service users and carers not just staff
- The impact of any other broader changes recommended by the review on BAME communities

### Children and young people

- Which barriers to the delivery of care and treatment stem from poor understanding and/or implementation of the existing legal frameworks and associated guidance
- How to identify and secure the appropriate place for family members in decisions about admission and treatment

- The impact of any other broader changes recommended by the review on children and young people

#### Learning disabilities and autism

- How services can support people with a learning disability or autism in ways that avoid the need for detention, including responses to challenging behaviour
- The arguments for and against continued inclusion of learning disability and autism in the scope of the MHA
- Opportunities to improve awareness among professionals of the needs of people with a learning disability or autism in the context of the MHA
- The impact of broader changes recommended by the review on people with a learning disability or autism

### CRIMINAL JUSTICE SYSTEM

#### Prisoners, immigration detainees and transfers to/from hospital

- How to streamline and speed up the process of transfer to and from hospital for prisoners and immigration detainees
- How to streamline and speed up decisions on release for transferred prisoners serving life or other indeterminate sentences

#### The restricted patients system

- How to speed up decision making for restricted patients
- Whether the specific decision-making powers relating to restricted patients set out in the MHA remain necessary and appropriate, and if it is clear enough how decisions should be made
- Which individual(s) or organisation(s) should best hold the decision-making powers for restricted patients

#### Courts powers and processes

- The potential to reduce inappropriate use of custody for people with acute mental illness
- How to make it easier for courts to use section 35 when appropriate
- Sentencing options for courts and the circumstances in which they are used

### COMPATIBILITY WITH HUMAN RIGHTS OBLIGATIONS

- Relevant international instruments and statements of international bodies
- Relevant recent law reforms in other jurisdictions, including but not limited to Scotland, Northern Ireland and India
- The legal, ethical and political issues arising out of the statements of the Committee on the Rights of Persons with Disabilities

### THE MENTAL HEALTH ACT IN WALES

- Opportunities to engage key stakeholders and service users in Wales to consider how reform options will impact Welsh legislative frameworks and associated practices