Lambeth & Southwark Mind - Mental Health Act Reform Submission

Background

This submission to the public consultation on ‘Reforming the Mental Health Act’ White Paper (the “White Paper”) is made by Lambeth & Southwark Mind (“LSM”). LSM is an independent charity that aims to represent and improve the lives of the nearly 650,000 people in Lambeth and Southwark who may experience and suffer from mental distress.

The White Paper acknowledges that ‘profound inequalities exist across mental health services and under the Mental Health Act for people from ethnic minority communities, and in particular black African-Caribbean people.’ With Lambeth and Southwark being highly diverse boroughs with significant BAME communities, particularly those of black ethnicity (around 25%), and with twice as many people of black heritage likely to have a mental illness compared with white British counterparts, the people LSM represent are disproportionately affected by these inequalities, and it is our duty to speak up for them at this time.

LSM has spent the first part of 2021 discussing the key topics set out in the White Paper with employees, trustees, volunteers, LSM members, members of the public, community leaders and other key stakeholders, including MP for Dulwich & West Norwood, Helen Hayes and Lambeth Councillor, Dr Jacqui Dyer MBE, to help shape this submission.

The topics that will be covered are as follows:

- Tackling Ethnic Discrimination
- Mental Health Vehicles
- Detention Threshold
- Nominated Persons
- Advanced Choice Documents
- Accident & Emergency
- Advocacy

Tackling Ethnic Discrimination

*White Paper Reference – Chapter 11. The experiences of people from black, Asian and minority ethnic backgrounds*

Following extensive engagement with members of the public, LSM members and key local stakeholders, three key improvements were identified to help tackle ethnic inequalities in the mental health services and under the Mental Health Act (the “Act”).

Firstly, one of the key areas of development is improving relations with local and cultural leaders. Due to the often dynamic community structures present in BAME communities, greater effort needs to be made in reaching out and establishing partnerships with local community leaders. One LSM member commented that the significant influence leaders of their temple had would make it the perfect platform to raise the issue of mental health in their community. This improvement in community engagement may also have the added benefit of increasing the number of culturally appropriate
advocates, which has rightly been earmarked as a key change to help reduce BAME inequalities in the mental health service. This is why we welcome the work of the Patient and Carer Race Equality Framework (PCREF) and strongly encourage the Government to support its work so that NHS mental healthcare providers and Local Authorities can better engage with the local communities in Lambeth and Southwark, and nationally.

Secondly, a key piece of feedback we received was increasing investment in more culturally focused peer support groups and counselling. There was a general consensus that peer support groups and counselling are crucial preventive tools that could help reduce the level of detention under the Act and provide much needed community focused mental health care. Due to the diverse demographics of Lambeth and Southwark, a significant number of people felt that more culturally focused peer support groups and counselling would be hugely beneficial in providing better preventative mental health care to residents. LSM currently runs a peer support group for the BME community and a black counselling service. These have both been very well received, with the black counselling service currently running with a significant waiting list. A number of LSM members felt that by extending and supporting more culturally focused community services, such as a black women’s or south Asian peer support group, would prove crucial in increasing access to mental health services in more communities across Lambeth and Southwark, and nationally.

Finally, a number of LSM members believed that due to the stigma that still surrounds mental health in some communities, a rebranding of certain terminology was needed. For example, by changing the term ‘mental health services’ to ‘wellbeing services’, it may be possible to reduce the level of reluctance an individual has before seeking out help with their mental health.

**Summary:** tackling ethnic discrimination in mental health services will require greater community engagement, culturally focused peer support groups and counselling, and a rebranding of certain terminology to reduce potential stigma.

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**Detention Threshold**

*White Paper Reference – Chapter 2. Clearer, stronger detention criteria*

The White Paper has proposed that the criteria for section 2 and 3 detention under the Act be guided by the following core principles:

- *therapeutic benefit* – more consideration must be given to how care and treatment provided under the Act will promote recovery and facilitate patients to get better.
- *least restriction* – ensuring a person is only detained where it is absolutely necessary, and where not detaining poses a substantial risk of significant harm being caused to themselves or others.

The new core principles are welcome changes to the current legislation, and we agree that detention should be a last resort and provide therapeutic benefit. However, there is a risk that by increasing the threshold for detention under the Act, people will potentially be left even longer without appropriate care before they are deemed to be a ‘substantial risk of significant harm’ to themselves or others. Under the current system, too many people are left waiting for hospital beds on the justification that they are not deemed as unwell as the least unwell person on the ward. The severe shortage of beds...
and underfunding in community care has allowed people in Lambeth and Southwark, and across the country, to unnecessarily deteriorate to the point at which they are finally offered a bed.

For the new detention principles to serve in the best interests of the individual, appropriate care in the community needs to be available in order to avoid the need for detention under the Act. This is why we welcome the NHS Long Term Plan’s commitments to improve community provision by providing earlier support for people with serious mental illness and to ensure that alternatives to detention are available for those in crisis. However, there is a risk that if community care is not suitable or sufficient in an area such as Lambeth and Southwark, then an individual may not receive the treatment needed and their condition will need to worsen even further than under the current rules in order to receive hospital treatment under the Act.

The White Paper makes it clear that the rules on detention should not be ‘so stringent that people who need the protection of the Act can no longer be legally detained.’ However, the new core principles may result in an increased reluctance by those determining whether a person should be detained under the Act, even if community care is insufficient to fully meet the needs of the patient at that time.

Understanding each of these risks and taking the necessary steps to address them will be crucial in ensuring that a person receives suitable care and treatment, either in the community, or if it is not available at that time, in a hospital.

**Summary:** increasing the threshold of detention under the Act will only benefit the patient if there is appropriate care in the community available.

**Mental Health Vehicles**

*White Paper Reference – Chapter 11. Policing and Ambulances*

We welcome the NHS Long Term Plan’s commitment to a dedicated national investment programme to improve the capacity and capability of the ambulance service to meet mental health demand, including having mental health staff based in NHS 111/999 control rooms to improve telephone triage and support, as well as a national programme to increase mental health training and education of ambulance staff. We also welcome the NHS Long Term Plan’s support for introducing new mental health transport vehicles to help reduce inappropriate journeys by ambulance or police cars to A&E. However, we are concerned that the White Paper states that any investment in mental health vehicles is ‘subject to future decisions on capital investment.’

Following discussions with LSM members it was clear that people believed that discreet mental health vehicles would likely be more suitable than ambulances or police cars in a mental health crisis. One member explained from their own personal experience that being taken to, and returned from, hospital in an ambulance or police car was ‘anxiety-inducing’ and ‘stressful’. In particular, being transported to hospital by police car led this individual to feel like they were a ‘criminal’.

Going through a mental health crisis can be very scary and the addition of flashing lights and sirens could potentially exacerbate an already stressful situation. We therefore strongly urge the Government to green light capital investment into new discreet mental health vehicles. Not only do we believe it will be in the individual’s best interest at a critical time, but it will also free up the use of ambulances for other more appropriate emergencies. Furthermore, investing in mental health
vehicles will be more cost effective over time than dispatching an ambulance for each emergency mental health call out.

**Summary:** the use of discreet mental health vehicles is more suitable for transferring those in a mental health crisis to hospital and will help free up the use of ambulances for other more appropriate emergencies.

**Nominated Person**

*White Paper Reference – Chapter 5, Nominated Person*

We support the removal of the outdated ‘Nearest Relative’ provision in the Act as it can often lead to patients being assigned an inappropriate Nearest Relative who is not best placed to support their needs. The introduction of the ‘Nominated Person’ is a significant improvement and will provide the patient an opportunity to have more choice and autonomy over who will be best placed to support them.

We are concerned, however, that these changes could potentially give rise to issues that have not been addressed by the White Paper. Firstly, in the scenario where an individual is subject to an abusive relationship from someone outside the Nearest Relative list, then there is a high likelihood that the abuser will pressure the patient to choose them as the Nominated Person if they are subsequently detained under the Act. If there is no nomination in the Advanced Choice Document to allow other individuals to receive information regarding the individual, then it could result in a closed loop whereby family, carers and friends are completely cut-off from receiving information regarding the individual.

This issue also throws up another concern, the method by which a Nominated Person can be removed from the role. Currently, the power to displace the Nearest Relative sits with the County Court, which means that changing the Nearest Relative is a costly and timely route that few can or do opt for without legal aid. As the White Paper sets out, there is a discussion as to whether the power to overrule or displace a Nominated Person should instead sit within the Tribunal Service’s remit, and consideration is ‘needed on whether representation should be funded on a non-means tested basis, in line with other proceedings before the Tribunal.’ If the aim of the changes is to give patients genuine choice and autonomy, whilst still protecting them, then it should be significantly more accessible for a Nominated Person to be removed by either the patient or the approved mental health professional (AMHP) should they be unsuitable.

Finally, where an individual’s capacity to choose a Nominated Person at the time of detention is impaired, it is important that guidance in the Code of Practice for AMHPs sets out clearly a priority order where main carers and family members rank highly, providing that there is no good reason to suspect abuse or lack of ability to fulfil the role.

**Summary:** steps need to be taken to ensure that patients are protected from potentially abusive individuals becoming the Nominated Person, and it should be easier for a Nominated Person to be removed should they be unsuitable.
**Advance Choice Documents**

*White Paper Reference – Chapter 4. Advance Choice Documents*

We agree that the introduction of ‘Advance Choice Documents’ (‘ACDs’) will provide patients with a far greater role in their own treatment by making it a legal requirement for decision makers to consider their advance wishes. There are, however, a number of concerns relating to ACDs that we would like to bring to your attention.

Firstly, the White Paper does not make it clear how long the ACD’s will be in effect. In the scenario where someone has completed an ACD in 2021, and is subsequently detained under the Act in 2030, would the ACD still carry the same weight if that same person were detained under the Act in 2022? An individual’s circumstances may be drastically different from the date the ACD was drafted to the date of detention under the Act. It may be prudent for the time elapsed and any change of circumstances to be taken into consideration should the Responsible Clinician (‘RC’) consider overruling the ACD. One potential solution would be for the introduction of an ACD renewal process every 24 months, particularly for those who have previously been detained under the Act.

Secondly, we agree that formal authentication should not be necessary for the ACD to have legal effect. However, determining whether an individual has ‘relevant capacity’ at the time the ACD was drafted is particularly complex, especially when you consider fluctuating capacity. This risk is potentially heightened if, as suggested in the White Paper, those who have been previously detained under the Act are encouraged to complete an ACD. Without any authentication there is a greater likelihood that the ACD could be challenged on the grounds that the individual did not have ‘relevant capacity’ when it was drafted. One potential solution would be to include a section on the ACD which indicated who the ACD was shown to (e.g. Independent Mental Health Advocate, Nominated Person, GP or other trusted health professional) and whether they approved or disapproved of its contents. Though the ACD will still have legal effect regardless of their response, this change may help provide the RC with additional evidence should they be determining whether the individual had ‘relevant capacity’ when the ACD was drafted.

**Summary:** ACDs should include a section that indicates who it was shown to and whether they signed off on its contents, in addition to it being renewed at least every 24 months to take into account an individual’s changed circumstances.

**Accident & Emergency**

*White Paper Reference – Chapter 7. Accident & Emergency*

We welcome the review of potentially improving the powers available to health professionals in A&E so that individuals in need of urgent mental health care stay on site pending a clinical assessment. An LSM member recalled how they had been unable to convince an individual to remain in A&E on numerous occasions due to the length of time it had taken for that individual to receive an assessment. We believe that extending section 5 of the Act will be more effective and efficient than amending section 4B of the Mental Capacity Act as a method for health professionals to temporarily hold individuals in A&E when they are in crisis but are trying to leave A&E.

However, the main concern we have with extending section 5 of the Act is the lack of clarity in the White Paper on the time limit for this temporary detention. As it stands, section 5 of the Act places a
72-hour time limit for an ‘in-patient’ to be temporarily detained in hospital pending assessment. If section 5 of the Act is extended to ‘out-patients’ in A&E, then would the same 72-hour limit apply to out-patients in A&E? If this is the case, then we believe that this detention time is too long, and that any temporary detention as an out-patient should be limited to 6 hours prior to a decision on whether individual is admitted. At the point of admittance, the remaining time of the 72 hours can be applied if a mental health assessment is still required.

We therefore urge the Government to take the necessary steps to ensure that clear parameters are in place for any extension of section 5 of the Act, and that no individual can be held under this temporary detention as an out-patient for any longer than is necessary.

**Summary:** introduction of a temporary detainment under the Act for an out-patient in A&E should be limited to 6 hours prior to a decision on whether the individual is admitted to hospital.

**Advocacy**

*White Paper Reference – Chapter 5, Advocacy*

We agree that high quality advocacy is critical to ensuring people get the support they need when detained under the Act. Under the current system, Independent Mental Health Advocate (IMHA) services are ‘opt-in’ for those detained under the Act. As part of the recommendations put forward by ‘The Independent Review of the Mental Health Act’ it was suggested that IMHA services are changed to ‘opt-out’. The Government has stated that they will consider making IMHA services ‘opt out’ but only if funding is available and there is capacity within the system to manage additional uptake of IMHAs among patients. We strongly believe that moving to an ‘opt-out’ system will have significant benefits for patients, as those who are detained under Act may not have the capacity to make an informed decision as to whether they need an IMHA. It is crucial that these individuals are provided with as much support as possible from the outset to help them understand and exercise their rights.

In addition, as discussed above, a combination of community engagement and additional funding will prove crucial in increasing the number of culturally appropriate advocates. This is why we welcome the Government’s commitment to launching a pilot programme of culturally appropriate advocates in partnership with Local Authorities and others. This initiative is a great start in identifying how best to represent the mental health needs of ethnic minority groups, and we encourage the Government to listen closely to the feedback of key local stakeholders following the pilot programme (e.g. Black Thrive in Lambeth) to ensure that the necessary steps are taken to increase the level of culturally appropriate advocates nationally.

**Summary:** improving community engagement and funding to help increase the number of culturally appropriate advocates, and changing the IMHA service to an ‘opt-out’ service.

This submission is approved and signed by:

*Alastair Smith-Agbaje*

Alastair Smith-Agbaje  
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