2022

A Mental Health Charter as a Manifesto

LONDON KONP & LONDON SHA

AUGUST 2022

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Foreword

A mental health charter as a manifesto

Relevant to the manifesto, we would just like to bring people's attention to some recent events that occurred after we finished writing and before we were able to find a home for this manifesto: Wol Kolade management team leader at Livingbridge and 25th inductee into the Private Equity Hall of Fame at the Real Deal Private Equity Awards has been appointed Deputy Chair of NHSE to Richard Meddings who, as I am sure you all know, was ex Chair of TSB and is a non-Exec at Credit Suisse. We would also point you towards the newly published book 'Cannibal Capitalism' by Nancy Fraser, Professor of Philosophy and Politics at the New School for Social Research New York, and an article about the coercion of psychological 'care' to reduce financial deficits (old but still so relevant to the way staff are being manipulated) https://www.opendemocracy.net/en/ournhs/dance-of-destitution-psychologys-clash-over-coercion/

This manifesto was written by Jude Ellis, Judith Varley, Paul Atkinson and Martin Blanchard (and with a lot of editorial help from Carol Saunders for the last section) over the course of 8-9 months. Having read several extremely good documents including information from the KONP crisis conference and the SWAN Charter, and noting no great 'purchaser penetration', as is said in some circles, and having careers in mental healthcare of many years (when added together) and therefore having lived and witnessed the long decline, we decided that this relative neglect of subject and services was more than just casual. So, putting together our experience, training and lots of research, and desperately trying to keep it cogent, after several iterations this is what you have.

It is not aimed at a particular audience but exists, we hope, as a potential resource for anyone interested in understanding not just the 'who and how' but also the 'why' any of us with a mental health problem may feel ostracised and receive a poor service. To understand and try to escape the current 'blaming of the individual' we have examined our current predominant ideology as 'our reality' and the harm associated with it.

Section 1 Pulls together some history, philosophy, politics and as you would expect, elements of psychodynamic theory to try to explain attitudes and behaviours towards people with mental illness; the 'practical barbarism' of the Poor Law Amendment Act of 1834 laid bodies bare to the full force of the marketplace, and marketisation of NHS healthcare has been a passion for certain politicians holding particular views for decades now and may finally reach its conclusion. Our politics of exclusion and the 'manipulation of reality' by capitalism with its requirement for continuous growth block any ideas of founding a truly inclusive society.

Section 2 Outlines the causal effects of our current global hegemonic system on mental health, with examples from government policy affecting levels of poverty, homelessness, and imprisonment; cuts to welfare benefits, the rise of a workfare ideology, denial of racism within state institutions and services, planned austerity, the exploitation of crises with private benefit at public cost- and all the time chasing surplus value.

Section 3. Is a note on the failure to achieve adequate mental health care provision in terms of resources and staff for hospitals and the community. Mental distress is increasingly seen as due to individual inadequacy: in some way not being 'able enough' to cope with life's vagaries; or due to certain disorders of the brain or genes or biochemistry best treated with Pfizer et al's products.

The idea that their economics and society may cause such distress is of course inconvenient for those who benefit greatly from the status quo.

Section 4 The final, major section is about needs and is in line with other Charters. However, the foundation of ours is an amazingly detailed piece of work by Judith Varley which was skilfully edited by Carol Saunders and then uncomfortably squeezed into what is the 'living' part of the document. It is long because there is so much that could be improved with better finance, estates, staffing, training, communication, attitudes and ways of working. We want it to get shorter, but we are happy to take and consider amendments to it as ideas develop and services change, or if more detail is needed, and also to make it longer if more services are lost or more care actively denied.

If you wish to comment, add, suggest amendments, or tell us that what we have suggested has now been achieved then please contact us:

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Brief biographies

Jude Ellis

Jude has led a lazy and undisciplined life, but somehow has been sensitive to the emptiness and loneliness that is the lived other side of the 'social' human condition. Having grown up close to the psychotic illness of a family member, she later grew a commitment to working in mental health social work and mental health law. (Her enjoyment of reading the writings of modern continental philosophy has been reawakened coincidentally at a time when the armchair philosopher needs to stand up.)

Judith Varley

Judith is a retired research biochemist /microbiologist in infectious diseases whose involvement in mental health began over 20 years ago with a close family member. She has a particular interest in progressive approaches to mental health and organisations like the International Society for PsychoSocial Interventions and Hearing Voices. She raised £30,000 to research and start a social enterprise offering paid work to people with mental ill health.

Paul Atkinson

Paul Atkinson has been swimming in the intersection of psychotherapy and political activism since the early 70s - with many spells of apathy, despair and watching telly. He helped found the Free Psychotherapy Network and the campaign for Universal Access to Counselling and Psychotherapy (uACT). He has five grandchildren.

Martin Blanchard

Martin truly fell out of love with psychiatry when the Clinical Director announced the arrival of the 'Harvard Business Model' in the service, when the priority suddenly became the assessment of a patient's 'currency' or 'value to the service'. Academia lost its shine with the REF and UCL's declared wish to become the 'Harvard of Europe'…. competing to chase income and promotion was beyond him, so he took instead to trying to understand what was going on.

A MENTAL HEALTH CHARTER AS A MANIFESTO August 2022 **SHA/KONP London** (version for group circulation)

'….when [as now] positivists seek to grasp and quantify the immeasurable problem of unhappiness, they encounter causes of that unhappiness that are far larger than economic or medical policy can calculate or alleviate. Is it too much to hope that, if critique can be rendered psychological, then the reverse may also be true: that mental ill-being may be rendered critical?'[1]

Section 1

Where the problem lies: 'for there is a gulf between top and bottom…and both bear human faces but have ceased to know each other'[2]

1. The history of mental health care in England[3] is one of shattered hope and betrayal. There are frequent plans, reports, and tragedies calling out for us to improve mental health services, but nothing really seems to bring the necessary change, and nothing like the suggested parity with physical healthcare services.

2. This is a deeper problem than casual neglect; the human element is being removed from services, relationships denied, time abbreviated and professionalism disavowed-things all essential for high quality mental healthcare.

3. So much energy and humanity has already been put into so many areas to try to bring about change, but these endeavours have ultimately turned out flawed or essentially wanting[4].

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[1] Davies, W. The political economy of unhappiness. New Left Review 71 (2011)

[2] Brecht, B. Die heilige Johanna der Schlachthöfe Bühnenfassung. Trans.by John Willett, Methuen Drama 1997.

[3] with the current redesign of health services, we, in London, can only talk about England now rather than anything like a National Health Service

[4] As Sedgwick states in his Psychopolitics: it could tentatively be said that many of the partial, sectoral campaigns that have been run over the years were examples of a form of evasion of the serious questions of long-term psychiatric care. The civil libertarian stance, the corporate trade union response, the hyper-politicised annexation of anti-psychiatry by the far left, the 'alternative therapies' which cater only for the milder and the more acute forms of distress all stand as displacements of the central problem of the asylum: how to create through 'fraternity' the economic means of employment, the material apparatus of housing, the ethical structures of fellowship and solidarity, for those who through various forms of mental disability cannot purchase these benefits as commodities in the marketplace.

4. However, the very passivity of many of us is highly dangerous at this present time when the amount of public money available for investment in health services, while already grossly inadequate, is to be further subject to global exploitation[5] including year-on-year financial constraints based on value-based systems with 'capped' budgets and system population resource allocation criteria based on 'value' that will leave much of mental healthcare at the bottom of any pile.[6,7]

5. It is as if there is a wish only for a cost-efficient service that should become the mind's 'industrial repair shop' simply to mend us for work and a life of tolerating the inequities set before us.

6. This manifesto arose from an uncomfortable realisation that necessary change in mental health care will only happen with political and social reconstruction.

7. Our suggesting these wider ideas may seem to make little pragmatic sense, but by taking a socio-political perspective it does enable us to consider 'chains of equivalence'[8] with so many other groups who are similarly affected: recipients of public welfare; poverty-laden workers; the unemployed; minority groups; 'immigrants' at home, and indeed the vast global populations who are 'dispossessed' by a new imperialism[9,10].

8. Medical enterprise is from its inception value-loaded; it is not simply an applied biology, but biology applied in accordance with the dictates of social interest. For those requiring mental healthcare it seems that social interest is particularly cruel[11].

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[5] https://www3.weforum.org/docs/WEF_Future_of_Healthy_How_to_Realize_Returns_on_Health_2016.pdf

[6] https://www3.weforum.org/docs/WEF_HE_SustainabilityHealthSystems_Report_2012.pdf

[7] https://keepournhspublic.com/wp-content/uploads/2022/03/value-MBJS-copy-copyMB-to-send-to-WG-copy.docx

[8] Laclau and Mouffe. Hegemony and Socialist Strategy: towards a radical democratic politics. Verso, NY 2014

[9] https://socialistregister.com/index.php/srv/article/view/5811

[10] www.tni.org

[11] It is apparent that the category of 'illness' carries weight when it comes to the provision of services in our current society, as if to serve to exclude those who may, by some, be considered to be simply 'weak' or malingering.

9. Our major argument points not to the incorporation of technology into the management of mental illness-for while this does serve to reduce severely the relational aspect of care there may be some new technology that could potentially bring some improvement- nor to the medicalisation of moral values (so obvious already in the practice of psychiatry). But no, both these aspects themselves fall under the influence of our major target: the industrial-political or, under its current guise, the 'multi- stakeholder' influence on medical goals, all in the name of the 'continuous growth of capital'[12,13]

10. We note the 170 years that healthcare has tried to guard those with mental 'illness' from harms including those of capital and the market (practical barbarism) as occurred following the Poor Law Amendment Act of 1834[14].

'Pinel vindicated the rights of science against the usurpations of superstition and brutality; and rescued the victims of cerebro-mental disease from the exorcist and the gaoler. The physician is now the responsible guardian of the lunatic and must ever remain so unless by some calamitous reverse the progress of the world in civilisation should be arrested and turned back in the direction of practical barbarism. (editorial prospectus for the opening issue of the Asylum Journal November 1853)'[15].

A major reverse of any progress is now to be marked by the destruction of universal healthcare in England[16].

11. A famous philosopher from Trier once said that 'men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past'. He also noted that all

[12] Capital is not a thing but a process specifically of the circulation of values. These values are congealed in different things at various points in the process: in the first instance of money and then as commodity before turning back into the money form. Not all money is capital. Capital is money used in a certain way. It's definition cannot be divorced from human choice to launch money power into this mode of circulation. A capitalist is 'the conscious bearer… of this movement; the possessor of money can become a capitalist. Their person or rather their pocket is the point from which the money starts and to which it returns.' From this it follows that 'use values must therefore never be treated as the immediate aim of the capitalist'; the capitalist produces use values only in order to gain exchange value and does not actually care about which or what kind of use value gets produced; it could be any kind as long as it permits them to procure surplus value (profit). The aim is rather unsurprisingly 'unceasing movement of profit making'. Harvey D. Companion to Capital.Verso NY.

[13] Navarro, V. Medicine Under Capitalism,New York: Prodist, 1976

[14] https://navigator.health.org.uk/theme/workhouses-and-poor-law-amendment-act-1834

[15] https://www.cambridge.org/core/journals/the-asylum-journal/article/abs/prospectus/947556B7E2C8B84E9B15E33002397DF4

[16] https://keepournhspublic.com/privatisation/

great world-historic facts and personages appear, so to speak, twice, adding: the first time as tragedy, the second time as farce.

12. May we present as tragedy the free-market libertarian Herbert Spencer 'the single most famous European intellectual in the closing decades of the nineteenth century' whose works were translated into German, Italian, Spanish, French, Russian, Japanese and Chinese, and many more languages? He was offered honours and awards all over Europe but especially in North America. His views on the state relief of poverty and disease preached a 'laissez faire' refusal to intervene against affliction, a brand of individualism that was not merely rugged but ruthless:

'there is a notion, always more or less prevalent and just now vociferously expressed, that all social suffering is removable, and that it is the duty of somebody or other to remove it. Both these beliefs are false....'

'Even though it seems hard that….unskillfulness should entail hunger upon the artisan, or widows and orphans should be left to struggle for life and death. When regarded not separately but in connection with the interests of universal humanity, these harsh fatalities are seen to be full of beneficence-the same beneficence which brings to early graves the children of diseased parents and singles out the low spirited, the intemperate and the debilitated as victims of an epidemic'[17]

13. The ideas of Herbert Spencer are not too far beneath the surface of our current hegemonic ideology, echoed farcically across the years through the mouth of the recent Secretary of State for Health and Social Care as a love for the ideas of Ayn Rand and her Institute which states:

'The entrenched premise of Medicare, Medicaid, and Obamacare is that someone's need for medical care entitles him to the unearned: the effort and wealth of others — not only taxpayers, but notably the medical professionals who make health care possible.

We [the Rand Institute] reject that premise as immoral. We view that premise as enabling the continual expansion of government's role in medicine — and as disarming advocates of freedom who concede it. To reverse course, what's needed is

[17] Spencer H. The Man Versus the State. Liberty Classics, Indianapolis 1981 (originally published by Williams and Norgate, London and Edinburgh 1884) http://files.libertyfund.org/files/330/0020_Bk.pdf

a willingness to challenge that premise and advocate for freedom on the moral principle of individual rights.'[18]

14. We, the members of the SHA/KONP mental health group in London reject these libertarian ideas and instead agree with much of the new psychoanalytically informed 'anti-politics' as they currently exist[19] - that is not a simple rejection of politics nor is it political indifference,[20,21] but a total rejection of the narcissistic greed, and the dismissal of 'negativity'[22] that capital enures within our current politics[23].

15. It is the apparent threatening aspect of 'negativity' that those with severe and enduring illness engender, that means that they will continue 'not to be seen or heard' with no hope of rescue by our politics - and will remain as 'the part of those who have no part' [*le compte des incomptés*] in our society[24]

16. And so, capitalism denies us the experience of living in a society in which our limitations, our destructiveness, enduring pain and failure

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[18] https://ari.aynrand.org/issues/government-and-business/health-care/50-years-down-the-road-of-socialized-medicine/

[19] Tomšič, S. The Capitalist Unconscious. Verso NY 2015

[20] There is a disjuncture between politics and modernity created by the seepage of economic fictions into our politics and the enthroning of economy as some sort of new 'queen of sciences'. It is capital that constructs an economic-theocratic order which entirely absorbs politics and science and therefore its abolition is the necessary condition for the synchronisation of politics with the modern universe.

[21] The notion of an anti-politics is also inferred from Rancière's '10 Theses' (see below) where our current politics and any suggested 'new' politics are simply the politics of those who already have a voice. They maintain the exclusions of the status quo and deny any possibility of a true democracy- 'Bourgeois democracy is the rule of the rich behind the façade of parliamentary Punch and Judy shows (Tory/Labour; Republican/Democrat)'

[22] If we accept that any developmental change requires contention such as in a dialectic then the 'negative' aspects of our society require genuine representation in our politics and democracy. It is because of capital's emphasis on narcissistic individualism and its widespread disavowal of any 'negativity' it creates or maintains, that capital can persist with the belief that there is [no need for any] alternative. It even fails to notice the paradox in that its cause of major contention, the intrusion of the state, actually proves to be part of the solution- 'the very 'normal' functioning of the market can be secured only by way of the state actively intervening in social security, ecology, law enforcement…' (Zizek, S. 'Tarrying with the Negative: Kant, Hegel, and the Critique of Ideology'.p. 93). But in light of such paradoxes, precisely how do we ascertain the truth of any social system? Adherents of any ideology are generally not aware of the hidden underside (the repressed truth) of the social reality, the exclusion of multiple minority groups and so what is wrong with the social order…. those who are disenfranchised experience the truth repressed from the hegemonic ideology.

[23] The dynamics and adaptability of capital, with its capacity to mystify, distort and repress subjective and social antagonisms, and to assimilate symptomatic or subversive identities, sufficiently indicates that capital should be understood as life without negativity, or more precisely, that the efficiency and the logic of capitalism is supported by a fantasy of such life, subjectivity and society.

[24] Rancière J 'Ten theses on politics' http://www.after1968.org/app/webroot/uploads/RanciereTHESESONPOLITICS.pdf

to thrive, our conscious or unconscious 'shadow' is not only tolerated but valued as part of the shared human condition – and instead offers us the transactional, individualistic, self-actualising commodities of its markets.

17. As it stands, our predominant economics contains a set of irrational beliefs and a systematic strategy to repress the fact that the creation of wealth requires the reproduction of premodern relations of domination and subjection.

18. Capitalism therefore needs to be seen as the restoration of pre-modernity within modernity, a counter-revolution that neutralises the emancipatory political potential of any scientific revolution.

19. Capitalism is clearly unstable, and this is structural to the extent that every economic crisis reveals the normal functioning of capitalism. However, the core of the crisis is not so much the incapacity of capitalism to regulate instability but through its 'normal' functioning the creation of global surplus populations[25] of the unemployed and destitute which personify the return of the rejected negativity.

20. Capitalist democracies claim to be the political inheritors and the beneficiaries of the modern scientific revolution. But within them the socio-political concepts of freedom, equality and amity, claimed by the French Revolution, were transformed by property and private interest. They have rejected the idea of amity, preferring instead the competitive self-interest of the individual,[26] and thus restricted the revolutionary character of freedom and equality 'for us all'[27], through the narcissism of the private.

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[25] Groups of people who are rendered unproductive and left unemployed or underemployed because of the structure of capitalist systems of production. In class society based on private ownership of the means of production, labour can realise the integration with the means of production only under the condition that they provide the exploiters with surplus value; therefore, a certain amount of labour is always becoming the relative surplus population.

[26] The portrayal of humans as consistently rational and narrowly self-interested, pursuing their subjectively defined ends to the best of their ability. Adam Smith 'The Wealth of Nations': It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own self-interest.

[27] Revolutionary 'freedom' for us would be existing as 'in and for itself' (an und für sich) where we are both at home in ourself and importantly we find ourself in the other. It contrasts with mere being 'in itself' (an sich) which is potential or implicit existence as simply separated from other things and (in the case of a form of consciousness) when it is unreflective; or 'for itself' (für sich) which is a reflective, explicit, self-comprehending, fully developed existence without the other.

21. Amity inspires hope and still 'strives to found the social link'[28].

22. Two aspects of modernity are required in our politics for any exit from capitalism:

a) the mobilisation of what some may see as the subversive dimension of modern science as opposed to the current combination of positivism and quantification that is used to dominate us. Science could and should amount to the 'liberation of the labourer from labour' by means of: i) the recognition and condemnation of the enormous acts of exploitation inflicted by a minority on the majority through the processes of human commodification and dispossession in the act of the accumulation of personal wealth[29] and ii) the use of technology for the benefit of global environmental rescue and human equality.

b) the making real of the third concept that drove the French Revolution- amity. This too will only be possible when there is acceptance that as individuals we matter as much as everyone else, no more and no less; that the creation of individual wealth and the wielding of power over others are not the pinnacles of human achievement that our current interpretation of history may want us to believe; and that as 'subjects' we should value what it is to be human, our differences and our limitations as part of the shared human condition, instead of manipulating reality with bewildering theories that maintain arrant narcissism[30].

23. Both the above will prevent the capitalist economy taking politics and the entirety of social reality as its hostage, and then perhaps our politics and democracy may become truly inclusive.

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[28] Tomšič, S. The Capitalist Unconscious. Verso NY 2015. What is it that invisibly brings bodies together, enough to make couples and societies, and what is the power that breaks them apart?

[29] Science is one of the central terrains of political struggle precisely because its misuse in economics became the main tool of capitalism against the realisation of political modernity and its prevention of the liberation of the labourer.

[30] Any materialist reading of modern science has to include the question of its subject, and with the suspension of narcissism, it may remove our politics from private interest.

Section 2

Capitalism as a cause of mental ill health

24. While attention to people's difficulties and suffering in their daily lives is of course welcome, the current framing of this attention has taken the form of creating a mental health market, individualising and medicalising psychological distress and commodifying behavioural remedies.[31]

25. A paradox of modern capitalism over the last two or three decades is the unfolding narrative of a global "common mental health crisis". In the UK, mental health has become a preoccupation of governments, and mainstream and social media,[32] something which is being presented as a discovery and major advance in the government's humane concern for the health and wellbeing of society.[33]

26. In fact, alongside the climate, financial and Covid-19 crises, the "common mental health crisis" characterises the structural erosion of this stage of capitalism's hegemony.[34]

27. But there is an elephant in the room! **Capitalism generates psychological distress and suffering.** Modern capitalism has created our mental health crisis,[35] and government policies support and deepen the mental ill-health of our capitalist society.

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[31] See Will Davies. The political economy of unhappiness New Left Review 71 (2011) for a discussion of the dilemma for capitalism of maintaining a workable balance between happiness and unhappiness. "To the pessimist, the fact that economists have discovered unhappiness and history may look like the final triumph of immanence. The optimistic reading would be that when positivists seek to grasp and quantify the immeasurable problem of unhappiness, they encounter causes of that unhappiness that are far larger than economic or medical policy can calculate or alleviate. Is it too much to hope that, if critique can be rendered psychological, then the reverse may also be true: that mental ill-being may be rendered critical?"

[32] For example, the Guardian newspaper published headlines containing the phrase "mental health crisis" 192 times in 2020/21, compared to once only in 2001. See also https://link.springer.com/article/10.1186/1471-2458-11-796. Many celebrities have declared their mental health problems to the public. Hundreds of government, NGO and charity reports have been written on the "mental health crisis" in UK and globally since 2000.

[33] See the marketing of the Improving Access to Psychological Therapies, in Layard and Clark *Thrive: The Power of Psychological Therapy* Penguin (2015), and https://www.nytimes.com/2017/07/24/health/england-mental-health-treatment-therapy.html

[34] https://www.versobooks.com/lists/5234-neoliberalism-is-collapsing-what-was-it-what-comes-next

[35] James Davies *Sedated: How Modern Capitalism Created our Mental Health Crisis* Atlantic Books 2022

28. The social determinants of mental ill-health have long been acknowledged by academics, health professionals, governments and most importantly by the common sense of the public.[36] We know that the material and social circumstances of someone's life play a major part in producing acute and chronic emotional distress. The kind of society we create and live in is critical for everyone's sense of security, experience of well-being and everyday optimism and creativity.[37]

29. Under capitalism, diagnosing and treating psychological and emotional suffering as a problem of individual psychopathology wants to legitimate socio-economic conditions as normal, and cast therapies as strategies for the individual's recovery to those conditions. Meanwhile, governments continue to produce policies which support and further the interests of capital while generating anxiety, loneliness, economic misery, transactional relationships, depression, and fear among a significant proportion of the population.

30. Examples of government policy, since Thatcher, that have inevitably impacted on the psychological as well as material well-being of the less well-resourced sections of our society abound.

31. We all know that income and wealth inequalities have massively polarised since Thatcher, while average real wages have been more or less stagnant.[38] Council house building fell from around 120,000

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[36] See APA 2000 statement on poverty and social status https://www.apa.org/about/policy/poverty-resolution; WHO 2014 report on social determinants of mental health https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf; Royal College of Psychiatrists 2010 report https://www.rcpsych.ac.uk/pdf/PS04_2010.pdf; the Marmot Review 2012 https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf; David Smail *The Origins of Unhappiness: A New Understanding of Personal Distress* Routledge 2015; Richard Wilkinson, Kate Pickett *How More Equal Societies Reduce Stress, Restore Sanity and Improve*

[37] The founding document of the World Federation of Mental Health in 1948, *Mental Health and World Citizenship*, understood "world citizenship" in terms of a "common humanity" respecting individual and cultural differences, and declared that "the ultimate goal of mental health is to help [people] live with their fellows in one world". A key contributor to this founding statement was the psychiatrist Harry Stack Sullivan (1892-19490), an ardent proponent of "world mindedness", who held that "personality can never be isolated from the complex interpersonal relationships in which a person lives" and that "the field of psychiatry is the field of interpersonal relations under any and all circumstances in which such relations exist". *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2408392/*

[38] https://www.theguardian.com/business/2014/jan/31/real-wages-falling-longest-period-ons-record

new homes a year in the '70s, to virtually zero by 1992.[39] Around 20% of the population live in private rented property - twice the number in 2000.[40] Poverty is on the increase, including food and fuel poverty.[41] Child poverty, with a brief intermission under Blair/Brown, has been rising since 1980. Unsecured household debt has doubled over the last 30 years. Homelessness in London has tripled since 2010. The prison population of England & Wales quadrupled in size between 1900 and 2018 - half of this increase taking place since 1990.[42]

32. The welfare state, created in the aftermath of World War II, has been dramatically eroded during the neoliberal period.[43] Benefits have been cut, and welfare based on social security has been replaced by workfare ideology over more than three decades. The torture of Work Capability and Personal Independence Payment assessments for people with mental and physical disabilities still continues.[44]

33. Health inequalities among different ethnic minority groups have also been highlighted by the Covid pandemic, but we know that institutional racism, income, wealth and health inequality across ethnic background have been with us for decades.[45] On the mental health front, black and brown people are more likely to be diagnosed with psychosis, more likely to be under Community Treatment Orders and less likely to get good quality care from mental health services.[46] The ongoing Windrush scandal and the UK's treatment of asylum seekers escaping theatres of war and economic destitution are shameful beyond forbearance.[47]

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[39] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on p.108*ff*

[40] https://www.generationrent.org/about_renting

[41] https://www.hrw.org/report/2019/05/20/nothing-left-cupboards/austerity-welfare-cuts-and-right-food-uk

[42] https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf

[43] https://neweconomics.org/2021/02/social-security-2010-comparison

[44] https://www.disabilitynewsservice.com/mounting-evidence-of-assessment-crisis-as-dwp-halts-wca-reassessments/

[45] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

[46] https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[47] https://www.theguardian.com/society/2019/oct/09/windrush-scandal-survivors-mental-health-care

34. Poverty, punitive welfare policies and cuts in health and social care kill people, make us ill, destroy our psychological balance, shorten our lives, and drive us to despair, madness and violence of one kind or another. Austerity policies after the financial crash in 2008 are calculated to have killed tens of thousands of people.[48] Now in 2022, on top of a pandemic, we have another economic crisis fuelled again by the mindless avarice and extractive ideologies of the masters of our capitalist 'democracy', and again the cost of which will fall on the poorest, while the wealthy receive the dividend of crisis. And in the background, our planet burns and suffocates.

35. No government or political party in modern Britain has so far prioritised the basic material, relational and emotional needs of the people over the interests of capital. Social and economic policies have therefore consistently carried a cost of harm to the psychological welfare of the many in the interests of the few. Unless and until this changes, government mental health policies are likely to be taken up with attempting to mitigate the damage it is itself inflicting on the society it purports to serve.

Section 3

The failure of mental health care provision

36. The inadequacy of funding[49] and trained workforce[50] levels in NHS and local authority mental health services is historic and has significantly

[48] https://www.bmj.com/company/newsroom/uk-austerity-since-2010-linked-to-tens-of-thousands-more-deaths-than-expected/

[49] Real growth in the annual public spend on health fell from an average of 6% under Blair and Brown to under 2% since 2010 https://nhsfunding.info/nhs-crisis-making/ Mental health funding actually fell in real terms under the Tories between 2012 and 2017 https://www.theweek.co.uk/93320/fact-check-the-truth-about-mental-health-funding . Despite recent “parity of esteem" rhetoric mental health services continue to receive only 13-14% of the national CCG spend on health https://www.england.nhs.uk/publication/nhs-mental-health-dashboard/ - despite the fact that mental health problems constitute around 28% of the country’s disease burden.

See also: https://www.bmj.com/content/375/bmj.n2706 https://www.nhsconfed.org/articles/we-cannot-continue-neglect-mental-health-funding https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2_0.pdf

[50] https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-health-workforce-jan-2020.pdf. https://www.rcpsych.ac.uk/improving-care/workforce/campaigning-for-the-mental-health-workforce-of-the-future.

deepened since the financial crash of 2008 and the austerity policies that have been pursued by government since.

37. Due to lack of resources only the very unwell are hospitalised, and this is increasingly those admitted by compulsory sectioning where their behaviour is seen as dangerous to themselves or others. Informal hospital admission should be available in a crisis, for assessment, for asylum not simply under compulsory powers.

38. Major cutbacks to statutory services delivered by the NHS, public health and local authorities are leaving other individuals to 'find their own solutions', and too many people suffering mental ill health are ending up on the street[51] or in prison[52].

39. The increasing medicalisation of the wide diversity of human distress, reflects a shift, since the 1970s, to view distress and behavioural disorders as:

    a. separate, diagnosable, 'mental illnesses' – there are 360 in the 5th edition of the highly influential US Diagnostic and Statistical Manual (2013)[53]

    b. being due to individual inadequacy, and/or

    c. being due to (unproven) 'brain disorders' or 'bad genes' or 'bad biochemistry' – best treated with psycho-active drugs[54]

40. The move away from understanding distress as based in internal conflicts, life experiences, and economic or social difficulties (inconvenient to those who oppose social change) has been reflected in changes to psychiatric teaching and available treatments[55]

[51] https://england.shelter.org.uk/professional_resources/housing_and_mental_health

[52] https://www.justiceinspectorates.gov.uk/cjji/media/press-releases/2021/11/mentalhealth2021/

[53] https://www.madinamerica.com/tag/dsm-5/ https://adisorder4everyone.com

[54] https://www.goodreads.com/en/book/show/17852736-cracked

[55] https://www.pccs-books.co.uk/products/critical-mental-health-nursing-observations-from-the-inside

Section 4

WHAT IS NEEDED IN MENTAL HEALTH SERVICE PROVISION

General principles

41. Some mental health conditions can be managed effectively in the community, but others require hospitalisation – sometimes repeated hospitalisations over many years. Some people will go on to lead 'normal' lives, while others are permanently affected.

42. All mental health conditions affect not just the individual, but an entire family (or equivalent close supporters, thereafter termed 'family'). All services depend on free support from family. So, unless there are clear reasons for not doing so, the family needs to be involved in any recovery plan. Families should also be involved in the design and delivery of services.

43. As well as treating conditions with medication where appropriate, all patients will potentially benefit from making a trusting, reliable relationship with a registered psychotherapist, who has a recognised professional training. This should not be managed in a mechanical, time-restricted way.

44. All service users benefit from activities and kind, supportive, non-judgmental people and friendships in the wider community that are totally independent of mental health services. This is especially important to young people, who have to find their way as young adults in a complex, quickly changing and confusing modern world, often quite different from that in which they were children (e.g. climate change, becoming refugees, trafficked, separated from family / culture /community, maybe all of these)

45. The personal aims and aspirations of service users should come before those of mental health professionals.

46. Democratic feedback – which disappeared with the abolition of the Local Implementation Teams of the National Service Framework (NSF) and the Community Health Councils– need to be restored.

47. All resources need to be properly financed (trained staff as well as money).

48. Any serious attempt to lessen mental distress in the UK must include addressing inequalities. The proposals in the Department of Health's *Tackling health inequalities: a programme for action* (2003)[56] provided the foundation actions for meeting the wider causes of health inequalities.

49. The 2018 report of the UN Special Rapporteur, Professor Phillip Alston[57], which was excoriating on the UK's approach to poverty and inequality, pointed to key areas that need to change, including reversing cuts to local authority spending, the social security net and legal aid.

50. Treating mental distress must have the same priority as treating physical illness. The funding gap must be bridged.

51. Like the rest of the NHS, mental health care should be universal, comprehensive, free at the point of access, publicly provided, paid for by progressive taxation and based on need not ability to pay.

52. The mental wellbeing of NHS staff must be effectively addressed.

53. The permanent mental health workforce needs to be rebuilt. Restoring the nursing bursary would attract mature people as well as school leavers.[58,59,60]

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[56] https:www.bristol.ac.uk>keyofficialdocuments

[57] Bristol.ac.uk/poverty-institute/news/2019/un-rapporteur-final-report.html

[58] https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-health-workforce-jan-2020.pdf

[59] https://www.bmj.com/content/375/bmj.n2706

[60] https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2_0.pdf

54. People with enduring mental distress need more support to stay physically healthy.

55. Professional one-to-one support should be available to support patients to reduce or come off their psychiatric drugs. Pharmaceutical companies will need to provide smaller tapering medication doses.

56. The government needs to act on Coroners' court reports to prevent future deaths[61] on serious failings and mistreatment in mental health services. This information should also be more widely publicised.

57. Carers urgently need support, including respite, training and proper remuneration, recognising their invaluable, demanding and lifetime commitment.

58. A new National Service Framework to set out national standards in mental health treatment is needed and must be made to work and influence policy. It should recognise the importance of social and economic inequality, and the role of trauma and adverse childhood events.[62,63,64,65]

59. The NHS must be reinstated.

60. There is a waiting list scandal. Waiting lists need to be reduced.

61. There should be a wide range of psychotherapies on offer within the NHS, with official training qualifications and registrations.

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[61] https://www.judiciary.uk/subject/mental-health-related-deaths/

[62] NSF (1999) https://www.gov.uk>government>publications/quality-standards-for-mental-health-services .

[63] Herman, J (1997) 'Trauma and Recovery: from domestic abuse to political terror',

[64] Trauma informed mental health care in the UK' Sweeney A et al (2016) 'Mental Health Review J 21 174-192

[65] Scottish workforce training https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/national-trauma-training-framework.aspx

62. Publicly provided residential services should be restored as soon as possible.

63. Robust inspection of all services and residential facilities by teams of professional and (possibly) elected lay people is needed. Some inspections should be without notice, and the premises in which people live inspected, not just their main offices. This occurred under the Community Health Councils that were precipitately abolished without discussion or explanation in 2003, thereby depriving patients and the public the right to be properly consulted on new developments or proposals for change. The successor organisations Public and Patient Involvement Forum, LINKs or HealthWatch have nothing like the powers or responsibilities of the CHCs. The Care Quality Commission currently is unable to do an adequate job in our view. Community feedback mechanisms need to be restored see above- re: Local Implementation Teams.

64. Services should be fully publicly accountable- the mechanism for this is explored by Keep Our NHS Public.[66]

65. We recognise that the Third sector is often innovative and creative in its practices. These services should neither be co-opted nor replace statutory services.

66. Local respite houses and other promising alternatives to acute admission need to be pursued and an evidence base regarding impact on service user experiences and outcomes needs to be established. [67]

67. It is wrong to think specialist day centres for particular groups are redundant. The new hope that 'community link workers' can integrate people with long term conditions into high street cafes, leisure and educational facilities in mainstream commercial provision is desirable. However, there remains the need for quality day centres

[66] https://keepournhspublic.com/wp-content/uploads/2021/01/KONP-ICS-pt1-democratic-accountability-2021-01-03.pdf

[67] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8553397/

offering food, conviviality and social activities to people with major mental illness.[68]

68. We need to rebuild facilities, particularly in cities. This will require collaboration between the NHS, local authorities and local charitable groups, and active public participation.

Creating social inclusion

69. In February 2006 Tony Blair created a Cabinet member to combat Social Exclusion. The 2004 report's recommendations need to be implemented[69].

70. National survivor and campaign groups should be involved, for example, Hearing Voices Network, National Service User Network, SWAN (Social Work Action Network) and DPAC (Disabled People Against Cuts).

71. Funding needs to be available to support good resources and information provided by charities and professional groups. These would include rapid-response phone lines, training courses for professionals and service users, advice leaflets and other services.

Employment and benefits

72. Genuinely sensitive models of support – similar to the John Timpson model for ex-prisoners – would help those who genuinely want to go back to work[70].

73. Other people who cope better with unemployment should be properly supported by a compassionate benefits system. The link between severe mental ill-health and poverty and isolation needs to be broken with proper support from across the community.

74. People should not be compelled to work.

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[68] Clark,C. (ed) Adult Day Services and Social Inclusion: Better Days. (2001) London: Jessica Kingsley

[69] https://ec.europa.eu/employment_social/social_inclusion/docs/3uk_en.pdf

[70] The Timpson Foundation https://www.timpson-group.co.uk

THE MENTAL HEALTH OF PARTICULAR GROUPS

Women's mental health- general context

75. The ongoing issue of gender inequality must be addressed urgently.[71]

76. Sorting out the failings of the police and criminal justice system in prosecuting sexual and other offences needs to be prioritised.[72]

77. Better training is needed for NHS staff, including mental health staff, around sexual trauma[73]

78. The Domestic Abuse Act (2021) is an improvement as is the appointment (part-time) of a Commissioner for Sexual Abuse.[74] However, rape crisis and support services, as well as women's refuges, are dramatically underfunded and less than half survivors are able to access community based support which remains a post code lottery; this is particularly so for people with insecure immigration status.There are serious failings in reports to the police, and whilst non-fatal strangulation is now recognised as abuse, it is questionable whether there will be effective implementation. These anomalies need to be addressed.

Specialist services for women

79. Services need to be reintroduced or launched. In particular:

- peri-natal, maternity and neo-natal mental health services – with particular care for women who have a history of mental ill health.
- services for women with post-natal urinary or faecal incontinence (especially high in women who have suffered FGM).
- services for teenaged parents.
- domestic violence refuges and services – including workshops for abusers.
- services for women with no resource to public funds.

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[71] Evans, M. The Persistence of Gender Inequality. Polity Press, Cambridge and Malden, 2016

[72] https://publications.parliament.uk/pa/cm5802/cmselect/cmhaff/193/report.html

[73] https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf

[74] https://domesticabusecommissioner.uk

80. We urgently need more health visitors, district nurses, family liaison workers, midwives, mental health workers, psychologists and social workers.
81. Female asylum seekers need equal access to mainstream and specialist services.

Early years and family services

82. Counselling and support services need to be restored and expanded.
83. Sure Start Centres need to be restored, with the full range of support from nurses, health visitors and counsellors.
84. Young parents need places they can go for informal support and to share experiences.
85. Childcare funding needs to meet real costs.

Children and young people general and specialist

86. Poverty and inequality need to be urgently addressed.
87. Local and national authorities need to work together to provide intervention services for at-risk young people. Local charities and others doing good work should be supported with reliable funding and not privatised.
88. All service providers dealing with children need to be trained to recognise trauma, so that referrals for specialist therapy can be made. Scotland's National Trauma Training Framework (see footnote 65 above) has made a good start. Health visitors and midwives need particular training to identify troubled families for referral.[75]

[75] Powell, C. Safeguarding and Child Protection for Nurses, Midwives and Health Visitors: a Practical Guide. Open University Press 2016

89. Proper research is needed to assess the decisions being made by family courts.[76,77,78]

90. Teachers need training to increase their awareness of signs of mental distress in pupils[79]and to know what actions to take.

91. Every school and college should have easy access to a professional 'in-house' counselling service.

92. Mental Health Support Workers are to be organised in teams responsible to schools, and this is currently being implemented. There is a new post-graduate qualification that takes 12 months. This has emerged from the 2017 Green Paper Transforming Children and Young People's Mental Health Provision.[80] This development must be closely evaluated.

93. There should be a readily available locality CAMHS link-officer for every school.

94. All CAMHS Mental Health Assessments should be started within two weeks of referral. These and subsequent treatment should be close to home, easy to access by public transport and fully engage the family.

95. Cuts to CAMHS services must be reversed and the work of CAMHS extended to the age of 25 years, with well managed hand-overs to adult services where necessary. Any in-patient admission must prioritise the safety of the younger person, be in a service able to provide the necessary care, and be local enough for families to be involved in care.

96. Children need support in one-to-one relationships where trust can be built.

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[76] Sir James Mumby (President of the Family Division of the High Court of England and Wales 2013 – 2018) submitted his Transparency Review in 2021 emphasising the lack of long term outcome research when children are forcibly removed from the parent they have consistently chosen to live with, and the lack of genuine expertise and affiliation to any regulatory body of experts appointed by the Court of Justice when making these decisions, along with the lack of properly funded resources. https:// transparencyproject.org.uk

[77] Quote: James Mumby Transparency Review (of the inadequacy of the Family Courts) 'there are cases…where the only person being protected…..is the judge'. Sunday Times May 23 2021 https://www.thetimes.co.uk

[78] Thorburn J. 'Processes and determining factors when court judgements are made in England'. J. Social Welfare and Family Law (2021).

[79] https://www.rsm.ac.uk/media-releases/2022/teachers-mental-health-training-children/

[80] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

97. Youth and other public services need to be restored, with a particular concern for mental health.
98. When treating young people affected by adverse childhood events, it is essential that support is personalised and built on one-to-one relationships.
99. SATS should be abolished as they are harmful to children. More imaginative activities need to be reintroduced. Teachers need greater autonomy to reduce their unproductive tension and improve their workplace.[81]
100. School budgets need to be restored to support children with special needs.
101. Where they are failing to do so, schools should be supported to meet good practice around anti-bullying work and Personal Health and Social Education (PHSE) teaching (which should include topics such as self-image, relationships and social media use), and in seeing that parents get the support they need. More resources are needed for all schools to achieve this.
102. Schools need to be returned to the control of local authorities.
103. Further education colleges need funding restored so that they can offer counselling support to their students.
104. Experiments that bring young children and older residents together have proved beneficial to both. Imaginative community projects should be strongly supported.
105. Gambling and other addictive 'industries' need to be properly regulated – online as well as on the high street.
106. Doug Nicholls, Chair of the National Youth Agency[82] has founded the Choose Youth Campaign[83] to address 'austerity' based lack of opportunities and investment for young people facing major societal, and environmental challenges in their lifetimes.

[81] Davies, J. "Sedated: How Modern Capitalism Created Our Mental Health Crisis" 2022 Atlantic Books, Chapter 6 "Education and the Rise of New Managerialism"

[82] www.nya.org.uk

[83] www.chooseyouth.org

Cared-for, fostered and other vulnerable children

107. Children require careful, skilled assessment where there is family breakdown. Options of keeping the family together, fostering, children's homes and adoption should be decided on the basis of need not available resources. Well organised and properly resourced placements that suit the child/adolescent should be made available.

108. Better monitoring of and support for foster parents.

109. An end to privatised, unregulated accommodation for children. Children's residential placements need to be properly and regularly reviewed. Frequent inspections of all accommodation used for children – to include input from trained, independent, local authority social workers, who can support and befriend them and liaise when necessary with the police and mental health support services.

110. Restored youth work services and funding for charities like Barnardos.

111. True partnership working including education, parents, social and health services, local communities, mentors, and potential employers.

Young offenders

112. Services need to be drastically improved and returned to the public sector as soon as possible.

113. In the meantime, contracts should not be awarded to companies with poor records.

114. Institutions must be subjected to rigorous planned and unplanned visits.

115. The Scottish system provides a good starting point for changes across the UK[84].

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[84] The Kilbrandon Report (1973) https://www.govscot>govscot:document remains central to Scottish recommendations, with rehabilitation prioritised over punishments (Children and the Scottish Criminal Justice System https://archive2021-parliament.scot>SB_16-54 Children in Scotland must be at least 12 years before they can be tried in Court; in England they are often much younger. A 2017 Report of Young Offenders Institutions and Secure Training Centres in England housing children as young as 9, found none was safe for young people. Contd.

(https://www,independent.co.uk/news/uk/crime/in her 2014-15child-sexual-abuse-custody-detention-centre-inquiry-a8801221.html More than 1000 incidents of sexual abuse were reported between

Adults in the criminal justice system

116. Many people in the current prison population should not be there at all. In September 2021, around 10% of prisoners were recorded as receiving treatment for mental illness with one suggestion that as many as 70% may have some form of mental health need at any one time.[85]

117. They include people with mental health problems and women who are mothers. In her final report as Chief Inspector of Probation for England and Wales (2019), Dame Glenys Stacey considered the probation service 'irredeemably flawed' following budgets cut, and fragmenting services. She criticised both state (National Probation Service) and private (Community Rehabilitation Companies) provisions, but the latter especially and recommended greater consistency and better effective supervision.[86]

118. All prisoners should have access to the Samaritans phone line and should be able to speak privately with counsellors and supporters outside the system.

119. Rehabilitation should include effective one-to-one therapy with trained personnel, and support to gain literacy, numeracy, and other skills. The experimental Corbett Rehabilitation Centre offers a useful model[87].

120. More support is needed to house, settle, find good quality paid work for, and support ex-offenders.

121. The renationalisation of community probation services needs to be fully funded and include more trained, professional staff.

2009 – 2017, many in institutions run by Serco and G4S. Alison Redmond in her 2014 -15 report 'Children in Custody' for HM Inspectorate of Prisons Youth Justice Board found 34 – 40 % of children felt unsafe in them.

[85] https://committees.parliament.uk/publications/7455/documents/78054/default/#:~:text=Around%2010%25%20of%20prisoners%20were,need%20at%20any%20one%20time .

[86] https://www.justiceinspectorates.gov.uk

[87] https://www.dgft.nhs.uk

122. The Corsten Report (2007)[88] recommendations need to be revisited as they remain unimplemented. This is about women with particular vulnerabilities. It was undertaken following the high numbers of female suicides after progressive measures were abandoned during 'austerity'.

123. Psychiatric Forensic services have always been reasonably well resourced, particularly in Specialist Hospitals and Medium Secure Units. Many of the latter are run by the private sector. Lacking are the resources to discharge people back to the community, for which hostels, supported housing, structured activities, and specialist care and social workers are necessary.

124. Residential NHS Personality disorder services have been eroded with an increasing reliance on the private sector[89]. The Offender Personality Disorder Pathway Strategy (2015) is conspicuous in its concern only with those personality disorders with anti-social/criminal features[90].

Communities experiencing racial discrimination and. inequalities[91]

125. There must be a comprehensive race equality strategy, properly resourced and staffed, developed in collaboration with marginalised communities and committed to the eradication of systemic racism across every aspect of social and economic life – including mental health policies and services[92].

126. Iniquities and discrimination experienced by Black, Asian and other marginalised communities in relation to decent housing, education, welfare benefits, employment, physical ill-health and criminalisation contribute to disproportionate representation in mental health services and must be tackled by central and local government policies urgently[93].

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[88] www.justice.gov.uk/publication/doc/corsten-report-march-2007.pdf

[89] Personalitydisorder.org.uk/services/

[90] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/opd-strategy-nov-15.pdf

[91] https://www.centreformentalhealth.org.uk/guide-race-and-ethnicity-terminology

[92] https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[93] https://www.mind.org.uk/news-campaigns/news/existing-inequalities-have-made-mental-health-of-bame-groups-worse-during-pandemic-says-mind/

127. Mental health services need to address the multiple forms of marginalisation [90] experienced by Black, Asian and other minority ethnic service users in relation to the quality of assessment and treatment, the incidence of coercion[94] and contact with law enforcement,[95] the accessibility of appropriate information and communication.

128. Racial discrimination within the NHS workforce[96] needs acknowledgement and reparative action.

129. We need far more Black, Asian and other marginalised service user participation in researching, creating, running and monitoring mental health services[97]. There needs to be more independent funded service-user led peer as well as voluntary support from BAME communities and lived experience.

Asylum seekers and refugees

130. Discriminatory and inhumane government policies restricting refugee and asylum seeker access to housing, education, welfare support, physical and mental healthcare, employment, and freedom of movement all need to be reversed.[98,99]

131. The high prevalence of mental health problems among refugees and asylum seekers[100] is both exacerbated and generated by the UK's hostile environment[101]. This hostile environment must be reversed, and properly funded and staffed mental health services provided

[94] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

[95] https://www.clinks.org/sites/default/files/2018-09/race_mental_health_and_criminal_justice_30.pdf

[96] https://www.kingsfund.org.uk/blog/2019/11/lived-experiences-ethnic-minority-staff-nhs

[97] https://freepsychotherapynetwork.files.wordpress.com/2021/06/webpage.pdf

[98] https://www.mind.org.uk/media-a/4399/a-civilised-society.pdf

[99] https://www.medact.org/wp-content/uploads/2020/10/Patients-Not-Passports-Challenging-healthcare-charging-in-the-NHS-October-2020-Update.pdf

[100] https://www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health

[101] https://www.medact.org/2020/blogs/exploring-migrant-access-to-health-part-1-the-psychological-impacts-of-the-hostile-environment/

including specialist services responding to people's experience of trauma[102].

132. Interpreter[103] and advocacy[104] services, and appropriate community support[105] need to be provided.

133. The incarceration of immigrants at detention[106] and deportation[107] centres in the UK must end. The deportation of asylum seekers[108] for processing claims and/or settlement must stop.

134. The UK must at a minimum adhere to international law and conventions on human rights[109] with regard to immigration and asylum seeking. Processing asylum claims need to be transparent, efficient, and humane.

Trauma-informed mental health care

135. The impact of traumatic experience at any and all stages of life, and its long-term influence on people's psychological lives needs more recognition and must challenge the hegemony of biochemical and genetic aetiological narratives. Trauma-informed care[110] and therapy[111] acknowledge the relationship between people's life experience and the development of mental health difficulties.

136. We need well-resourced specialist services to respond to different forms of trauma in our communities – torture,[112] the trauma of war for

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[102] https://www.refugeecouncil.org.uk/our-work/mental-health-support-for-refugees-and-asylum-seekers/

[103] https://www.praxis.org.uk/interpreting

[104] https://www.mind.org.uk/media-a/4396/refugee_report_1.pdf

[105] https://refugeecouncil.org.uk/our-work/championing-the-rights-of-refugees/supporting-refugee-community-organisations/

[106] https://www.refugeewomen.co.uk/campaign/setherfree/

[107] https://www.theguardian.com/uk-news/2018/oct/11/life-in-a-uk-immigration-removal-centre-worse-than-prison-as-criminal-sentence

[108] https://msf.org.uk/article/public-letter-uk-medical-community-dangerous-health-consequences-rwanda-expulsions

[109] https://commonslibrary.parliament.uk/is-turning-back-migrants-at-sea-compatible-with-international-law/

[110] https://www.cnwl.nhs.uk/services/mental-health-services/cnwl-trauma-informed-approaches-tia

[111] https://www.bps.org.uk/psychologist/complexity-complex-trauma

[112] https://www.hhri.org/organisation/freedom-from-torture-medical-foundation-for-the-care-of-victims-of-torture/

both military veterans[113] and civilian victims, the victims of domestic violence and abuse,[114]experiences of acute loss and adverse childhood experiences.[115]

137. Community projects of all kinds can successfully help people process the distress of traumatic experiences. For example, the Community Self Build Agency,[116] which teaches building skills to homeless people and supports them to build their own homes cooperatively and become integrated into the community. Men in Sheds[117] and some of the work done by football clubs[118] seem to be very successful for men. Women may do better with friendship groups and talking therapy. **All need to be available and properly resourced.**

People at risk of suicide

138. We need proactive action in schools and workplaces.

139. Also, proactive work with people at risk (and better use of risk assessments). This would include psychological work to help people resolve long-term problems and address adverse childhood events – children in care need particular support. We note that addiction services for gambling, substance and alcohol misuse have been cut.

140. By extension, there needs to be a shift from managing individual episodes (including self-harm) to providing longer-term psychological support.

141. An increase in the numbers of qualified registered psychotherapists and psychologists employed in the public sector would help to meet this need. As would:

142. Consistent, long-term funding for services (too many organisations now 'signpost' rather than provide services).

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[113] https://combatstress.org.uk

[114] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/

[115] https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

[116] https://www.spatialagency.net/database/why/professional/community.self.build.agency

[117] https://menssheds.org.uk

[118] http://fc-communities.co.uk/resources/research-into-football-and-community/

143. Acknowledgement that social inequality and lack of work or poor-quality work and unrelieved debt[119] are risk factors. These are public health issues that need addressing by governments and employers.

144. Involvement of suicide prevention expert organisations, such as Samaritans, Papyrus and Action for Mental Health N. Ireland, in service planning.

145. More understanding and care in the A & E management of patients at risk of suicide.[120]

People with mental health and multiple disabilities

146. We need to acknowledge and take action to address the marginalisation and institutional discrimination[121] against people with severe and enduring mental health and learning disabilities. These iniquities are exacerbated by racial, class, sex, and gender discrimination as well as concomitant physical disabilities.

147. Social security support for people with disabilities is inadequate and must be improved. Workfare ideology[122] – back to work, Work Capability Assessments, and DWP employment "counselling" rather than support – is punitive and must end[123,124]

148. People with disabilities need better support to access services, employment, education, and housing.[125] A strong user-led advocacy movement should be supported.

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[119] https://pubmed.ncbi.nlm.nih.gov/20550757/

[120] https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

[121] https://dpac.uk.net

[122] http://www.boycottworkfare.org

[123] https://recoveryinthebin.org/put-pip-and-wca-assessments-on-the-record/

[124] https://www.bigissue.com/news/social-justice/universal-credit-new-sanctions-threat-sparks-fears-of-poverty-and-debt-after-four-weeks/

[125] https://www.hhrjournal.org/2013/08/mental-health-and-inequity-a-human-rights-approach-to-inequality-discrimination-and-mental-disability/

MENTAL HEALTH TREATMENT AND CARE

Treatment in the community

General

149. There needs to be greater emotional literacy in the general population so that people at risk can be identified and helped.

150. Mental health first aid courses, suicide awareness and prevention workshops should be more widely available in workplaces, schools, and public services such as the police.

151. Mental health training should be a mandatory part of Continuous Professional Development for medics, nurses, and their staff.

152. There should be at least one well-trained mental health member in police emergency teams, and in all settings, there should be a contact point to a well-trained professional.

153. An urgent review of Community Treatment Orders CTOs and the alternatives-this is a subject addressed in the current Mental Health Bill.

154. The active participation of local authorities, the police, mental health charities, the education sector, religious groups etc – in promoting education about mental distress and reducing stigma.

155. Service users and their carers should be equal partners in service design and future improvements as they have key, local, grassroots experience to offer.

156. There needs to be a service to provide the professional support needed to reduce doses of anti-psychotic drugs (as mentioned above).

157. Service users need the option of a longer-term, one-to-one relationship with a professional to process the trauma that has caused their mental health symptoms and, in some cases, the added problems that have been caused by the inadequacies of the system.

158. There needs to be more support for families and professional help to manage issues known to affect relapse such as high 'expressed emotion'.[126]

159. Open Dialogue looks very promising as a way of working and is currently being evaluated for possible extensive use in the NHS.

160. Professional domiciliary social care for patients in their own homes needs to be properly funded, with adequate time for human interaction and paid for travel time.

Primary Care

161. General Practitioners (GPs) and their teams are the cornerstone of mental health service provision- Community Mental Health Teams (CMHTs) tend to do short-term or 'focussed' work and most patients are discharged back to General Practice from CMHTs or hospitals with or without an associated care package in place.

162. 'Consultant Connect' is a basic telemedicine source of advice for GPs from community psychiatrists in CMHTs when dealing with adults and children in mental distress.

163. The new Single Point of Access for everyone to CMHTs has helped with communication.

164. Primary Care Networks are increasingly expected to use 'social prescribers' to advise adult patients about the benefits of local resources, hopefully re-developing, to meet the need of this user group after a decade or so of cuts.

165. It is rare now for GPs who may know the patient to be part of an assessing team under the Mental Health Act. Time for that commitment must be provided for.

166. It is vital that a proper care pathway for people with mental health problems that works is identified. Meaningful care plans and contact details for key workers should be known to patients and their families.

Psychological therapies

167. The monopoly of psychological therapies by short-term courses of cognitive behavioural therapy[127] must end in favour of a full range of

[126] Leff, J. Kuipers, J. Berkowitz, R. Sturgeon, D. A controlled trial of social intervention in the families of schizophrenic patients: two year follow-up. Br. J. Psychiatry, 146 (1985), pp. 594-600

[127] https://www.routledge.com/CBT-The-Cognitive-Behavioural-Tsunami-Managerialism-Politics-and-the/Dalal/p/book/9781782206644

therapeutic modalities - including group and individual longer term relational therapy where appropriate[128].

168. The reduction of psychological distress and suffering to medical models of individual genetic, biochemical, and behavioural pathology[129] needs to be replaced with holistic understandings of the human condition – existential, emotional, relational as well as physical. People not pathology.

169. Severe cuts in psychological therapies provision in secondary mental health services need to be reversed.[130]

170. The assessment of efficacy and outcomes of psychological therapy should be based on client need and a mutual process of understanding and review by practitioners and service users. Mechanistic, tick box assessment of outcomes and their use as the evidence-base of random controlled trials and NICE approved treatments has limited clinical value in the psychological realm[131].

171. The Improving Access to Psychological Therapies service is a failing and unaudited service. It urgently needs external audit.[132]

172. There should be follow-up of the efficacy of treatment for people who complete courses – after six months or a year. There should be universal follow-up of referrals who either drop out or never start a course of treatment.

Support for care provided by unpaid, informal, or family carers

173. All mental health trusts need to implement the Triangle of Care.[133]This was launched in 2010 and is recognised as best practice in all NHS mental health wards; it is equally applicable in community practice and was being extended there prior to Covid.

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[128] https://blogs.bmj.com/bmj/2019/10/21/improving-access-to-psychological-therapies-an-idea-thats-failed-to-deliver/

[129] https://www.pccs-books.co.uk/products/drop-the-disorder

[130] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/mental-health-workforce-report

[131] https://www.pccs-books.co.uk/products/the-industrialisation-of-care

[132] https://novaramedia.com/2020/02/17/marketising-the-mental-health-crisis-how-the-cbt-empire-builders-colonised-the-nhs/

[133] https://carers.org>resources>all-resources/53-the-triangle-of-care-carers-included-a-guide-to-best-practice-in-mental-health

174. Carers benefit from short training sessions on issues such as psychiatric drugs, mental health law, models of care, different forms of talking therapies, and ways to care for their own health and wellbeing. This would bring carers together to allow informal supportive networks to emerge and facilitate better working with professionals, and most importantly to reduce the isolation to which so many family carers (mainly women) are condemned, perhaps for the rest of their lives. A support worker who is familiar with how services operate and knows who best to approach when additional help is needed, someone who genuinely empathises with the carer's lot is absolutely invaluable.

175. Carers need a 24-hour helpline and emergency contact number – as happens with long-term, physical, medical conditions.

176. Ward carers' handbooks, setting out routines, naming staff and sources of help in the local community are helpful. A 'buddy' familiar with the system can also make a big difference. When wards were fully staffed, there used to be one-to-one meetings with specially trained carers' leads.

177. Local carers' groups that support each other can offer training and self-help techniques, and lobby politicians for improvements – instead of people becoming isolated in impossible situations.

178. Carers should be entitled to an annual – or more frequent – review and have access to respite and other help.

179. Carers welcome the opportunity to share their experience with professionals in training.

180. Carers who have to resign their own paid work and careers to take on full-time caring responsibilities should be properly supported financially, not locked into long-term penury through and into retirement.

RESIDENTIAL CARE

181. There must be a return to publicly provided services where possible. There is always a conflict between the quality of care and making profits and the concomitant fragmentation of privatised services.

182. Annual reviews of facilities and contracts.

183. Statutory standards of care, including implementing legally prescribed safe minimum staffing levels.

184. Better staff recruitment with proper career structures, training and remuneration.

185. Staff should be employed for their humane approaches and 'mental health' best practice.

186. Residential facilities should be local to where family networks are located.

187. Robust complaints processes and redress.

188. Where hostels are used, carers are contracted to provide extra services for vulnerable residents. It is desirable that residents are connected to mainstream leisure and educational services, but there is also a role for specialist Day Centres.

PSYCHIATRIC WARDS

189. Local beds for local patients.

190. Beds should not be in the private sector.

191. As a rule, children under 18 should not be placed in adult wards.

192. Frail older people should not be placed in general psychiatric wards. Many have psychiatric symptoms and/or cognitive deficits and require specialist wards of their own.

193. In the past decade, wards have improved, but all should be light, well-decorated and furnished, with a range of activities available. Friends and family should be able to visit. Single bedrooms in psychiatric wards are now common, but 'shared areas' can still become a problem for women and girls if there are disinhibited men.

194. Wards must be staffed to ensure women's safety and in line with legal guidelines.

195. Families need to be involved in plans for leave and should be able to report back on how things went, with their comments taken seriously. Triangle of Care principles, England (see Collaborative care) should apply (see above footnote 133).

196. An advance statement[134] should be at the top of every patient's notes.

[134] https://www.rethink.org/advice-and-information/rights-restrictions/rights-and-restrictions/planning-for-your-care-advance-statements-and-advance-decisions/