COMMENT:

THE IMPACT OF REFORMING THE MENTAL HEALTH ACT ON THE CARE OF PEOPLE WITH INTELLECTUAL DISABILITIES AND AUTISTIC PEOPLE

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Over the past few years, the NHS and the Government have suggested the most sweeping changes of the Mental Health Act following a limited revision in 2007. The overall premise of the proposed reform is not just the modernisation of mental health legislation but more importantly the provision of high-quality mental healthcare in the least restrictive environment. [1]

In 2007, the Act was changed such that a person with an intellectual disability was liable to detention under the Act only if their intellectual disability was associated with "abnormally aggressive behaviour or seriously irresponsible conduct". Hollins et al (2019)[2] argued that both autism and intellectual disabilities should be fully removed from the reformed Act as they perpetuated discrimination and that detention of those individuals was effectively a deprivation of liberty. This is echoed by the Independent Review of the Mental Health Act (Scotland, 2019)[3] which used the Human Rights framework to argue for the need to remove these conditions from the definition of mental disorder as applied in the Act.

However, counter-arguments have also been made, notably by Courtenay (2021)[4], who maintained that removing these conditions altogether may give rise to the unintended consequence of care not being provided to individuals who are at great need of long-term skilled support and significant community resources. International reports have acknowledged the gaps created by the removal of intellectual disability from mental health legislation which led to individuals who present a serious risk to self or others, to be diverted inappropriately to the Criminal Justice pathway[5]. It is of note that the current proposals suggest retaining intellectual disability as a reason for detention under Part III but not for Section 3 within Part II of the Mental Health Act. The inherent contradictions of this approach merit further discussion. Many people with intellectual disabilities, who come into contact with criminal justice agencies, may not be sent for trial because of the nature and degree of their intellectual disability. In some cases, detention under Part II of the Act may be used to keep both an individual and the public safe, as the risk of further serious offending is recognised. Removal of intellectual disability from Part II of the Act, as currently proposed, would mean that a person with an intellectual disability could only be detained for 28 days, and then not at all, unless there are grounds for detention using mental disorder. Some may therefore commit further criminal offences and sentenced to prison as intervention in the form of detention under Part II of the Act would no longer be available, or detention under Part III would be possible, but only once serious criminal

offending had occurred, which in some cases, could have been prevented if detention under Part II were available.

It must be recognised that the proposed reforms embrace concepts such as personalised care and the inclusion of the voices of people with intellectual disabilities, and autistic people across the lifespan. These are all welcome additions which are supported by families and professionals. Parent carers, in particular, are invested in coproduction and engaging in service developments and see those as central to improving the care and well-being of their children.[6] In the ever changing landscape of NHS and social care, those tasked with delivering the right provision must be committed to designing effective, person-centred facilities including credible alternatives to inpatient care. The White Paper[1] states that it will place a duty on the NHS and Local Authorities to deliver adequate therapy and support but the parameters for that are unknown at present and possibly not enforceable in practice. The Act also places great capital on current structures such as the Care (Education) and Treatment Reviews which are to be tasked to review the duration of stay and to hold clinical teams to account. The impact remains to be seen given that between 2000-3000 people with intellectual disability and autistic people are currently inpatients in both NHS and private/independent hospitals with the majority subject to sections of the Mental Health Act 1983.[7] Many of those individuals were admitted because they displayed aggressive challenging behaviour-often in the absence of identifiable mental illness-deemed to be of such severity that it could not be managed safely with specialist support in the community.

We still know little about how mental health legislation affects outcomes for people with intellectual disabilities and of autistic people. For example, compulsory supervision under a Community Treatment Order whilst not reducing (re)admissions[8] can be seen as an aid in the promotion of engagement and adherence with treatment[9].

In our view, there appears to be tension between the desire to reduce coercive treatment of people with intellectual disabilities and autistic people and the valid scepticism about the impact of the reform on the access to care for many with complex needs. In-patient admissions may be needed for some and for longer than 28 days. Clinical experience indicates that lifelong difficulties, trauma, and comorbidities require careful assessments by multiple professionals. Without clearer understanding of aggressive challenging behaviour, availability of evidence-based alternatives to admission and measures for better ascertainment of mental ill health in those with comorbid developmental conditions and severe intellectual disability, the reforms may overpromise and under-deliver. We assert that this would betray the faith of people with intellectual disabilities and autistic people and their carers in achieving equity in mental health care provision.

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