

Correspondence

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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.

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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

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.

- 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 Berryessa CM. Judiciary views on criminal behaviour and intention of offenders with high-functioning autism. *J Intellect Disabil Offending Behav* 2014; **5**: 97–106.
- 3 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/>)
- 4 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.