Submission: Royal College of Nursing Evidence to the Joint Committee on Human Rights call for evidence on the reform of the Mental Health Act

With a membership of around 450,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

1. Introduction

1.1. The Mental Health Act has wide ranging human rights implications. This response highlights the role that nurses should play in addressing inequalities in the design and application of the act and outlines the changes needed in terms of professional development, patient pathways and strengthening of the workforce needed to address these inherent inequalities. Recommendations are set out at the end of this document.

1.2. As the main professional group implementing and delivering care under the Mental Health Act, it is vital that the voice of nursing staff is heard throughout the development of these reforms.

1.3. This response has been developed in collaboration with a range of RCN members including mental health nurses (MHNs) and learning disabilities nurses (LDNs).

2. Human Rights Issues raised by the Mental Health Act

2.1. Since the Mental Health Act involves the restriction of liberty and autonomy, any unfair design or application of the Act interferes with this right.

2.2. Specifically, the detention criteria set out in the Act are the fundamental justifications that allow decision makers to remove a person's liberty and give them treatment without consent.

2.3. The reforms refer to the idea of "therapeutic benefit" as a necessity to justify detention under the Act. We are concerned that the definition of therapeutic benefit: "ensuring patients are supported to get better, so they can be discharged from the act" is open to interpretation.

2.4. For 'recovery', it is important to consider from who's perspective recovery is being assessed. Clinical-recovery and personal-recovery mean two very different things. Therefore, therapeutic benefit through the eyes of the patient may be very different to those of clinicians.

2.5. There are also very concerning statistics regarding specific communities. For example, Black people are four times more likely to be detained under the Act and twice as likely to be arrested under Section 136. They are put on Community Treatment Orders (CTO) eight times more frequently than white people.[1]

[1] Mind (2019) Discrimination in mental health services. Available at: Discrimination in mental health services | Mind

2.6. The overuse of restrictive interventions for some Black Asian and Minority Ethnic (BAME) communities, specifically black men, has remained unaddressed in the legislation. This disparity may be due to institutional racism and stereotypical views of black men being perceived as dangerous and violent when mentally ill. Services are not seen as accessible to all communities. Many black men find their first interaction with services via the police during a crisis.[2]

2.7. We welcome The Patient and Carer Race Equality Framework (PCREF) to support NHS mental healthcare providers and local authorities to improve access and engagement with the communities they serve. The reforms should include the importance of transcultural practices to meet the varying needs of individuals from culturally diverse backgrounds.

2.8. There is widespread evidence that CTOs do not deliver on their intended effect of reducing admission and preventing relapse[3], they are applied in a discriminatory way (with black people far more likely to be recipients of CTOs than white people), and they are resource intensive[4]. The RCN has for this reason long recommended the abolition of CTOs.

2.9. The proposed reforms have kept CTOs in place with changes intended to improve the equity of their application. For example, the provision for the new role of "nominated person" for those detained under the Act to have the power to object to a CTO and increase the frequency of referral to a tribunal during a CTO - from every 3 years, to every 12 months.

2.10. There is a need to invest in effective community provision if the use of restrictions such as CTOs are to be reduced.

2.11. Without increased investment in community services, the proposed changes will have implications on the nursing workforce, particularly the possible increased 'burden of risk' (holding increased responsibility for patient's wellness and safety). If unaddressed, this may negatively affect the provision of care provided to people with serious mental illness in the community.

2.12. Through better investment in custody and court liaison and diversion models, we know earlier intervention (often by nursing staff working with police) leads to better outcomes for people; effectively reconnect people in the community rather than sending to prison.[4]

2.13. There should be a framework to ensure those subject to the Act are able to return home safely following treatment. This includes robust human rights-based tests, advocacy, peer support, a good range and spread of practical services and a minimum set of psychological support practice standards (not just requirements or orders). To ensure that this framework works, it should be coproduced with those with lived-experience.

3. Strengthening and supporting the role of the mental health and learning disabilities nursing

3.1. The Act should explicitly emphasise the importance of training and education for all staff especially around Human Rights and the Mental Capacity Act.

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[2] Centre for Mental Health (2020), Racial disparity in mental health: challenging false narratives. Available at: Racial disparity in mental health: challenging false narratives | Centre for Mental Health

[3] BMJ (2018), Community treatment orders: Are they useful? Available at: Community treatment orders: Are they useful? | BJPsych Advances | Cambridge Core

[4] Bromley Briefings Prison Factfile (2021). Available at: Winter 2021 Factfile final.pdf (prisonreformtrust.org.uk)

Nurses report that training is rarely focussed on human rights and patients' rights.

3.2. Nurses, and all mental health professionals, need adequate training and education to address inequalities experienced by BAME patients. This should include raising awareness of the different forms of bias and discrimination, including unconscious bias, underpinning the application of the Act.

3.3. Uptake of statutory roles, such Approved Clinician (AC) and Responsible Clinician (RC) has been limited among nurses and other professionals, compared to psychiatrists.[5] There is a clear value to multi professional opportunities in this area both for patient experience and outcomes, as well as professional development.[6] Likewise, the role of the Approved Mental Health Practitioner (AMHP) is most often held by social workers rather than MHNs and/or LDNs.

3.4. Nurses are central to the patient journey, care planning and discharge pathway. There is a need for a career development framework for nurse as AC/RC to encourage uptake and to support a clear definition of the role.

3.5. Members who are AC/RC have told the RCN how feedback from patients has been positive. Reporting more flexibility in their availability to meet with patients, building therapeutic relationships, while being more inclusive and holistic in their decision-making processes.

3.6. People from BAME backgrounds are significantly overrepresented in terms of the number of people detained under the Act, and yet underrepresented within the statutory MHA roles (i.e. AMHP and AC/RC). It is imperative that the workforce is representative of the people we care for, which will help to turn the tide in terms of organisational culture.

3.7. There must also be access to clinical supervision for those who hold more commensurate responsibility for the Act. A minimum standard should be in place.

4. Strengthening the workforce and improving patient safety

4.1. Currently, mental health accounts for 28% of the impact[7] of all illness in the UK but receives only 13% of NHS spending.[8]

4.2. Changes to the Mental Health Act are coming at a time when mental health services are struggling to cope with chronic staff shortages and vacancy rates for MHN posts. In quarter 3 of 2020/21 in England, the vacancy rate stood at 13.1%, the highest rate for any NHS nursing sector.[9]

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[5] Veitch P and Oats J (2016), Strange bedfellows? Nurses as Responsible Clinicians under the Mental Health Act (England & Wales). Available at: Strange bedfellows? Nurses as Responsible Clinicians under the Mental Health Act (England & Wales) - Veitch - 2017 - Journal of Psychiatric and Mental Health Nursing - Wiley Online Library

[6] Oats J et al. (2021), Implications for mental health workforce strategy, professional training and supervision of more widespread adoption of the multi-professional Responsible Clinician role: Results of a qualitative inquiry. Available at: Implications for mental health workforce strategy, professional training and supervision of more widespread adoption of the multi-professional Responsible Clinician role: Results of a qualitative inquiry - ScienceDirect

[7] As measured through cost, mortality, morbidity and other indicators

[8] Centre for Mental Health (2020), Parity of Esteem. Available at: "Parity of esteem" | Centre for Mental Health

[9] NHS Digital (February 2021) England NHS quarterly vacancy statistics. Available at: Home - NHS Digital

4.3. Mental health and learning disability services are struggling to cope with chronic staffing shortages and a high turnover of staff as a result of the pressurised working environments.[10]

4.4. Ineffective rostering of staff has a knock-on effect that prevents nurses from attending mental health tribunals or stopping nurses from receiving the quality education they need to adhere to the Act and address wider human rights concerns.

4.5. With growing pressures and increasing number of people needing mental health care and support, the government must urgently take steps to remedy the supply, recruitment and retention of the nursing workforce in order to ensure that services can continue to provide safe and effective care.

4.6. Low levels of staff, unstable teams, and poor working conditions can lead to compassion fatigue and poor practice. Low staffing levels have been shown to increase the occurrence of restrictive practices, while negatively affecting patient outcomes[11]. Addressing these underlying issues will create the conditions for good care and allow advocacy to thrive.

4.7. We continue to call for the expansion of accountability for workforce planning and funding in law and investment into nursing higher education in England. A commitment in law is critical to provide assurance to our nursing community that our workforce shortages will be tackled.

5. Patient pathways and environments

5.1. Environments within emergency departments (ED) need to be able to provide quiet and supportive spaces to promote safety and de-escalate situations that may lead to a detention. Our members are concerned about a lack of guidance for ED staff, psychiatric liaison teams and hospital security on how they can maintain a patient's safety and alleviate their distress.

5.2. During the COVID-19 pandemic, more appropriate environments as alternative care pathways to ED were provided across the UK for people with mental illness.[12] These rapid changes show the ability of the system to respond to change when the needs arise. Despite using alternate pathways in recent months, those with mental health needs must continue to be welcomed by staff in ED.

5.3. LDN liaison roles help promote access to services by directly supporting people, while developing systems, influencing policy and educating hospital staff. There is widespread acknowledgement of the value provided by LDN liaison roles in

[10] CQC (2019), The State of Health Care and Adult Social Care in England 2018/19. Available at: THE STATE OF HEALTH CARE AND ADULT SOCIAL CARE IN ENGLAND 2018/19 (cqc.org.uk)

[11] McKeown M et al. (2019) "Catching your tail and firefighting": The impact of staffing levels on restraint minimization efforts. Journal of Psychiatric and Mental Health Nursing. 26(5-6):131-141

[12] Royal College of Psychiatrists (2020), Alternatives to emergency departments for mental health assessments during the COVID-19 pandemic available at: alternatives-to-eds-for-mental-health-assessments-august-2020.pdf (rcpsych.ac.uk)

acute hospitals.[13] However, these roles are under-invested in and regional variation still exists in England[14].

6. Recommendations

6.1. The historic and contemporary issues surrounding the concept of 'recovery' in mental health care, underpinned by power imbalances between patients and clinicians, must not be ignored. We recommend that the definition of 'therapeutic benefit' must be co-created with people that have experience of mental illness and those who use services, and have been detained under the Act.

6.2. In addressing the disproportionate use of the Act on certain BAME populations, specifically black men, the legislation must set out the need for mandatory training for all staff working under the Act. It is imperative that staff receive training on human rights and unconscious bias in the context of the Mental Health Act, including the impact of institutional and systemic forms of racism and discrimination. Monitoring of this training should be included in CQC inspection guidance under regulations 18(2)(a)[15] and 10(2)(c)[16].

6.3. There should be a statutory requirement for all mental health services to report on their duties as set out in the Public Sector Equality Duty, linked to objectives reflecting the Patient and Carer Race Equality Framework.

6.4. To further address race inequalities and ensure the mental health and learning disabilities workforce is representative of their local populations, the need for ethnic diversity within the statutory roles of AMHP and AC/RC must be clearly embedded within the Patient Carer Race Equality Framework (PCREF).

6.5. The Act must promote the continued investment in hospital, custody and court liaison and diversion models, with the aim for these to become statutory in every locality.

6.6. To address the significant staffing shortages that impact on the whole of the health service, including the safe delivery of care for people with serious mental health conditions, government in England must commit to law setting out accountability for workforce planning and funding and investment into nursing higher education.

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[13] Tuffrey-Wijne I et al. Identifying the factors affecting the implementation of strategies to promote a safer environment for patients with learning disabilities in NHS hospitals: a mixed-methods study. Southampton (UK): NIHR Journals Library; 2013 Dec. (Health Services and Delivery Research, No. 1.13.) Chapter 9, The role of the learning disability liaison nurse. Available at: https://www.ncbi.nlm.nih.gov/books/NBK259497/

[14] Health Education England (2020) Project report: understanding the who, where and what of learning disability liaison nurses. Available at: Report template (ldcop.org.uk)

[15] Part of staffing regulation concerning the receipt by staff of appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

[16] Part of the dignity and respect resolution concerning due regard for protected characteristics