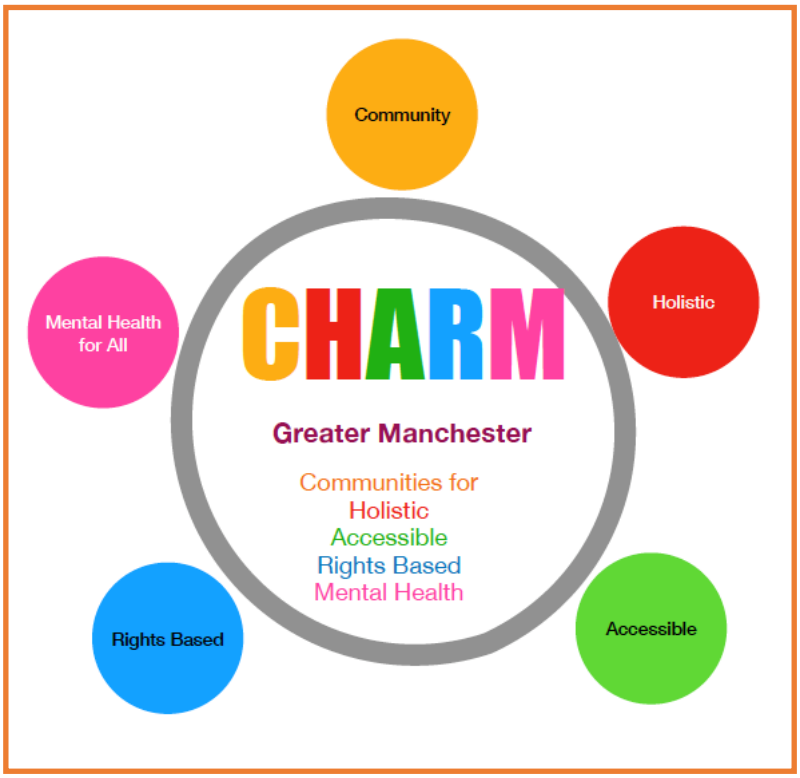

We have established CHARM, following the concerns that we raised about the lack of meaningful consultation and co-production that took place regarding the re-development of Park House as a single site psychiatric hospital.

We have analysed the situation in Greater Manchester and reflected on the policy changes that are currently being addressed by the Department of Health (The Community Mental Health Framework for Adults and Older Adults; the new Mental Health Bill 2022; and the Long Term NHS Plan).

Our demands are not new ones. Many of these demands for justice and rights were made in the 1980s, we know because many of us were there. Nearly 30 years later, how much longer must we wait for change?

OUR DEMANDS

Our demands are based on our own strong value base that holds human rights and justice as the essential components of any health and social care system.

COMMUNITY

The strengthening of existing community networks, underpinned by a partnership that is built on trust, openness and accountability and founded on:

- Community based responses and the establishment of a wider systems model within the city – including education, leisure, housing, culture, employment.
- Neighbourhood-based community mental health services, that are founded on the importance of community and address inequalities in mental health care.
- The essential role of families, friends and social networks is recognised as integral to community support and must be fully supported by services.
- The right to access all educational and employment opportunities with tailored support.
- All services and businesses including entertainment, social facilities and housing must ensure complete inclusion, social integration and access.

HOLISTIC

A whole person, whole life approach that de-pathologises[i] distress and acknowledges social determinants as central to people's experiences and the right of every individual to participate fully in the social life of their community.

- Continuity of care must be seen as a right with each individual permitted to choose a key worker for long term relational support.
- Support should focus on achieving the person's aspirations and be tailored to a person's unique needs and circumstances.
- The diagnoses used within psychiatric services should be acknowledged as constructed and not the evidence of a 'disease'. We recognise that diagnoses are currently necessary to access benefits and services.
- A recognition that a person's beliefs, spirituality or faith are deeply held convictions and must be respected and responded to, particularly during periods of crisis or challenge. This can be an important part of people's self-defined recovery.
- Services should focus on understanding distress as relational and seek to enable people to find meaning in their experiences alongside their families and social networks.[ii]
- From the start, individuals must be able to determine the focus of their needs and support, whether that is with or without psychiatric medication.
- A de-prescribing route must be available with a recognition of issues related to both withdrawal and unwanted effects of medication.[iii]

Services should be transparent, open and accessible at the point of need. For this to be achieved we demand:

- Funding for mental health to be increased to achieve parity with physical health.
- Zero-threshold facilities such as crisis support schemes open to all with no gatekeepers and a single point of access for all mental health enquiries.
- Creation of informal spaces:
    - buddy schemes;
    - Crisis lounges focused on talking and relational support available 24/7;
    - alternatives to hospitalisation[iv] e.g. appropriately supported peer led crisis houses
    - family host schemes.
- Community care coordination must be properly resourced with an end to unsafe caseloads for community staff,. (for example a maximum CMHT caseload of 25 and EIT of 12)
- An end to inappropriate 'stepping down' of those people who need long term support to primary care.
- Accessible psychological, occupational and other support when requested by the service user.
- Openly available data that is broken down by protected characteristics[v]

Justice and Human rights are integral to mental wellbeing in society.

- We call for all Greater Manchester health and social care organisations to tackle the issues in a manner consistent with the UN Convention on the Rights of Persons with Disabilities (UNCRPD).[vi]
- The social model of disability should be used to inform all services, with changes led by service users and self-identified survivors and their supporters.
- The lived experiences of people who identify as neurodiverse to be fully included in shaping services, including people who identify as autistic whether verbal or nonverbal equally.
- An end to homelessness discharge from hospital, ensuring the availability of good quality housing with full tenants' rights (including supported and independent living with social care support).
- End of medication and treatment misuse:
    - Stop giving users misinformation about medications correcting chemical imbalances.

- Physical health damage and over-sedation from psychiatric medication must be recognized as an abuse of human rights both in hospital and in social care. Such misuse of medication cannot be used to address a lack of resource provision.
- End the use of Electro Convulsive Therapy given its association with brain damage.
- Long term use of high dose medication is dangerous and life shortening, therefore people should be sustained on minimum doses of medication if they choose medication at all. The dangers of polypharmacy must be recognised and kept under close review.
- End the use of community treatment orders because they are expensive, are ineffective and violate people's human rights.
- End to forced medication treatment in hospital not least because the unwanted effects of enforced medication often leads to trauma and prolonged hospital stay.

- Services must fulfill their responsibility to challenge all forms of discrimination.
- Access to women's only safe spaces must be seen as a right.
- An active anti-racist service must be a priority. It must recognise racism exists and the psychological and social impact of the trauma of racism and its intergenerational trauma. This work demands:
  - Training staff to recognise and challenge institutional and individual racisms.
  - Employ more black and Asian therapists qualified to work with the trauma of racism.
  - Annual monitoring of treatment approaches and outcomes by ethnicity in order to assess and address inequalities of treatment.
  - Community and ward environments/ services to be actively culturally inclusive and affirm diverse traditions and cultures.
  - Safe ways for patients, carers and staff to report racism (e.g. through a racism reporting tool) and for those concerns to be acted upon and not to be treated as part of a pathology
  - Immediate right to an independent second opinion, advocacy and advice where there are concerns over discrimination and stereotyping
  - Support black led trauma informed services such as a black led recovery house and initiatives such as Fika Welie - a project to establish a specialist adult mental health unit for Caribbean and African adults for Manchester.

MENTAL HEALTH

We recognise that there are multiple and interacting factors linked to mental distress and trauma. Social determinants such as poverty, homelessness, racism, patriarchy, sexual abuse, war and torture, are key factors underpinning many people's shaping of mental distress. As such we need a service that holds at its core a system of compassionate care that recognises distress as a societal responsibility.

CHARM, 24 February 2021. This is a living document

NOTES

[i] To 'depathologise' is to cease to treat as a medical disorder. Mental health services are currently so laden with the connotations of "sickness" or "disease" that it is isolating and oppressive. To see the wide range of emotions, thoughts, and behaviors encompassed by such labels as human responses to life stressors by people who are coping as best they are able is a much preferred and more healing approach.

[ii] eg. Open Dialogue http://opendialogueapproach.co.uk; the Hearing Voices approach https://www.hearing-voices.org; Recovery houses, such as Soteria Network wwwsoterianetwork.org.uk; Hannah Prytherch , Anne Cooke & Ian Marsh (2020): Coercion or collaboration: service-user experiences of risk management in hospital and a trauma-informed crisis house, Psychosis; Angela Sweeney & Danny Taggart (2018) (Mis)understanding trauma-informed approaches in mental health, Journal of Mental Health, 27:5, 383-387, DOI: 10.1080/09638237.2018.1520973

[iii] del Barrio LR, Cyr C, Benisty L, Richard P. Gaining Autonomy & [corrected] Medication Management (GAM): new perspectives on well-being, quality of life and psychiatric medication. Cien Saude Colet. 2013 Oct;18(10):2879-87; GuideGAM-EN-2019.pdf (rrasmg.com)

[iv] Soteria Network UK for example promotes the development of drug-free and minimum medication therapeutic environments for people experiencing psychosis or extreme states, following the pioneering work of the Soteria Project, California in 1970

[v] E.g. Monitoring and accessible data on service user goal achievements to include: their own self defined recovery; data on hospitalization: e.g. length of stay; use of restraint; isolation; medication regimens; psychological treatments; use of MHA, number of patients repeatedly hospitalized; Access to psychological support; Untoward deaths and injuries of service users in secondary and those stepped down primary care; Housing status to include homelessness (to include unstable housing) and service users living in independent stable living accommodation; Education and employment status of service users; Physical health markers such as number of service users with diabetes, obesity, cardiovascular disorders and other long term conditions

[vi] The Convention promotes, protects and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The inherent principles of CRPD are thus of non-discrimination, equal opportunities and promotion of autonomy. The CRPD takes on a social model of disability as opposed to a medical one. The medical model of disability suggests fixing the disability will allow the individual to function like everyone else. The social model places emphasis on overcoming barriers produced by environments, attitudes, laws and policies.