Written evidence submitted by the King's College (KCL) Centre for Society and Mental Health (CSMH) Lived Experience Advisory Board (MHB0030)

1. The KCL Centre for Society and Mental Health Lived Experience Advisory Board.

The King's College (KCL) Centre for Society and Mental Health (CSMH) is a collaborative research centre aimed at shifting public debate about mental health away from individualised interventions and towards social practices and policies that promote and sustain good mental health in communities (1). To achieve this aim, the Centre's work is divided into three research programmes: 1) Young People and Social Change 2) Marginalised Communities and 3) Work and Welfare Reform (2).

As the Lived Experience Advisory Board (LEAB) within the Centre, we seek to ground the Centre's direction and wider conversations about mental health in our direct experiences of neurodiversity, trauma, mental distress, and/or (ref)using mental health services (3).

2. Our Vision for a Socially Just Mental Health Care System.

In line with the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), we envision a mental health care system rooted in the principles of respect, equality, and accessibility (4). This system should highlight the intrinsic social nature of many factors leading to and maintaining poor mental health, and the inequalities experienced by different social groups (5–10). It is widely acknowledged that the mental health care system in the United Kingdom (UK) does not meet this vision, with many people unable to access the care they need.

3. Modernising the Mental Health Act.

We appreciate the Government's commitment to modernising the Mental Health Act (MHA) for the 21st century. We are encouraged by the replacement of the Nearest Relative role with the Nominated Person (NP) role and the amendment of the conditions that a person subject to Community Treatment Orders (CTO) may be required to follow.

Given our expertise, however, we believe the below changes and their consequences require further attention.

(1) Definition of Therapeutic Benefit and Medical Treatment

The Draft Mental Health Bill is grounded in four guiding principles, which include "therapeutic benefit," defined as "patients are supported to get better, so they can be discharged from the Act" (11). Other areas of the Bill refer to "appropriate medical treatment" which "[requires] that the treatment must have a reasonable prospect of alleviating, or preventing the worsening of, the patient's mental disorder or one or more of its symptoms or manifestations."

We are concerned by these terms and definitions for multiple reasons. First, the terms "therapeutic benefit" and "appropriate medical treatment" are largely rooted in a biomedical approach to mental health and mental health care. Although research has demonstrated the effectiveness of non-medication solutions to mental illness, this biomedical approach almost always favours medication solutions over psychosocial support, interventions, and social care (12). Furthermore, a mental health care system which prioritises short-term solutions without addressing the societal-level factors influencing mental health is not sufficient.

Additionally, we are concerned that the definitions of "therapeutic benefit" and "appropriate medical treatment" may be used to exclude people from getting care. For example, it is widely acknowledged that, due to system inadequacies, inpatient care is often not therapeutic for many patients. If the requirement for demonstrable therapeutic benefit is applied in this situation, a person in crisis may be left to manage their mental distress on their own. Furthermore, if medical treatment is a condition of sectioning, we are concerned that judgements of therapeutic benefit may be used to deny access to care for those individuals for whom improvement seems unlikely. Further consideration of the unintended consequences of the "therapeutic benefit" and "appropriate medical care" requirements is needed.

(2) People with Autism and Learning Disabilities

The draft Mental Health Bill "[clarifies] that . . . autism and learning disability would not be considered to be conditions for which a person could be subject to compulsory treatment under section 3" (11).

We appreciate that it may not be appropriate to include autism and learning disability in the Mental Health Bill as they are fundamentally different from other mental health related disabilities. However, we are concerned that removing these groups from the Mental Health Bill will make them more vulnerable to being held under the Mental Capacity Act (MCA) (13). Unlike the Mental Health Bill, the MCA includes fewer safeguards of human rights, less capacity to appeal decisions, and no provision of aftercare services. More work is needed to address the interface between these two pieces of legislation.

(3) Places of Safety

Clause 41 of the Draft Mental Health Bill would remove prisons and police cells from being places of safety when a bed is not immediately available. It proposes the use of hospitals or healthcare-based settings instead (11).

At face-value this change seems like a necessary shift from the involvement of police and the criminal justice system in mental health care. We are concerned, however, that unless adequate resources are channelled towards other places of safety, this change will encourage the funnelling of individuals experiencing mental distress from the mental health care system to the criminal justice system, particularly as police officers are often first

responders to crisis situations. Already, Black people are disproportionately likely to access mental health treatment through the police or criminal justice routes, as their behaviour often gets identified as criminal rather than as mental distress. More resources are needed within the health system to ensure that those in crisis have appropriate health-based places of safety.

4. Addressing the Root Problem.

Although we appreciate the Government's commitment to modernising the Mental Health Act, we believe the problems currently inherent in the mental health care system will not be fixed by legislation, particularly if changes are made with cost neutrality in mind. Instead, the Government must demonstrate its commitment to mental health by making sufficient investment in care and culture change across all levels of the system.

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