

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

- The case against removing intellectual disability and autism from the Mental Health Act
- Balancing non-discrimination and risk management in mental health legislation for autism
- The case for removing intellectual disability and autism from the Mental Health Act
- Authors' reply
- The case for removing intellectual disability and autism from the Mental Health Act – further debate required

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

Mental disorder is defined broadly across classification systems and legislation worldwide (see ICD-10, DSM-5 and World Health Organization definitions, all of which include intellectual disability within the definition). It is difficult to understand why Hollins et al seek to remove only intellectual disability and autism from the definition of mental disorder whereas all other mental illnesses and disorders would fall within the category.¹ It has never been the case that mental disorder only refers to episodic or psychotic illnesses. Dementia, acquired brain injury and personality disorder equally fall within the conditions where mental health legislation can apply. The concern seems to be 'stigma'. Removing intellectual disability and autism from the definition of mental disorder will not result in less stigma. These conditions have carried significant stigma well before such legislation was in place, and unfortunately will continue to do so for some time to come.

There seems little justification for separate legislation only in relation to these two neurodevelopmental disorders. It would appear to be far better to protect rights by being included in broader mental health and incapacity legislation. The experience of New Zealand (the only jurisdiction that has removed intellectual disability from its mental health legislation) was that this resulted in separate legislation that replicated the rights and protections in mental health legislation (unnecessary duplication) while eroding the clinical expertise available to individuals and services.² There is no evidence of significant positive outcomes for people with intellectual disability or autism being removed from definitions of mental disorder. The New Zealand experience resulted in more people with intellectual disability going to prison and a loss of clinical expertise.

It seems extraordinary that someone of the experience and expertise of Baroness Hollins could truly be of the view that all individuals could be managed within their home environments, no matter the level of challenging behaviour or the risk posed to others. The failure of the Transforming Care programme to substantially reduce the number of individuals receiving in-patient care (while transferring more individuals from National Health Service care to independent providers) highlights that this is an overly simplistic view that does not address the complexity of the underlying issues. Appropriate environments and highly trained staff can have significant positive outcomes for individuals,

improving their quality of life. However, for some, significant levels of physical and/or sexual violence towards others requires provision beyond what can effectively be provided in isolated community services. In Scotland, the 'Coming Home' report noted that physical and sexual violence were the main causes of community placement breakdown, with individuals with both intellectual disability and autism being particularly difficult to manage outwith specialist health settings.³

Hospital-based services can undoubtedly benefit from increased resources and investment in order to fulfil their role as intended. The main issues facing specialist in-patient settings are delayed discharges and the lack of appropriate community provision for individuals who no longer require in-patient care. Removing intellectual disability and autism from the definition of mental disorder will do nothing to address this lack of provision and runs the considerable risk of poorer physical and mental health outcomes for this vulnerable group.

Declaration of interest

none declared.

- 1 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.
- 2 McCarthy J, Duff, J. Services for adults with intellectual disability in Aotearoa New Zealand. *BJPsych Int* 2009; **16**: 71–3.
- 3 MacDonald A. *Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs*. Scottish Government, 2018.

Jana de Villiers, Forensic Network Clinical Lead for Intellectual Disabilities, The Forensic Network, The State Hospital, Carstairs, Scotland. Email: janadevilliers@nhs.net

doi:10.1192/bjp.2020.181

Balancing non-discrimination and risk management in mental health legislation for autism

Hollins et al¹ argue that since autism and intellectual disability are not mental disorders, they should be excluded from the Mental Health Act (MHA); their current inclusion is held to be discriminatory and resulting in unjust deprivation of liberty.

However, the potential impact of this on managing 'abnormally aggressive or seriously irresponsible behaviour'¹ that poses a serious risk to others and may be exhibited by those with autistic spectrum disorder (ASD) or intellectual disability is not fully considered. Individuals with ASD are seven times more likely to intersect with the criminal justice system than those without ASD.² This is likely as a result of features associated with the condition, including aggression triggered by disrupted routine or social misunderstanding, as well as obsessive behaviour alongside a failure to grasp the consequences.³

The authors argue that the approach of allowing individuals with ASD or intellectual disability to be detained under the MHA is likely to result in a lack of interest in looking for causes for this behaviour. They note 'an individual who is simply communicating their distress may find themselves detained in hospital for prolonged periods and subjected to restrictive practices including the inappropriate use of psychotropic medication.'¹ They add that hospital admissions may distress individuals and exacerbate their behavioural problems.

These are very valid points, but it is unclear if the situation would be improved if certain individuals with ASD or intellectual disability who pose a severe risk to others could not be detained under the MHA. Admission to hospital may not be an ideal environment, but ruling that out potentially risks greater rates of