Mental Health Bill, 2025

(and its potential impacts on autistic people and people with learning disability)

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The “Mental Disorder Act”? – a caveat

- I personally dislike the term ‘mental disorder’.
- But ‘mental disorder’ is the term used in law, and there is no other accepted ‘catch all’ term that encompasses mental health, developmental, neurological, emotional, behavioural, psychological, psychiatric, neurodevelopmental, etc… conditions. Each of these terms implies aetiology which is at best only provides partial coverage.
- **Words and terms matter:** part of the debate is about how autistic people objected to being included within a group of people believed to have ‘mental health conditions’ (I agree autism isn’t a mental health condition, but is acquired brain injury or dementia?)

Mental Health Act, 1959

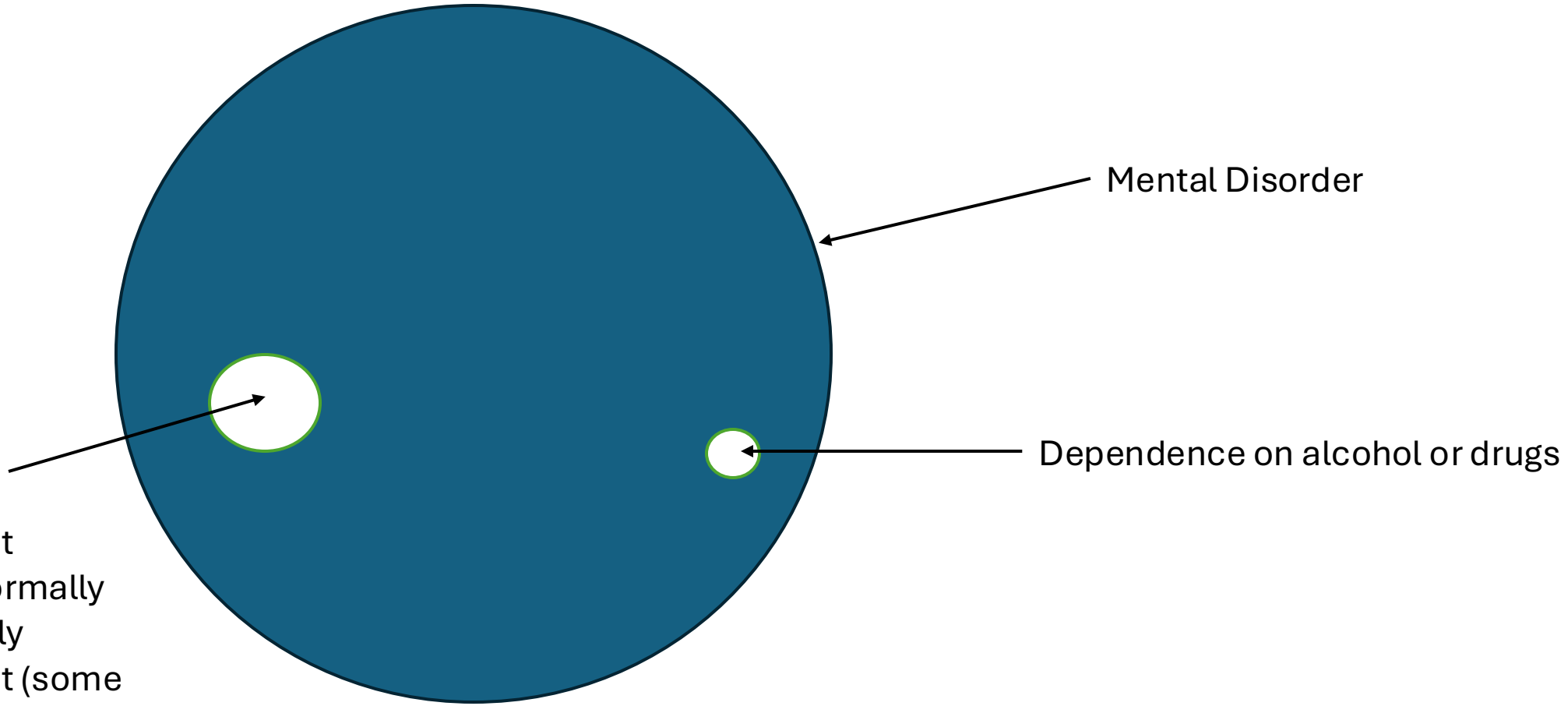
7 & 8 ELIZ. 2 CH. 72

Definition and classification of mental disorder.

4.—(1) In this Act "mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and "mentally disordered" shall be construed accordingly.

First reference in Hansard: 20.04.1915: https://hansard.parliament.uk/Commons/1915-04-20

Mental Disorder (s.1. MHA): the current situation



Detention: the current situation

The argument of whether somebody has a ‘mental disorder’ is usually important, because the definition is so broad.

Out of a very broad definition some small but specific exceptions are created.

“**Nature or degree”,** related to risk, is the focus, and the thing which separates somebody in the population who has “mental disorder” and will never be detained from somebody who might.

MHTs spend very little time debating whether a person *has* a mental disorder (they will argue about nature and/or degree)

The new situation – new definitions

3 Application of the Mental Health Act 1983: autism and learning disability

(1) The Mental Health Act 1983 is amended as follows.

(2) In section 1 (application of Act: "mental disorder")—

(a) in subsection (2), at the appropriate places insert—

""autism" means a lifelong developmental disorder of the mind that affects how people perceive, communicate and interact with others;";

""learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence;";

""psychiatric disorder" means mental disorder other than autism or learning disability;";

- The only type of mental disorder which can lead to a s.3 admission is psychiatric disorder.

The new situation: the importance of understanding what is ‘psychiatric disorder’

SCHEDULE 1 section 3(4)

APPLICATION OF THE 1983 ACT TO AUTISM AND LEARNING DISABILITY: AMENDMENTS AND TRANSITORY PROVISION

Amendments of Part 2 of the Mental Health Act 1983

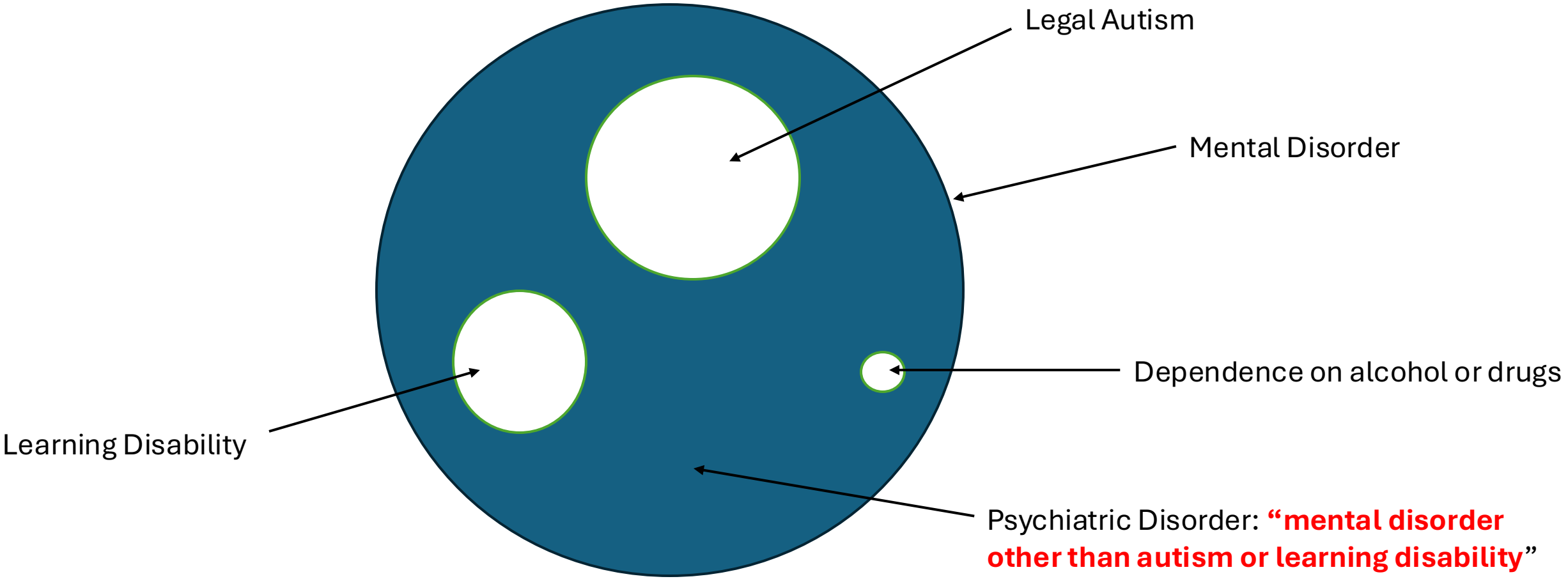
1 Part 2 of the Mental Health Act 1983 (compulsory admission to hospital and guardianship) is amended as follows.

2 In section 3 (admission for treatment), in subsection (2), for paragraph (a) substitute—

“(a) the patient is suffering from psychiatric disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital,”.

- The only type of mental disorder which can lead to a s.3 admission is psychiatric disorder.

Mental Disorder (s.1. MHA): the proposed/intended situation for s.3



The new situation

Proposed ‘Legal Autism’ is *very* broad:

“**Autism is a lifelong developmental disorder of the mind that affects how people perceive, communicate and interact with others**”.

Is this a correct definition of Autism?

Yes.

Is this a specific definition of Autism?

No.

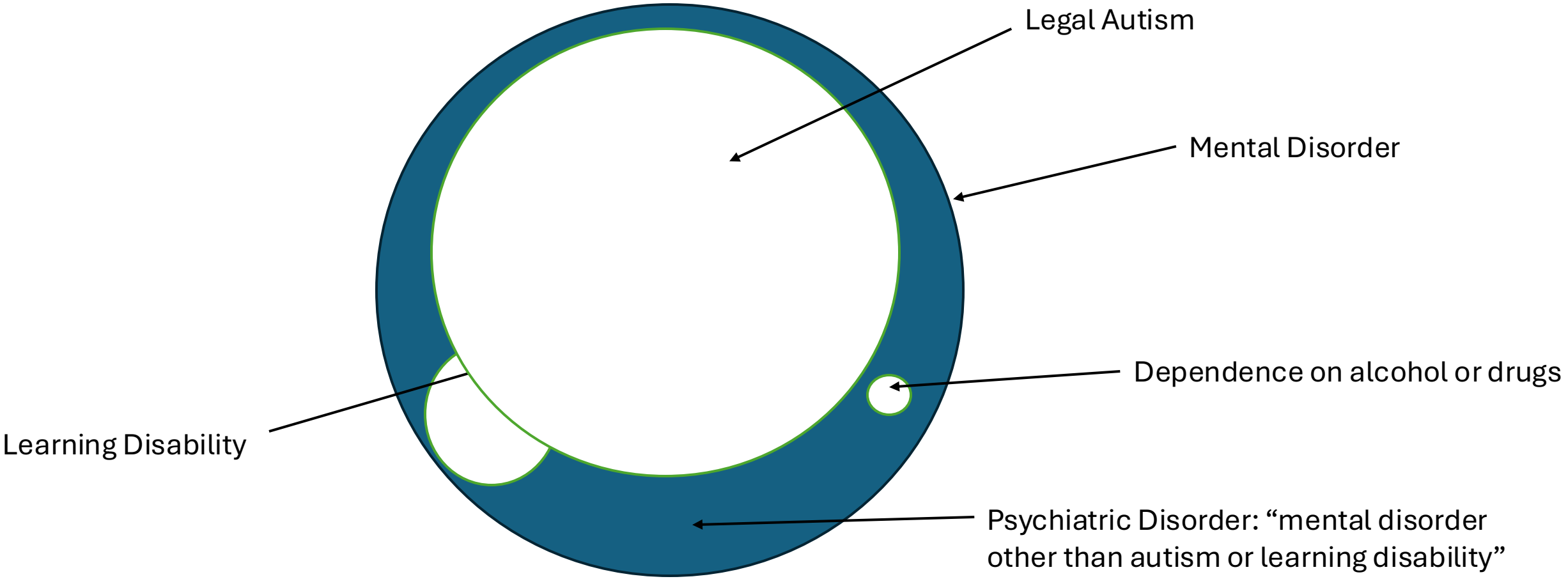
The new situation

Proposed ‘Legal Autism’ is *very* broad:

“a lifelong developmental disorder of the mind that affects how people perceive, communicate and interact with others”.

- **Most ‘mental disorder’ is developmental (name a disorder not impacted by trauma or brain development)**
- **Most (all?) mental disorder affects ‘how people perceive, communicate and interact with others’**
- **Many mental disorders could be argued to be lifelong (latent dysfunction preceding acute onset) – becomes philosophical…**
  - How do you know something will be life long at the point of assessment?
  - What’s the basis for believing autism to be lifelong?
  - When is ‘lifelong’ measured from? (what about ABI?)
  - Other disorders e.g. personality disorder arguably no less ‘lifelong’ than autism

Mental Disorder (s.1. MHA): a more realistic outcome?



Academic and logical reasons against the change

- No mandate for these changes in the Wellesley review; only highlighted in the White Paper for the first time after lobbying.
- Basis for the changes is inconsistent with conceptualization of other mental disorders (why these disorders? why together?)
- How to distinguish autism from presentations/disorder with overlapping symptoms? Personality disorder? Brain injury? *Which creates the need for nature and degree*.
- Notion of 'psychiatric disorder' problematic – labelling disorder by a branch of medicine?
- No other legislation has created a legal definition of Autism; even the Autism Act, 2009, specifically chose not to create such a definition, recognizing the difficulty of doing so and ongoing research.
- It is unclear how the proposed definition of Autism was developed. Appears no research behind it.
- Other jurisdictions which have implemented these changes have spent time rolling them back (New Zealand particularly)
- Inconsistent to remove from Part II but not Part III
- Risk of loss of specialist knowledge from hospitals (exactly what happened in NZ)

But

- In the context of the culture of the debate, these sorts of reasons have not been seen as compelling or even important.

"I had a detailed briefing from the group Liberation, a user experience group led by people who have experience of mental distress and trauma, which has the slogan "for full human rights". It is seeking a complete end to involuntary detention in psychiatric hospitals and forced treatment for the people it represents—people given mental health diagnoses. It asked me to exclude all people from what is known as detention or sectioning.

Liberation says that involuntary detention and forced treatment are forms of disability-based discrimination, and these people should not be subject to them."

[Baroness Bennett, speaking to this Clause in the House of Lords, 14th January 2025]

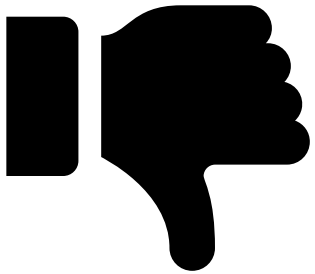
And…

- In the context of the culture of the debate, these sorts of reasons have not been seen as compelling or even important.

"the evidence is that putting people with learning disabilities and autism in a psychiatric hospital—and that is where they will go if there is no provision, because that is where they go at present—is damaging. It is not the correct provision. I believe that what she is arguing for—to continue the neglect of provision by putting them somewhere—is significantly not in their best interests and causes damage."

[Lord Scriven, speaking to this Clause in the House of Lords, 14th January 2025]

In sum…



‘Detention in hospital is always a bad outcome’
Not…

‘Detention in hospital is sometimes the least worst outcome’

So, what are the practical and specific concerns about these changes?

Four hypothetical case examples:

What might happen now?

What would happen if these changes are enacted?

(LDA = Learning Disability / Autism)

Scenario 1:

People with LDA whose behaviour presents a significant public protection risk, but who have not necessarily committed an offence (or a sufficiently serious one)

- Person with LDA and interest in fire-setting identified by member of public behind petrol station with matches and paper.
- Person with LDA and sexual interest in young children identified regularly visiting school and talking to young children.
- Person with LDA stalking high profile celebrity.
- Person with LDA in residential accommodation is highly distressed, removes knife from kitchen and runs into public place.

Scenario 1: What might happen now?

People with LDA whose behaviour presents a significant public protection risk, but who have not necessarily committed an offence (or a sufficiently serious one)

- If suspicion of an offence: police arrest.
- If serious concerns about risk but no crime: civil detention may be used. This may be beyond 28 days to manage risk and provide appropriate treatment and support. Upon discharge, s.117 aftercare provided.
- Likely need for assertive community intervention: what happens in reality will vary.
- CPS may not pursue a criminal offence because judged not in the public interest if person is detained and/or believed to be receiving appropriate support.

Scenario 1: What happens if changes are enacted?

People with LDA whose behaviour presents a significant public protection risk, but who have not necessarily committed an offence (or a sufficiently serious one)

- Police will still arrest person if necessary/appropriate.
- Section 2 admission could occur, but only 28 days. What if significant concerns at end of 28 days? May avoid s.2 because of anticipation of this concern.
- CPS may be more likely to pursue a criminal charge given uncertain risk management.
- Unlikely person will be remanded in custody (unless serious offence) so → residence. Increased risk of eviction?
- Risks here could be partly mitigated through far more assertive/well resourced community intervention – but: a. will these arrive; b. these won't be complete mitigations.

Scenario 2:

People with LDA whose behaviour does represent a serious criminal offence but who have significant cognitive impairments.

- Person with serious cognitive impairments associated with LDA seriously sexually assaults care worker in residential accommodation
- Person with serious cognitive impairments associated with LDA takes a knife and stabs a fellow resident (perhaps as a result of distress)

Scenario 2: What might happen now?

People with LDA whose behaviour does represent a serious criminal offence but who have significant cognitive impairments.

- Largely as Scenario 1, but civil detention far more likely.

Scenario 2: What happens if changes are enacted?

People with LDA whose behaviour does represent a serious criminal offence but who have significant cognitive impairments.

- Police will take immediate action of arrest, and may be more likely to pursue criminal charges. However:
  - Criminal charges may not be pursued by CPS as not in public interest due to perpetrator's impairments
  - If brought to trial, the *mens rea* of offence may not be met, which will result in charges being dropped.
  - Alternatively, perpetrator may not be judged not fit to plead, which could result in charges dropped or (or ultimately possibly disposal via Criminal Procedure Insanity Act (1964)).
  - Evidential issues could mean criminal charges not progressed
- Overall, there is a significant likelihood that perpetrator would receive no criminal charges, and no form of detention would be possible beyond the 28 days of s.2.
- Near certainty that residence provider would refuse to take resident back into accommodation → person becomes homeless. **There is literally nowhere for them to go.**
- **More violence likely ensues (and high risk of person being subject to abuse/grooming)**

Scenario 3:

People with LDA whose behaviour presents a serious risk to themselves.

- Person with LDA head banging in residence causing significant self-injury. Significant efforts made to support/intervene but efforts in residence unsuccessful and concerns about risk escalating.
- Person with LDA found in residence with severe self-inflicted injuries
- Person with LDA identified on a bridge attempting to jump off.

Scenario 3: What might happen now?

People with LDA whose behaviour presents a serious risk to themselves.

- Efforts would generally be made to manage risks where possible within the person's residence/community.
- Where this is not possible/successful then detention under s.2/3 could occur.
- It would not be important whether there is a separate mental health condition driving the behaviour; the focus would be on the 'nature and degree' of the person's mental disorder as a whole.

Scenario 3: What happens if changes are enacted?

People with LDA whose behaviour presents a serious risk to themselves.

- Increased attention will need to be given to demonstrating that ‘psychiatric disorder’ created the ‘nature’ and ‘degree’ AND that ‘learning disability’ and ‘autism’ DID NOT. If there was not, or if unclear, person could not be detained beyond 28 days.
- In people with severe impairment from LDA, demonstrating whether a separate mental health condition was present and driving the risk may be impossible, and these people thus could not be detained (or would be discharged by tribunal)
- Increased likelihood that risks to self would escalate and lead to death or more serious self-injury.

Scenario 4:

People detained for a mental health condition who is challenging their detention at MHT and has LDA or ‘features’ of LDA

- Person with LDA who also hears voices / has psychosis
- Person with LDA who has personality disorder
- Person with LDA who also has acquired brain injury or dementia.
- Person who definitely doesn’t have LDA but does have personality disorder and argues “my personality disorder is legal autism”

Scenario 4: What might happen now?

People detained for a mental health condition with features of LDA who are challenging their detention at MHT

The focus of the MHT would be on ‘nature and degree’ of the person’s mental disorder, associated risk and need for treatment.

There would be no process of needing to identify which disorders led to which elements of risk.

Scenario 4: What happens if changes are enacted?

What will impact of proposed changes be?

- Significant importance will be placed by the MHT on whether the person has Autism or LD and if so to which elements of 'nature' or 'degree' it contributes towards or explains. This will often be an impossible question to answer.
- As the burden of proof is on the detaining authority, it is more likely that such people will be discharged by the MHT: continued detention for Autism will risk arbitrary detention (→ Article 5).
- The definitional breadth of autism may mean arguments such as "my personality disorder is autism" are successfully made out at the MHT.
- The changes may drive advocates to seek autism or LD diagnoses for their clients because this will be seen as a route to discharge, even if this is not the primary diagnosis driving risk. **These assessments will focus on whether the legal definition of Autism is met, not the clinical one**.

Wider risks…

- Hospitals will close:
  - Transfer of existing patients between hospitals
  - Fewer hospitals, further apart = more out of area admissions for those who warrant it
  - Risk of loss of expertise unless roles are incorporated into community teams

- Hospital care for LD/Autism will focus primarily on:
  - Those under s.3 where it is *absolutely* clear that neither nature or degree are influenced by Autism or LD – but more likely to go to standard psychiatric wards?
  - Those under s.37 where there is sufficient evidence, capacity etc to go through court system (or serious enough for CPIA)
  - Increased need for prison transfers given expected increase in prison population of people with LDA
  - Possibly admissions under s.2 under crisis – but need to immediately consider what happens after 28 days

In summary…

- If these proposed changes are enacted as proposed:
  - More people with LD and Autism will end up in prison because unmanaged risks will lead to an offence (may be mitigated to some extent if community intervention gets really good)
  - Some people with severe impairments will end up literally nowhere, and therefore subject to exploitation and ongoing risks to public.
  - People without LD or Autism, or those who have features of LD or Autism, will be discharged at an MHT because of the definitional breadth of the proposed “legal Autism”.
  - People with LD or Autism and another mental health condition may be less likely to be able to be detained, and more likely to be able to challenge detention at tribunal

My crystal ball

Largely out of legislative road to amend the current legislation prior to Royal Assent.

Crystal-Ball-Gazing-Option 1:

Long implementation window allows recognition of potential problems and subsequent rolling back through further primary legislation, perhaps by new government

Crystal-Ball-Gazing-Option 2:

Effort made to develop Code of Practice to *narrow* the breadth of 'legal autism' (e.g. to people who have had a formal autism assessment) – itself a likely controversial exercise.

Crystal-Ball-Gazing-Option 3:

Huge increase in use of DoLS as an alternative framework – DoLS system collapses – argument becomes about closing the DoLS 'loophole'…

Crystal-Ball Gazing-Option 4:

Implementation leads to a serious adverse public safety incident after a "my personality disorder is autism" discharge → emergency legislative action (and therefore more reliance on private sector to provide beds, because NHS buildings will have been de-commissioned…)

Crystal-Ball-Gazing-Option 5:

A rush for Section 7 Guardianship?

Other ways to make things better?

- Continuing focus and emphasis on improving, enhancing and maintaining quality of care provision for LD/A – community care ++
- Throwing every tool in the book at ensuring that abusive cultures in hospitals and institutions **cannot develop**:
  - **Care staff**: paid well, supervised well, regulated well.
- Improving the accountability, regulation and oversight of residential care.
- Think about the design of hospitals/treatment/care centres for people with LDA with their needs at centre, *meaningfully*.
- Consider our social positioning of hospital treatment under MHA: are these really 'hospitals' in any case?
- Personal view: bring all MHA care for people with Autism/LD back to the NHS (or at least take shareholders out of the equation)

Some potential legislative directions

1. Development of ‘fusion’ legislation covering both DoLS and MHA detentions, offering the safeguards of MHA to all (but £££)
2. Remove Clause 3 entirely (best but seems v unlikely to happen)
3. Come up with better terminology for “mental disorder”
4. Fudge amendments to reduce the worst risks, for example:
    1. Redefine ‘Autism’ (narrow the definition) or create the definition using secondary legislation so it can be updated.
    2. Exclude a narrowed ‘Autism’ from Section 3, but not LD.
    3. Change the relationship between autism/LD and psychiatric disorder; avoid making psychiatric disorder dependent on autism/LD.
    4. Create a route to allow detention of person with Autism/LD under section 3 if MHA assessment is triggered after arrest.
    5. Clarify how a tribunal is supposed to respond where not possible to separate out the part of mental disorder that contributes to risk.

These may be bad ideas which create their own unintended consequences: fundamentally needs more thinking through.