**Psychosocially Disabled people**

**Terminology used**

In England, it is now very usual for those of us who support the full implementation of the UNCRDP to call ourselves people with experience of mental distress. It is our equivalent of the term ‘psychosocial disabilities’. It reflects our concern to move away from language traditionally used in the UK which reflects and tends to reinforce the medical model dominant in this country, for example ‘people with mental health problems/mental illnesses’.

**Key issues for people with experience of mental distress**

**Article 1 of the Convention**

Despite the Disability Committee’s recommendation in its 2017 Review report, the Government has failed to ensure that law and policy addressing issues for people in mental distress enshrines the human rights model of disability. Instead, we are very much regarded still as people who need protection against ourselves and clinical treatment. As a result, the [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf) (Department of Health and Social Care, 2021) which sets out proposals for reform of the [*Mental Health Act 1983*](https://www.legislation.gov.uk/ukpga/1983/20/contents), continues to use a medically orientated, diagnostic model and to set significant limits to our human rights. (See also below) Whilst some developments such as the [*Five Year Forward View* *for Mental Health*](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) (Independent Mental Health Task Force, 2016), which contains a five year improvement plan, and the [*COVID-19 Mental Health and Wellbeing Recovery Action Plan*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973936/covid-19-mental-health-and-wellbeing-recovery-action-plan.pdf)(HM Government, 2021) put quite a focus on social factors also, they still rest on a clinical understanding of mental distress.

**Article 4.3**

In its approach to mental health law and policies stemming from it, the government continues to fall short of adequately consulting and involving people in mental distress, despite improvements recommended in the Disability Committee’s 2017 Review report. A major factor is that, although people in mental distress, too, had the opportunity to take part in a consultation about the reform of mental health law, many were in no more of a position to make informed choices than they had been during the [Review](https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act) (Wessely, 2018) which formed the basis of the [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf). That is because the government has failed either to promote general awareness of the UNCRDP, or to provide the scale of funding which would enable DDPOs to do so on the comprehensive scale needed. Compounding factors have been the inadequate representation of the White Paper in the [easy read version](file:///C:/Users/Dorothy/Desktop/Folders/Liberation/UNCRPD/DDPO%20shadow%20report/Liberation%20MHA%20submission/Changes%20that%20the%20government%20wants%20to%20make%20to%20a%20law%20called%20the%20Mental%20Health%20Act%20(easy%20read)%20-%20GOV.UK%20(www.gov.uk)) and the online nature of consultation processes; there is a growing digital ‘underclass’ among the many people in mental distress who are also socioeconomically disadvantaged. In addition, the government’s [report](https://www.gov.uk/government/consultations/reforming-the-mental-health-act) about its consultation (Department of Health and Social Care, 2021) omits calls for full compliance between mental health law and the UNCRDP made by several DDPOs.

**Articles 5 and 6**

Whilst the government has put some focus on intersectional issues for people in mental distress, there continue to be major flaws and gaps in its approach. The [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf) rightly has a strong focus on people in mental distress from racialised communities (Black, Asian and other minority ethnic communities), on children and young people, on people with learning difficulties and on people diagnosed with autism. Nonetheless, there are serious flaws in the approaches taken. For example, the proposed Patient and Carer Race Equality Framework (PCREF) and culturally appropriate advocacy seem unlikely in themselves to resolve issues in a mental health system dominated by a white western, medical model and in a society whose institutions remain structurally racist. A further worry is the [report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf) from the Commission on Race and Ethnic Disparities (2021), an independent commission which the government invited Dr Tony Sewell to chair. A major criticism of this report is that it does not give credibility to structural racism and there are serious concerns that it will weaken further the White Paper’s proposals about race issues.

A significant point of concern, too, is that the White Paper has limited coverage of issues for women and no specific coverage of issues for older people, people who identify as lesbian, gay, bisexual, trans, or intersex (LGBTI) and (except in the case of people with learning difficulties and/or a diagnosis of autism) people who also have physical and/or sensory impairments. Ongoing calls to address these shortfalls from significant numbers of people affected by intersectional issues have been bypassed. Similarly, although NHS Digital’s [statistics](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures) for 2019/2020 demonstrate that people living in the most deprived areas of England are 3.5 times more likely to be detained, there is no focus on this disparity in the White Paper. In addition, a further two-tier system is due to be created through the White Paper’s proposal to give fewer new rights to people in mental distress who come under the criminal justice system.

In these respects, the White Paper falls short not only of the UNCRDP, but of other international treaties such as the Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAR) and the Convention on the Rights of Older Persons. It also falls short of the Sustainable Development Goals.

**Article 10**

There continue to be major shortcomings in the government’s respect for our right to life, including serious shortcomings in its implementation of Recommendation 27 in the Disability Committee’s 2017 Review report. As the [study](https://www.thelancet.com/pdfs/journals/lanepe/PIIS2666-7762(21)00214-3.pdf) from Das-Munshi *et al* (2021) indicates, not only have people experiencing major mental distress continued to die considerably earlier than other members of the public, but, as with people who have learning difficulties, death rates among them have been disproportionately high during the Covid-19 pandemic. In addition, mortality rates of those treated under the [*Mental Health Act 1983*](https://www.legislation.gov.uk/ukpga/1983/20/contents) rose significantly during the pandemic; [data](https://www.cqc.org.uk/sites/default/files/COVID-19%20Insight%209.pdf) from the Care Quality Commission (2021) records 490 deaths between March 2020 and March 2021 compared with a yearly average of 273 between 2012 and 2019.

**Articles 12 and 14**

One of the four guiding principles in the [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf) is ‘choice and autonomy’ for people in mental distress. However, in a concerning development, the application of the term ‘autonomy’ to people in mental distress diverges from the usual sense of the word. That is because the White Paper proposes only some increase in choices available to us, together with a reduction in numbers and lengths of detention, but not an end to detentions as such, nor to community treatment orders. The government is opposed to making more fundamental changes to the detention criteria which would mean that people whom it thinks need the Act’s ‘protection’ can no longer be sectioned. A further issue is the plan to have a two-tier system which gives stronger rights to people who are judged to ‘have capacity’.

The White Paper’s proposals for Advance Choice Documents (ACDs) remain in breach of Articles 12 and 14, despite Recommendations 31 and 35 in the Disability Committee’s 2017 Review report, both for people judged to ‘have capacity’ and for those who are not. The former will gain a statutory right to use an ACD to specify what treatment they wish and do not wish to have when they have been detained and to have their choices taken seriously into account. However, they will not be able to use an ACD to refuse detention. In addition, a clinician will still be able to overrule an ACD if s/he explains the reason and provides justification. People judged to ‘lack capacity’ will not be given even this right, although it is expected that efforts will be made to determine their wishes so far as possible.

In view of the government’s stance on the use of coercion, a serious worry is that it will not oppose the draft Additional Protocol for the [Oviedo Convention](https://www.coe.int/en/web/bioethics/oviedo-convention) put forward by the Council of Europe’s Committee of Bioethics, a Protocol which would endorse involuntary detention in psychiatric hospitals and forced treatment among all 47 States with membership of the Council of Europe and so be in conflict with the UNCRDP.

On a more positive note, the White Paper recognises that neither a diagnosis of autism, nor a learning difficulty alone should justify involuntary detention under the [*Mental Health Act 1983*](https://www.legislation.gov.uk/ukpga/1983/20/contents),. However, detention will still be possible if someone is also thought to have a mental health condition. In addition, detention will remain possible under the [*Mental Capacity Act 2005*](https://www.legislation.gov.uk/ukpga/2005/9/contents)and the [*Mental Capacity (Amendment) Act 2019*](https://www.legislation.gov.uk/ukpga/2019/18/enacted)which is due to come into force during 2022.

**Article 15**

Contrary to Recommendation 37(a) in the 2017 Review report, the government continues to authorise both the use of restraint on grounds related to mental distress and the employment of Taser guns against people in mental distress. In the [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf), the initial phase of a Mental Health Safety Improvement Programme has been described as successful in reducing restrictive practice. However, evidence of this is not provided. The overall usage of Tasers has also increased and has done so despite evidence that people from racialised communities are disproportionately affected; Pandian (2020) highlights this in her article on [taser trauma](https://irr.org.uk/article/irr-news-1-14-july-2020/).

A potentially positive development, relevant also to Recommendation 37(c), has been the [*Mental Health Units (Use of Force) Act 2018*](https://www.legislation.gov.uk/ukpga/2018/27/contents/enacted) (often known as ‘Seni’s Law’). The Act resulted from a major campaign after Olaseni Lewis, a young Black man, died in 2010 when, horrifically, he was restrained face-down by 11 police officers in the Bethlem Royal psychiatric hospital in London. The Act aims to curb physical, mechanical and chemical restraint of a patient, together with isolation, seclusion and segregation. One of its purposes, too, is to address bias against people from racialised communities. However, a serious concern is that it took eight years to bring in this Act and implementation of it has been very delayed, even though new legislation normally takes effect a few weeks after parliamentary approval has been given.

Consultation about statutory guidance for the Act occurred only during 2021 and the [guidance](https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018) was not issued until December 2021 when the Act then came into force. Positive aspects of the guidance are the recognition that people from racialised communities (black and minority ethnic communities), women and girls and people with autism or intellectual disabilities are among those disproportionately affected by the use of force in services and that the ministerial foreword contains the following statement:

‘When patients are cared for in what feels like a safe and positive environment, organised around their needs and individual requirements, situations should not arise when the use of force is needed’.

However, the guidance itself focuses on the reduction of force, rather than on an end to it, and a fundamental issue is that, in breach of human rights, the guidance assumes a continuing use of detention under mental health legislation.

The White Paper remains in worrying contravention of Recommendation 37(d) as regards non-consensual electroconvulsive treatment (ECT). In the case of people judged to ‘have capacity’ who are not consenting to ECT, ECT could still be allowed if the Responsible Clinician regards it as necessary to save a person’s life, or to prevent serious deterioration, and if court approval has been obtained. In the case of people judged not to ‘have capacity’, ECT will still be allowed if both the Responsible Clinician and a Second Opinion Appointed Doctor (SOAD) agree that it is required.

**Article 19**

The [Mental Health Act White Paper](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf) is non-compliant with Article 19 in its continued emphasis on the use of institutions (psychiatric hospitals) and its allocation of large amounts of money to improve these and to build more. A step forward is an increased emphasis on community support, particularly in the case of people with learning difficulties and people given a diagnosis of autism. However, despite some mention of alternative resources, there is still an unduly clinical ethos to the approach taken which contrasts with the whole-life stance inherent in Article 19. An example of this is the implementation of support through the [*NHS Long Term Plan*](https://www.longtermplan.nhs.uk/) and the accompanying [*NHS Mental Health Implementation Plan 2019/20-2023/24*](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf)*.* In addition, there have been disruptions stemming from the impact of Covid-19 itself and from shortcomings in the government’s handling of the pandemic.

**Changes needed**

1. Law and policy which comply fully with a human rights approach (Article 1)
2. Meaningful involvement of DDPOs which represent people experiencing mental distress - in the content of all relevant law and policy (Article 4.3)
3. Comprehensive government measures which successfully address the full range of intersectional issues that affect people in mental distress (Articles 5 and 6)
4. Effective government action which pre-empts disproportionate mortality rates among people in mental distress (Article 10)
5. Equal recognition before the law for all people in mental distress and people with learning difficulties/autism (Article 12)
6. The repeal of mental health and mental capacity law which authorises detention in psychiatric hospitals and involuntary treatment on the basis of mental distress and/or a learning difficulty/autism (Article 14)
7. Effective government opposition to the Oviedo Convention’s draft Additional Protocol (Articles 12 and 14)
8. An end to the use of restraint on the basis of mental distress, the employment of Taser guns against people in mental distress and non-consensual ECT, together with speedy implementation of law and guidance which brings these and related measures into effect
9. Full implementation of the concept of independent living and community participation which is enshrined in Article 19.

Dorothy Gould: on behalf of Liberation

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