Written evidence submitted by the National Survivor User Network (NSUN) (MHB0074)

About NSUN

The National Survivor User Network[1] (NSUN) is a membership organisation and a network of community groups and people who have experience of mental distress, ill-health and trauma who come together to create, challenge, and campaign. As a user-led organisation, all of our staff, members and Trustees have lived experience.

We work to redistribute power and resource in mental health. We do this by:

- Building, amplifying, and distributing the knowledge that is held by people with lived experience
- Creating collaborative spaces with members and partners to build momentum and sustainability for the work
- Building an alternative approach to mental health policy work
- Working with funders and acting as a microfunder to redistribute resources to grassroots user-led groups[2], as well as working to build capacity and sustainability in other, non-material ways

Background

We initially responded to the White Paper in January 2021[3] and responded further in April 2021.[4]

While we welcomed the increased focus in the White Paper on the principles of choice and autonomy; least restriction; therapeutic benefit and the person as an individual, we also observed that these are not the same as a set of rights for the individual subject to the Mental Health Act. This concern, that mental health reform is not and has not been grounded in a rights-based understanding of mental health[5], remains central to our reading of the Draft Bill and its potential impact.

For campaigners, the White Paper and subsequent draft Mental Health Bill may not be what some had hoped for. However, we are aware that small changes in the Act may make a significant difference to the lives of people who are detained[6], their families and friends, and people who live in fear of the Act.

We know that the work of the scrutiny committee is critical in ensuring changes in the Act best serve the people it is intended to protect.

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[1] National Survivor User Network https://www.nsun.org.uk/
[2] What do user-led groups need? https://www.nsun.org.uk/news/what-do-user-led-groups-need/
[3] NSUN initial response to the Mental Health Act White Paper 2021 https://www.nsun.org.uk/news/nsun-initial-response-to-the-mental-health-act-white-paper-2021/
[4] Response to the MHA White Paper https://www.nsun.org.uk/news/response-to-the-mha-white-paper/
[5] A Rights-Based Approach to Mental Health Crisis Response https://www.madinamerica.com/2020/07/rights-based-approach-mental-health-crisis-response/
[6] What is it like to be sectioned? https://www.shortlist.com/news/what-is-it-like-to-be-sectioned

> *"For anyone in NHS leadership, executive board members, senior managers reading this I want to say to you- please stop locking up survivors and holding us down, please stop diagnosing us with disordered personalities. Please stop hurting us. We are desperately trying to manage the devasting impact of trauma and mental illness. People are dying because of a lack of support and access to care. Listen to specialist charities and grassroots organisations, listen to survivors about what works for us. Work with us to create safe places where we can heal and try to move on with our lives."* Jennifer Reese, Psychiatric Hospital Left Me Suicidal and Homeless – We Need a Human Rights-Based Approach to Mental Health Care[7]

The Draft Mental Health Bill

The Draft Mental Health Bill contains some positive changes that will make a difference to those held under the Act once implemented. Changing nearest relative to nominated person, stopping the use of police and prison cells as places of safety, making advocacy opt-out, and introducing a time limit for the transfer of prisoners and detainees in crisis are all important steps.

However, many of the changes in the bill, for example regarding decisions around treatment, advanced choice, and Community Treatment Orders (CTOs) appear to be more bureaucratic than transformative. Whilst the tightening of detention criteria is certainly welcome, impact assessment and clear resourcing of decision making is needed.

Critically, it is not clear how some proposals will be funded. An investment of £150m has been announced alongside the Draft Bill to support implementation of reforms, primarily for the funding of alternative crisis provision. The additional resourcing necessary to implement change is unclear. The impact of investment will be questionable if it is not sufficient to implement the full suite of reforms and without concurrent investment to address the current staffing crisis, and in modernising the mental health estate.

It can be said that the Bill is lacking in ambition to truly impact the experiences of those who are detained under the Act and reduce the coercion that is an ongoing challenge in the delivery of mental health services. Whilst there is some progress around treatment choice, access to genuine care remains distant for many. It is easy to state: "People should expect parity of esteem between mental health and physical health services" but the reality remains that parity of esteem remains distant, even with the current suite of reforms.

To ensure that the positive changes in the Bill are effective and make a difference, clear strategies for funding, timely implementation, and monitoring and evaluation must go hand in hand with the proposed legislative shifts.

Implementation, evaluation and funding

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[7] Psychiatric Hospital Left Me Suicidal and Homeless – We Need a Human Rights-Based Approach to Mental Health Care https://www.nsun.org.uk/psychiatric-hospital-left-me-suicidal-and-homeless-we-need-a-human-rights-based-approach-to-mental-health-care/

- The Independent Review was released in 2018. Since then, we have been through multiple rounds of consultation. With the current draft bill, the implementation timeline suggests the final stage will commence in 2030/31.
- There is risk in a long implementation timeline without regular evaluation. In addition, whilst £150m[8] has been announced for reforms, there is need for protected, long term funding and to ensure adequate staffing levels and appropriate standards for the mental health estate.

Racial disparities in use of the Act

- One of the purposes of the 2018 Independent Review and drivers of reform was "the disproportionate number of people from black and minority ethnic groups detained under the Act"[9].
- The Bill does not explicitly reference racialised communities. It appears to 'internalise' recommendations, for example, in amending parts that acutely impact racialised communities, such as Community Treatment Orders (CTOs).
- As part of the Mental Health Alliance, we wrote an open letter to the then Secretary of State for Health, Sajid Javid, regarding this issue[10]. We asked the Secretary of State to:
    i. Publically acknowledge institutional racism in the use of Mental Health Act.
    ii. Commit to concretely improving disparities in detention rate by ethnicity, with publishing of clear annual targets to progressively reduce disparities by 2025.
    iii. Commit to long-term resourcing of all the recommendations pertaining to racialised groups outlined in the MHA Review.
- The tightening of detention criteria is welcome. However, we are also acutely aware of the ways in which neglect[11] and gatekeeping[12] of services are now part of mental health systems. Any commitment to reducing rates of detention must be met with significant resourcing to support care in the community.
- Those with precarious immigration status are often excluded or missing from conversations around the Mental Health Act and racism. It is key to include those who do not have access to care when evaluating racism and detention rates. For some people, detention may be the only way in which they are able to access mental health services. For those who are detained at Immigration Removal Centres (IRCs) lack of access to services is particularly acute. Specific assessment of impact of reforms on this group is an essential component of evaluation.

> *"NHS England's £1.4 billion investment in mental health services includes no specific funding allocations or guidelines to support the mental health of asylum seekers, refugees and other vulnerable migrants with undocumented migrants actively excluded from formal health care settings through the hostile*

[8] Press release: Better mental health support for people in crisis https://www.gov.uk/government/news/better-mental-health-support-for-people-in-crisis
[9] Mental Health Act Reform – Race and Ethnic Inequalities https://post.parliament.uk/research-briefings/post-pn-0671/
[10] Open letter to Sajid Javid on institutional racism within Mental Health Act reform https://www.nsun.org.uk/news/open-letter-to-sajid-javid-institutional-racism-mha-reform/
[11] Section Zero (indefinite exclusion) https://www.nsun.org.uk/section-zero-indefinite-exclusion/
[12] Magical thinking and moral injury: exclusion culture in psychiatry | BJPsych Bulletin | Cambridge Core

environment" Rose Ziaei, State violence and distress: the false separation between migrant justice and mental health [13]

Reducing coercion: summary

- We view reducing coercion as the central purpose of mental health reform.
- The Mental Health Units (Use of Force) Act 2018[14], also known as Seni's Law, increases protections and oversight on use of force in mental health setting.
- One measure of reduced coercion is a fall in the number of people under Community Treatment Orders (CTOs), especially among Black and minoritised people who are disproportionately impacted.
- The white paper suggested an evaluation timeline of 5 years for CTO reduction. It is imperative that during this period, regular (annual as a minimum) monitoring and evaluation data is transparently shared with stakeholders.

Community Treatment Orders (CTOs)

- CTOs were introduced as part of the 2007 reforms of the Mental Health Act 1983. Since their introduction, a significant body of evidence has emerged that tells a story of a coercive instrument lacking in effectiveness.
- CTOs acutely impact those from racialised backgrounds, in particular, Black men. A key driver of reform was the disproportionate detention of people from racialised groups.
- The baseline trajectory in CTO reduction is estimated at 40% reduction over 5 years from 2028/29, this must be closely monitored and evaluated. For many, the 2031/32 timeline for reduced coercion will be too little and too late.
- NSUN calls for the repeal of CTOs. We do not support the reforming of an instrument despite evidence that tells it is ineffective and coercive.

Supervised community discharge

- Supervised discharge is seen by some as a means by which some of the most restricted patients may gain greater freedom.
- However, we are concerned about supervised discharge amounting to a deprivation of liberty becoming yet another coercive instrument.

Treatment choice

- A significant issue with treatment choice is the lack of appropriate treatments. The availability of 'appropriate medical treatment' is included as a criterion for admission.

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[13] State violence and distress: the false separation between migrant justice and mental health https://www.nsun.org.uk/state-violence-and-distress-the-false-separation-between-migrant-justice-and-mental-health/

[14] JUSTICE FOR SENI The Olaseni Lewis Campaign for Justice and Change: https://www.justiceforseni.com/

- Whilst the Long Term Plan addresses lack of appropriate treatment, ultimately, our current model of mental health care and treatment does not hold adequate flexibility and resource to truly account for choice
- Despite proposals in the White Paper, Mental Health Tribunals are not being extended to treatment decisions. This is a critical omission.

Opt-out advocacy

- Opt-out advocacy is a welcome introduction. However, the current wording around advocacy details a "duty placed on advocacy services to arrange for qualifying patients to be interviewed to find out whether they want to use these services". This is appears to be closer to a facilitated opt-in system instead of truly opt-out.
- The right to refuse an advocate, and to have an alternative choice, is also important.
- Long term commitment to resourcing advocacy is a critical aspect of making opt-out advocacy effective. The proposals are unlikely to be effective without adequate resourcing for the full span of reform implementation.

Learning disability and autism

- We share concerns raised by experts in mental health and capacity law regarding unintended consequences of taking autism and learning disabilities out of Section 3 of the Act. For example, this blog by Prof. Lucy Series, covers unintended consequences and details ways of legislating to avoid negative impact of reforms: https://thesmallplaces.wordpress.com/2022/06/24/no-loss-of-safeguards-for-people-with-autism-or-learning-disability-taken-out-of-the-mental-health-act/[15]

Additions we would like to see to the draft Bill

- Legally binding advanced choice documents: moving towards parity between physical and mental health and a real reduction in coercive practices
- Significant commitment and investment in monitoring and addressing racial inequity in the use of the Act
- Commitment to capital investment in community services including a duty on commissioners
- Comprehensive monitoring and evaluation embedded into the Bill and implementation timeline

Conclusion

We invite legislators and others to undertake as deep an examination of the Draft Mental Health Bill as possible, and in particular to scrutinise the proposed changes for unintended consequences.

[15] No loss of safeguards for people with autism or learning disability taken 'out' of the Mental Health Act https://thesmallplaces.wordpress.com/2022/06/24/no-loss-of-safeguards-for-people-with-autism-or-learning-disability-taken-out-of-the-mental-health-act/

We are keen to challenge the view that any change is better than none. Without detailed scrutiny of the real-world implications of the proposed changes and the input of a broad range of views from those who may be subject to any future powers, we are concerned that unintended consequences may compound the negative effects of the powers of the Mental Health Act for some people, while alleviating harms for others. The implementation timeline for change is long, and in the meantime many will continue to experience coercion in mental health services. If these proposals are to truly make a difference, they must be adequately and sustainably funded and transparently monitored.

16 September 2022