

imprisonment. The authors suggest the Mental Capacity Act may provide adequate alternative provision for such individuals – but this leaves them with fewer independent safeguards over detention, treatment and appeal. A ‘fusion’ approach in legislative reform around mental disorders and capacity, similar to that introduced in Northern Ireland,⁴ offers a better framework to safeguard the needs of these individuals in a non-discriminatory manner, while recognising the need to sensitively manage risk to others.

Declaration of interest

I advise the Liberal Democrats on mental health policy in unpaid roles, but my views here are not reflective of the Liberal Democrats.

- Hollins S, Lodge K-M, Lomax P. The case for removing intellectual disability and autism from the Mental Health Act. *Br J Psychiatry* 2019; **215**: 633–5.
- Berryessa CM. Judiciary views on criminal behaviour and intention of offenders with high-functioning autism. *J Intellect Disabil Offending Behav* 2014; **5**: 97–106.
- Chiacchia M. *Autism Spectrum and the Criminal Justice System*. Purdue Global University, Criminal Justice, 2016 (<https://www.purdueglobal.edu/blog/criminal-justice/autism-and-the-criminal-justice-system/>)
- Campbell P, Rix K. Fusion legislation and forensic psychiatry: the criminal justice provisions of the Mental Capacity Act (Northern Ireland) 2016. *BJPsych Adv* 2018; **24**: 195–203.

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The case for removing intellectual disability and autism from the Mental Health Act

The Faculty of Psychiatry of Intellectual Disability of the Royal College of Psychiatrists welcomes the editorial by Professor Sheila the Baroness Hollins on the use of the Mental Health Act (MHA) in the care of people with intellectual disability.¹ It furthers the debate on the MHA, an issue about which the Faculty has remained concerned. The Faculty supported retaining the qualified criteria to detain people with intellectual disability at the time of the MHA Review. This was based on feedback from psychiatrists working in clinical services with first-hand experience of supporting people with intellectual disability with altered mental states and/or high-risk behaviours. We address specific points raised in the editorial.

On the issue of mental disorder, it is correct that people can be detained where a concern of severe and enduring mental disorder is evident. However, as the authors rightly assert, in people with intellectual disability it may be difficult to make a clear-cut diagnosis of mental disorder in the presence of high-risk behavioural challenges that could be further complicated by comorbid disorders for example, physical health disorders such as epilepsy, autism or other communication difficulties. In such circumstances, an assessment period under a supportive legal framework may be warranted to clarify the aetiological factors accounting for the presentation that include physical health, mental health and social factors.

In the absence of mental health legislative support for people whose behaviour is a challenge, or presenting with an altered mental state, there is a risk that the criminal justice system (CJS) would be used to process and support people. This would raise significant concerns for psychiatrists as skilled assessment may be difficult to achieve in the CJS. This could deny a vulnerable group of people, sometimes without advocacy, access to healthcare that all citizens deserve. Such an approach could potentially expose the most vulnerable to abusive treatment.

We fully concur that ‘all people with a learning disability are people first with the right to lead their lives like any others, with the same opportunities and responsibilities, and to be treated with the same dignity and respect’.² Thus it is our view they should have the same opportunities to avail of care that may, by necessity, be delivered under the MHA. Under the current proposal there is a lowering of the threshold in denying them such opportunities. The authors refer to people having ‘opportunities and responsibilities’ but this requires that they understand them in order to make an informed decision, which is not always the case. People with intellectual disability are a heterogeneous group for whom ‘one size does not fit all’. We have to be mindful of the most vulnerable, especially those without mental capacity, when designing services and appropriate legislation.

With respect to the issue of intellectual disability as a ‘lazy diagnosis’, the current Code of Practice highlights the need for clarity when assessing people under the MHA. It is recommended that clinicians skilled in working with people with intellectual disability are involved in decisions on detention. We are not assured that removing intellectual disability would safeguard the process of elucidating the aetiological reasons for high-risk behaviours that could lead to more punitive measures and the inappropriate use of medication in people who pose risks to themselves and others. Under the MHA, there are safeguards in place to protect the rights of the person and where practice and ‘appropriate treatment’ can be scrutinised to expose examples of ‘lazy diagnosis’ through the system of Mental Health Review Tribunals. No other legislation can provide such level of support when compared with the current MHA. We assert that ‘lazy diagnosis’ and ‘lazy practice’ could be more common without such safeguards to support people.

Behaviour can certainly be perceived as communicating distress but using the lengths of time that people spend in hospital as an argument is not justified since time spent in hospital can be related to factors beyond the control of the in-patient services for example, insufficient provision of support in the community for the person.

Although people with autism may currently be detained without ‘available treatment’, it may be because of the risks associated with their behaviour that cannot be supported positively by alternative approaches or that may not be available. The Transforming Care Programme has had some positive impact on practice as advocated by the authors where clinicians and social care agencies work together to seek non-medical alternatives to hospital admission.

The absence of a consensus of opinion to the MHA Review on removing intellectual disability and autism from the Act serves to highlight the complexity of the issues. No one approach, as suggested by the editorial, would be fitting for every person with intellectual disability currently satisfying criteria for detention. The ‘exploratory work’ needed, as acknowledged in the MHA Review, is a necessary step in considering the issues and with which all stakeholders, including psychiatrists, need to engage.

We agree with the authors’ point that it should be unnecessary to detain people with intellectual disability without mental illness for prolonged periods but with the caveat that due process of assessment might be required in in-patient settings under the MHA.

From a direct Human Rights perspective, we would agree with the authors but we are concerned about the consequences that exclusion from the Act and the inability of this vulnerable population to assert their Human Rights would lead to their not receiving effective care because of the absence of a suitable legal structure. We are keen to engage in debate in order to achieve the best support for people presenting with altered mental states and/or extreme challenging behaviour that cannot be assessed or supported safely in the community utilising usual resources.

Declaration of interest

none declared.

- Hollins S, Lodge K-M, Lomax P. The case for removing intellectual disability and autism from the Mental Health Act. *Br J Psychiatry* 2019; **215**: 633–5.
- Department of Health. *Valuing People Now: A New Three-Year Strategy for People with Learning Disabilities 'Making it Happen for Everyone'*. Department of Health, 2009.

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Authors' reply

We welcome the responses to our editorial on removing intellectual disability and autism spectrum disorder (ASD) from the Mental Health Act (MHA)¹ and value the authors' contributions to this important debate. We address the key points raised.

De Villiers² questions why we seek to remove only intellectual disability and ASD from the definition of mental disorder in the MHA. The reason is simple: there is clear evidence that people with intellectual disability and/or ASD experience restrictive practices including inappropriate use of psychotropic medication, physical restraint and seclusion, and prolonged, ineffective admissions resulting in suffering, trauma and serious harm to their human rights when detained in hospital,^{3–5} yet they are particularly vulnerable to their voices going unheard. De Villiers suggests our concern is 'stigma';² in fact, our fundamental concerns are to protect human rights and to raise the standards of mental healthcare provided to people with intellectual disability and ASD.

We agree with Courtenay⁶ that a person with intellectual disability and/or ASD should have the same opportunities as others to avail of care that may be delivered under the MHA. Indeed, under our proposed changes if a person with intellectual disability and/or ASD also had a mental disorder, they could be detained under the MHA like anyone else. We also agree with Courtenay that aetiological factors accounting for 'behavioural challenges' can include physical health and social factors,⁶ but we argue that the right place for these to be assessed and addressed is in the community; where mental health factors are thought to be causal, the MHA would remain an option if treatment really cannot be offered in the community.

Through our clinical experience, we have encountered MHA detentions where the underlying aetiological factor was pain because of a physical health problem. We argue that a person without intellectual disability and/or ASD would not accept being admitted to a mental health hospital because of pain arising from a physical health problem, particularly without efforts being made to elicit and treat the cause in the community. This is an example of the lazy practice and lazy diagnosis to which we refer. Watts questions the grounds for our statement on lazy diagnosis and practice.⁷ It is based both on our opinion informed by our experience, and on evidence⁵ including on the inappropriate prescription of psychotropic medication among people with intellectual disability and/or ASD without adequate clinical formulations.⁸ Removing intellectual disability and ASD from the MHA would emphasise the need to elucidate and address aetiological factors in the community, clarifying that there should be a presumption against mental health hospital admission for any non-mental health crisis in people with intellectual disability and/or ASD.

Courtenay⁶ suggests the MHA provides safeguards against 'lazy diagnosis' through Mental Health Review Tribunals. We ask what the evidence is for this. It is our experience that clinicians may misunderstand or even misconstrue distressed behaviour in a person with intellectual disability and/or ASD as a mental illness when in fact other

aetiological factors, such as environmental or sensory factors, are causal. It is our experience that professionals participating in Mental Health Review Tribunals may not always have an understanding of these factors, rendering the intended safeguards ineffective. Additionally people with intellectual disability and/or ASD face barriers to participating in their Tribunals when information about the process or their rights is not provided in an accessible format, yet it is our experience that professionals may lack the communication skills required.

Watts suggests the powers of the 'nearest relative' is another inbuilt safeguard.⁷ In our experience, it is rare for a nearest relative to challenge the professionals who have detained their relative, and we are not aware of any published evidence on this. We wondered if this statement was the author's own opinion, and whether he had asked individuals with intellectual disability and/or ASD or their families and carers their views? Furthermore many patients who are admitted do not have involved family.

We disagree with Courtenay's assertion that using the lengths of time that people spend in hospital is not justified as an argument⁶ – on the contrary, this is central given the negative impact on human rights to a private or family life and to live free from inhuman or degrading treatment or punishment. We agree with de Villiers that the Transforming Care programme is not working well enough.² The most recent data shows there are still 2185 people with intellectual disability and/or ASD in in-patient units with an average length of stay of 5.4 years.⁹ Delayed discharges are usually because of lack of appropriate housing and social care.⁹ The Transforming Care³ and Building the Right Support¹⁰ policies pledged to address this by investing in appropriate estate and resources in the community, including staff with the training and skills to be able to respond to a person with intellectual disability and/or ASD at times of distress, and emergency respite 'crash pads'. But this is not happening. Concerns about the impact of these failings on human rights led the Equality and Human Rights Commission to launch a legal challenge against the Secretary of State for Health and Social Care in February 2020.¹¹ Removing intellectual disability and ASD from the MHA would make it clear that it is no longer acceptable to rely on the fallback position of compelling people with intellectual disability and/or ASD to remain in hospital to cover for the failure to deliver community-based health and care services.

We agree this is a complex issue and changes to the MHA could not be made in isolation. Courtenay,⁶ Watts⁷ and Khan¹² raise concerns that removing intellectual disability and ASD from the MHA would lead to a risk of people being processed by the criminal justice system. We argue that we can learn from the New Zealand experience, and agree with Khan¹² that careful work is needed around how best to fuse changes to mental health legislation with changes to criminal justice system and mental capacity legislation to ensure people with intellectual disability and/or ASD in the criminal justice system have equitable access to thorough assessment, evidence-based treatment and relevant support from mental health services when this is needed, including forensic community support.

Since the publication of our editorial, the final report of the Independent Review of Learning Disability and Autism in the Mental Health Act in Scotland has concluded that intellectual disability and ASD should be removed from the definition of mental disorder.¹³ The report states:

'...to comply with duties in international human rights law, our law must be set up to ensure that autistic people and people with intellectual disability can get access to the support, care and treatment that they need to be mentally healthy, through choice and in their own communities. Our current mental health law does not enforce the protection and promotion of positive rights that are required to achieve all of this.'¹³

The report suggests legislative changes to strengthen the human rights protections of people with intellectual disability and/or