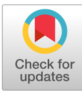
BJPsych
The British Journal of Psychiatry (2024)
224, 180–181. doi: 10.1192/bjp.2024.57




Commentary

# The potential unintended consequences of Mental Health Act reforms in England and Wales on people with intellectual disability and/or autism: commentary, McKinnon et al

Iain McKinnon and Patrick Keown

**Keywords**
Autistic spectrum disorders; human rights; inpatient treatment; intellectual disability; psychiatry and law.

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## Response

We agree with Tromans et al[1] that there are potential unintended consequences of removing intellectual disability and/or autism (ID/A) from section 3 of the Mental Health Act 1983 (MHA) in England and Wales.

Proposals allowing detention only under section 2 of the ‘civil’ MHA are fraught with problems. Data from the National Health Service (NHS) digital show that the median length of stay for people with intellectual disability (ICD-10 codes F70-F79) is 42 days, considerably longer than the 28-day duration of section 2.[2] We estimate that the assessment of people with mild (F70), moderate (F71) and severe (F72) intellectual disability would in approximately four out of every five cases be failed by only allowing detentions under section 2. For patients detained under section 2 who cannot proceed to section 3, a legal ‘limbo’ results with fewer safeguards. Clinicians may be driven to offer informal admission with treatment administered under the use of the Mental Capacity Act 2005 (if lacking capacity) or detention for a mental health diagnosis, which may lack diagnostic accuracy.

They draw attention to those with ‘high-risk’ behaviours (e.g. sexually harmful behaviour). We are also concerned about the potential for more people with ID/A being imprisoned.[3] Prison suicide is associated with overcrowding,[4] and when one considers the additional sensory needs of people with ID/A, there is the potential for serious adverse consequences. Increased use of Part III (forensic) detentions[5] could have the paradoxical and unintended consequence of MHA detentions being more restrictive for people with ID/A. Offenders awaiting trial would no longer be able to be risk-managed in hospital under section 3, thus increasing the likelihood of being remanded in custody. It could also preclude preventative risk management or definitive treatment in hospital until a significant offence has been committed, or where the person engaging in offending behaviour becomes the victim of retribution. Currently there is no legal framework to compel offence-specific treatment in the community, unless directed by a Court.

Intellectual disability and autism appear to have been considered together for exclusion from section 3, suggesting an ideological rather than evidence-based approach. To consider them as equivalent entities is to ignore clear differences in the needs of these two groups.[6] Whilst intellectual disability is a risk factor for comorbid Autism Spectrum Conditions (ASC), current epidemiological evidence suggests that the majority of patients with ASC do not have intellectual disability.[7] Therefore considering intellectual disability and autism together is not supported by epidemiological evidence. Will every person detained under section 2 in England and Wales need to be assessed for ASC, in order to ascertain whether or not it is the primary reason leading to detention? Given the 100 000+ people triaged and on waiting lists for assessment of ASC, this seems to be wishful thinking.

We agree that these legislative changes must be carefully scrutinised. They alone will not prevent the scandals at Winterbourne View and Whorlton Hall, without providing adequate funding and support necessary to allow people with intellectual disability and autism the best lives possible.

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First received 14 Feb 2024, final revision 20 Feb 2024, accepted 27 Feb 2024

## Data availability

Data used in the writing of this letter are freely available from NHS Digital[2].

## Author contribution

I.M. and P.K. drafted and approved the final version of this letter, and agree to be jointly accountable for all aspects of its content.

## Funding

There is no funding from any agency, or commercial or not-for-profit sector associated with this commentary.

## Declaration of interest

I.M. is an in-patient and community psychiatrist who works with offenders with intellectual disability and autism. P.K. is a medical director with responsibility for in-patient and community intellectual disability services.

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https://doi.org/10.1192/bjp.2024.57 Published online by Cambridge University Press

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BJPsych

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March 2024

http://www.cambridge.org/bja

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