Submission to Commons Mental Health Bill Committee

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Date: 5th June 2025

Context

1. The author of this submission is Dr Peter Beazley, an Associate Clinical Professor at the University of East Anglia. I am a Clinical Psychologist by background and have previously worked clinically in inpatient mental health settings. I now work in a role training Clinical Psychologists. I am also involved in research, teaching and training concerning the clinical applications of Mental Health Law.
2. I am pleased to provide this submission in response to the call for evidence submitted by the Commons Mental Health Bill committee. In this statement I will summarise concerns about the potential for unintended consequences arising from the proposed changes concerning autism and learning disability in the Bill.
3. These concerns are outlined in detail in previous scholarly work which my colleagues and I have produced (Beazley et al, 2023; Beazley, 2024). However, of critical importance to the committee are the concerns summarised in a recent paper which has just been accepted by the *British Journal of Psychiatry* (Beazley et al, 2025), but is not yet published. The content of this paper is of direct interest to the committee. The authorship of this paper includes 21 academics working in different institutions nationally and additionally four carer authors. The contents represent the synthesis of concerns which have been presented by a number of the authors across at least 12 separate publications (see article reference list).
4. Whilst this paper has not yet appeared in print, we are able to share it with you in full as it has now been formally accepted by the journal. It appears below this summary.
5. Some of the concerns raised in our article were reflected and considered within the Lords' debates, but many of them were not. We hope that the Commons will consider these concerns before the Bill passes into law.
6. This document provides an executive summary of our concerns. We also attach a copy of the accepted manuscript for the consensus paper above. All quotes arise from the above paper unless otherwise stated.

Executive Summary

Concerns for Autistic People and/or People with a Learning Disability

7. Detention under the Mental Health Act 1983 (MHA) generally involves a crisis where there are no other immediate options and where admission to a hospital is judged as the only way of managing the person's ongoing risk. Such risks are not limited to the 28 days which would be permitted under Section 2.

8. If the changes are implemented as proposed, the most obvious and immediate outcome is that practitioners will seek other ways around the restrictions which would be created by the Bill. It has been recognised that the most obvious alternative is the Deprivation of Liberty Safeguards (DoLS) framework to authorise detentions in hospital, at least for the group of people who do not object to their treatment in hospital (Case E, Schedule A1, Mental Capacity Act, 2005). In our paper above, we have stated that *"[t]he DoLS framework is without question a much more poorly safeguarded option than the MHA. It is also a much more challenging framework under which to manage risk. It offers no access to a Second Opinion Approved Doctor (SOAD) to authorise treatment, no 'Nearest Relative' who can initiate discharge, no Article 8 right to an appeal with the corresponding free legal representation, and no regular automatic tribunals even if no appeal is made"*. It also means loss of 'aftercare' provision afforded by s.117 of the MHA. These are very important concerns, meaning that the group who these changes are intended to protect may in fact be directly and significantly disadvantaged by the changes.

9. We note that similar concerns were voiced during the House of Lords debates, and consequently there may be proposals to close what is seen as a 'DoLS loophole'. If neither DoLS nor MHA become available options, there are significant potential adverse and unintended consequences for the group of people who might otherwise be detained.

10. One of the most prominent concerns is that autistic people and people with a learning disability will instead be sent to prison in greater numbers "*because of unmanaged and unnecessary escalation of risk in the community*". This is a concern that has been voiced by several authors independently. We have noted the potential consequences both for the individuals involved, but also for the wider public, highlighting that *"[whilst] most autistic people or people with a learning disability present no wider risk to others… in some cases there are risks including fire-setting, sexual violence and stalking. Some 'special interests' in autism can also cause concern (e.g., poisons or explosives). These behaviours occur for a complex range of reasons and effective risk management is important to assure public safety, including that of carers. When such risks begin to escalate, a detention under Section 3 is a key mechanism to prevent further development with more serious consequences"*.

11. Community and residential services, as they are, are poorly equipped to manage and respond to the needs of autistic people or people with learning disability who present with risky behaviours. Even if their ability to support this group is enhanced, we do not believe that it is realistic to assume that it is possible to remove the need for compulsory care occurring in each and every case. Moreover, there is a risk that building the necessary support in the community for people who present with such risks simply means building residential provision which shares many of the restrictions of hospital, but which provides none of the safeguards. Poorly equipped and supported residential provision may be worse than hospital provision, particularly given the much more limited institutional safeguards.

12. We note that after New Zealand introduced similar legislative changes, it has been subsequently rolled back for precisely these reasons. Brookbanks (2019) summarises that within the group of people released there were "*a small number of intellectually disabled men with co-existing behavioural issues, some of whom, upon their unsupervised release into the community, committed serious criminal and sexual*

assaults. This unintended consequence of the amendment of the definition of 'mental disorder' led to the development of new policy for the care and containment of such individuals". The result of the subsequent legislative repair work has been more, rather than fewer, autistic people and people with learning disability subject to compulsory care. There is no reason that the situation in England and Wales is fundamentally different. We must learn from the experience of New Zealand, which we understand is the only common-law jurisdiction to have attempted similar changes previously.

Particular concerns for people with profound impairments

13. One distinct issue are the concerns for a group of people who have more profound impairments (e.g. people who are non-verbal, people who need longer term residential care) and who engage in offending. For example, a person with a moderate or severe learning disability, who lives in supported accommodation and who physically or sexually assaults a support worker. At present, a civil detention under s.3 of the MHA is a pragmatic way of managing the resultant and reasonable concerns about ongoing risk. Criminal proceedings are unlikely to be initiated (because the person will either not be fit to plead or the CPS will decide charges are not in the public interest) and if they are, may be unlikely to effectively conclude (if the person's learning disability interacts with the *mens rea* in the offence). This means there are a group of people for whom neither a custodial sentence nor a Hospital Order under s.37 of the MHA are likely outcomes (unless recourse is found in the very rarely used proceedings laid out in s.5 of the Criminal Procedure (Insanity) Act, 1964). What will happen to these people? Their residential provider will almost certainly make efforts to evict them, but without recourse to hospital, and no prison sentence, they may be left with literally nowhere to go, becoming homeless and therefore vulnerable to grooming and exploitation in the community.

Unintended consequences for people without autism or learning disability

14. We have significant concerns about the proposed definition of autism. No other legislation has created a legal definition of autism; not even the Autism Act (2009). The explanatory notes to this Act reflect the difficulty of doing so: "*[t]he word "spectrum" is used because the characteristics of the condition vary from one person to another… It is because of this that no definition of the term "autistic spectrum condition" has been included in the Act*". This position has not changed.

15. The proposed definition in the Bill is very broad – much broader than a clinical definition – and therefore works well for an inclusionary purpose. However, the function of the proposed definition is an exclusionary one. From this perspective, it is important to consider what might be unintentionally encompassed within this definition, as this will also be excluded from the scope of section 3. As currently proposed, a number of conditions other than autism could be encompassed within the proposed definition. Personality Disorder is the most obvious example, but there are arguably others. There are enormous potential consequences, in particular for the operation of Mental Health Tribunals (MHTs). Currently, the focus of MHTs is very rarely on the issue of whether or not somebody *has* a 'mental disorder', but rather on the 'nature' or 'degree' of that disorder and its connection to the person's risk. It seems inevitable that this will change, with advocates advancing illogical but legally compelling arguments that a person who has personality disorder does in fact have autism as legally defined. Given the breadth of the proposed legal definition of autism, and the fact that it is on the detaining authority to prove that the person meets the criteria, we anticipate many of these challenges may be successful.

16. The breadth of the definition is also a concern where a person does indeed have autism but where they also have other conditions which overlap or interact with the presentation of autism. The proposals to exclude autism therefore ignore the pragmatic clinical difficulties there often are in differentiating autism from other presentations, or at least in concretely attributing a particular risk to a particular disorder. To illustrate, how would a Mental Health Tribunal decide how to resolve an argument that the 'rigid thinking',

social withdrawal, or unusual interpersonal engagement demonstrated by a person with both schizophrenia and autism, and relevant to their ongoing risk, is in fact part of the person's schizophrenia, rather than their autism? How do the medical practitioners proceed when they identify such a situation at the point of detention? Is there a risk of arbitrary detention if a subsequent diagnosis of autism is established for part of a person's presentation which was previously held to be personality disorder?

17. In sum, whilst it is the intention of the proposed changes to *allow* detention of somebody with autism where they have a co-occurring 'psychiatric disorder' (a term which we note raises objections itself through its identification of a disorder with a branch of medicine), we note that the definitional breadth of autism creates a significant risk that the presence of autism – or a condition that might have similarities to it – will simply overshadow the ability to effectively detain such people, arguably creating a situation where detention can only occur where autism – as legally defined – has been definitively and entirely ruled out.

Recommendations

18. In our paper, we primarily advocate for the removal of clause 3 because "*of the likely unintended consequences and adverse impact on people affecting their quality of life, liberty, and access to treatment and care*". It remains our view that this is the preferable option. If clause 3 was removed, we also note that the wider safeguards and higher thresholds applied in the proposed Bill would still apply equally to autistic people and people with learning disability. In making this recommendation, we also note that the proposals in clause 3 were specifically recommended against in the Independent Review of the Mental Health Act.

19. Efforts to develop differential pathways for the compulsory care of people with different conditions need to be underpinned by reliable, valid and effectively operationalised definitions of those conditions that reflect the complex and intersecting nature of clinical problems observed in mental health and neurodevelopmental services. There is a significant need for more research to underpin any changes to the definitions of mental disorder. There is also a need to consider the clinical and legal rationale (and implications) separately for autistic people and people with learning disability.

20. We note that the Percy Commission, which preceded the 1959 Act, argued that "we attach considerable importance to finding suitable new terms to replace those contained in the present Mental Deficiency Acts and Lunacy Acts". We argue that the term 'mental disorder' is now, itself, in need of review, quite possibly as part of the above proposed research.

21. We strongly recommend that the committee consider more carefully the experience of New Zealand as a means of illustrating the likely unintended consequences that will arise from these changes.

22. Beyond these broad issues, there are a number of partial solutions which may mitigate against some of the worst unintended outcomes from these changes. We stress that these solutions require more detailed consultation to ensure that they themselves do not create unintended consequences.

23. Amend the definition of autism in the Bill so that it is more specific and avoids encompassing people who do not have autism.

24. Retain access to Section 3, or broaden access to Section 37, to allow civil detention beyond 28 days to occur for people with autism and learning disability after an arrest has occurred. This may help avoid situations where people with profound impairments commit a serious offence but cannot be realistically prosecuted. There may need to be some legislative safeguards to prevent incentivising arrest as a route to

detention, and potentially an interface with the Criminal Procedure (Insanity) Act 1964 to ensure that people are not denied the opportunity to be properly tried for their actions.

25. Change the relationship between autism/learning disability and psychiatric disorder in the Bill, by making 'psychiatric disorder' less definitionally dependent on autism or learning disability. This could be achieved in different ways, possibly by defining broader categories of mental disorder each with separate definitions (e.g. mental illness; autism; learning disability; personality disorder; brain injury and dementia), or possibly by adding wording such as "including any form of mental disorder which presents concurrently in someone with autism or learning disability" to the proposed definition of 'psychiatric disorder'. We emphasise, however, that amended definitions should be based on research rather than individual proposals.

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Appendix

Version of manuscript shared with the Commons Mental Health Bill committee prior to publication in the British Journal of Psychiatry.

The Mental Health Bill (2025) for England and Wales: A professional and carer consensus statement summarising concerns and unintended consequences from proposed changes to Autism and Learning Disability.

Status: Accepted by the British Journal of Psychiatry for publication.

Advance Manuscript DOI: https://doi.org/10.1192/bjp.2025.10324 (will become live when published)

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Abstract

The Mental Health Bill, 2025, proposes to remove autism and learning disability from the scope of Section 3 of the Mental Health Act, 1983. The present article represents a professional and carer consensus statement which raises concerns and identifies likely unintended consequences if this proposal becomes law. Our concerns relate to the lack of clear mandate for such proposals, conceptual inconsistency when considering other conditions which might give rise to a need for detention, and the inconsistency in applying such changes to Part II of the MHA but not Part III. If the proposed changes become law, we anticipate that detentions would instead occur under the less safeguarded Deprivation of Liberty Safeguards (DoLS) framework, and that unmanaged risks will eventuate in behavioural consequences which will lead to more autistic people or people with a learning disability being sent to prison. Additionally, there is a concern that the proposed definitional breadth of autism and learning disability gives rise to a risk that people with other conditions may unintentionally be unable to be detained. We strongly urge Parliament to amend this portion of the Bill prior to it becoming law.

Relevance Statement: The proposed changes to the Mental Health Act concerning autism and learning disability will result in a range of unintended consequences having relevance for all psychiatrists working with patients subject to civil detention. People with autism and learning disability may be more likely to be sent to prison, or detained under less well safeguarded regimes. More broadly, the changes may make it harder to justify detention particularly for people

with conditions which co-occur with autism and learning disability, or where similar symptoms are demonstrated.

Manuscript

The Mental Health Bill, 2025 ('the Bill'), was introduced to the House of Lords on the 6 November 2024. It proposes to make a number of changes to the Mental Health Act, 1983 (MHA) in England and Wales (separate processes of reform are underway in Scotland (1) and a different legislative context exists in Northern Ireland). The process of legislative reform commenced in 2018 with the Independent Review of the Mental Health Act (2), which ultimately resulted in the development of the near identical Mental Health Bill in 2022. The previous government never introduced this Bill to parliament (3). The aims of the legislative changes are broad, with the most recent impact assessment (4) identifying eleven separate objectives, many of which relate to the strengthening of patient rights and safeguards.

The present article concerns some of the specific proposed changes relating to autistic people or people with a learning disability[1] who might require detention and treatment in a hospital. The policy objectives behind these proposals are outlined in the White Paper, but in summary are to address concerns about autistic people and people with a learning disability being detained for too long or being subject to unnecessary restrictive practices, as well as contemporary concerns about institutional abuse (5). The proposed changes would amend Section 3 of the MHA, which governs the process for detentions in hospital for treatment occurring beyond 28 days, such that 'psychiatric disorder' (defined as mental disorder other than 'autism' or 'learning disability') is the only type of mental disorder that can give rise to a need for detention. Detentions could still occur under Section 2 for any type of 'mental disorder' (for a maximum of 28 days), and also under Part III of the MHA, which concerns the process of detention in hospital for offenders. Detention under the MHA, regardless of diagnosis, only occurs in relation to risks to self or others.

Several authors and clinicians (6) have expressed concerns about the potential for unintended consequences because of these proposed changes. This statement has thus been produced as a consensus statement to summarise these concerns. The statement represents the views of a number of academic, legal and clinical professionals but also includes the voice of a number of carers and Experts by Experience who share similar concerns, which are particularly highlighted in the Expert by Experience statement in Appendix 1.

Our concerns are summarised as follows:

There was no clear mandate for such changes, and their presumed aims are unlikely to be achieved

This key point, highlighted in several articles (7-9), is that the proposed changes were not recommended in the Independent Review of the Mental Health Act (2), and appeared first in the White Paper (5). Qazi et al (10) has reasonably asked '[w]hy not propose a consultation on change, rather than the removal?'.

[1] Several authors use the term 'Intellectual Disability', however the present article uses 'Learning Disability' to reflect the terminology of the Bill

It is not clear that changes to primary legislation are the best way to achieve the stated policy objectives. Beazley et al (11) and Tromans et al (8) argue that the changes are unlikely to prevent cases of institutional abuse. They highlight that the failings in such institutions have been neither unique to hospital settings or indeed to autistic people or people with a learning disability, with Tromans et al (8) concluding that 'the uncomfortable truth is that poor care can occur in any setting'. Instances of abuse may even increase if the changes result in more people being moved to less well-regulated residential environments.

More generally, because of the wider concerns which will be outlined, we believe that it is unlikely that the proposals will improve parity of esteem for autistic people and people with a learning disability or reduce stigma (12). One of our carer authors remarked that there was a 'very high risk of further exacerbating the chronic issue of health inequalities experienced by those individuals with a learning disability and autism, resulting in significantly poorer clinical outcomes for these individuals and causing them to unnecessarily experience a much poorer quality of life'.

The basis for removing autism and learning disability is inconsistent with the conceptualization of other mental disorders

There is no epidemiological or clinical reason why learning disability and autism should be considered together in the way proposed; they are distinct conditions. Moreover, there are no sound reasons for considering learning disability and autism as sitting apart from the wider legal classification of 'mental disorder'. As de Villiers (12) points out, 'it has never been the case that mental disorder only refers to episodic or psychotic illness'. More generally, Beazley et al (11) highlights that 'the practice of drawing a clear line between 'mental illness' and 'autism' is not necessarily so easy', and notes the complexity in meaningfully attributing specific features of a presentation to a specific condition.

Other papers have identified challenges with the specificity of terms used to differentiate autism and learning disability. For example, two papers (9, 11) challenge the logic that autism and learning disability are 'untreatable', highlighting that there are many other examples where the goal of treatment is not to remove a particular condition (for instance, psychological treatment for personality disorder is commonly about increasing the individual's ability to effectively manage emotional and behavioural symptoms).

It is inconsistent to remove autism and learning disability from the scope of Part II but not Part III

This point has been made by a range of authors (9, 11, 13), who highlight that there is an inherent inconsistency and inequity in allowing a detention to occur under the forensic sections of the Act but not allowing a civil detention under Section 3. The 28 days allowed under Section 2 is inadequate for meaningful care, treatment or assessment for people who continue to present with serious risks towards the expiry of this section (8, 13, 14), or where ongoing distress clouds the opportunity for assessment of a mental health condition, particularly in the context of the often different presentation of severe mental illness in this population. These were concerns also considered by the parliamentary joint committee (15).

McKinnon and Keown (14) have argued that the potential increased use of 'forensic' sections under Part III of the Act 'could have the paradoxical and unintended consequence of detentions under the MHA being more restrictive' for people with a learning disability. These concerns, as well as the associated concern that the criminal justice system may come under increased pressure to prosecute people with

autism and learning disability, were clearly detailed by the joint committee. The potential missed opportunities for treatment and intervention are equally concerning.

One of our carer authors highlighted a concern that by retaining autism and learning disability within only the 'forensic' sections of the Act, there is the risk of unintentionally reinforcing stigmatic beliefs about the dangerousness of autistic people and people with a learning disability.

It is unclear what will happen to those people who might otherwise have been detained under Section 3

This is a key point, considered in some form by most authors, reflecting concerns around both the potential for unmet care needs and unaddressed risks.

McKinnon and Keown (14) highlight NHS data indicating that the median length of stay for people with a learning disability is '42 days, considerably longer than the 28-day duration of Section 2'. This suggests that there will be a relatively large number of people with a learning disability who will, in practice, be affected by the proposed changes. What happens to those who would currently be detained under Section 3?

Tromans (8) has highlighted the unpreparedness of existing community services to address the care needs and risks presented by people within this group. Velani et al (16) conducted a survey of 45 English mixed mental health professionals and reported that 76% 'thought that substantial investment in community services was required in advance of the proposed reforms.' Taylor and Burrell (9, 17) have expressed concern that the proposed processes for supporting the development of community services will likely draw heavily on approaches (such as pooled budgets and joined commissioning) adopted in the 'failed Transforming Care programme'.

Without recourse to the MHA, it is likely that the Deprivation of Liberty Safeguards (DoLS) framework will be used instead to authorise detentions, at least for the group of people who do not object to their treatment in a hospital. In its present form, the Bill does nothing to prevent the use of DoLS in this way, although the current parliamentary process highlights potential amendments which could also remove this option (18).

The DoLS framework is without question a much more poorly safeguarded option than the MHA (9, 15). It is also a much more challenging framework under which to manage risk. It offers no access to a Second Opinion Approved Doctor (SOAD) to authorise treatment, no 'Nearest Relative' who can initiate discharge, no Article 8 right to an appeal with the corresponding free legal representation, and no regular automatic tribunals even if no appeal is made. If the Liberty Protection Safeguards (LPS) are introduced to replace DoLS, such safeguards may be reduced further as the authorisation for the LPS moves with the person, rather than needing to be renewed in each new setting. Similar concerns were identified by the joint committee (15). Our carer authors expressed a concern that detentions under DoLS might become longer than those under the MHA because of the limited safeguards.

A further disadvantage of an increase in the use of DoLS would be the loss of aftercare provision under Section 117 of the MHA. This provides funding for support in the community after discharge from a Section 3. Our carer authors referred to this as a 'vital safety net'. Several authors (8, 10, 11) have pointed out the implications of removing access to this with Tromans et al (8) also highlighting the potential implications for a breach of the Equality Act 2010 particularly if 'the fabric of social care engagement is not strongly and statutorily designed'. This exclusion might even create a perverse

incentive for providers to identify a diagnosis of autism or learning disability to avoid funding obligations under Section 117.

Beyond concerns about DoLS, one of the greatest concerns is the fear that autistic people and people with a learning disability may, instead, be sent to prison because of unmanaged and unnecessary escalation of risk in the community (8, 13, 14, 19). We note research has highlighted that the closure of psychiatric beds, particularly learning disability beds, has been strongly associated with an increase in the prison population (20). An increased likelihood of prison sentences was also a concern of our carer authors, who relayed personal experience of this occurring. Our carer authors highlighted that was a concern not only for the direct impact on the individual sent to prison, but also because of the stigmatisation associated with criminalisation, both for the individual, but also for the wider community of autistic people and people with a learning disability.

The fact that only a relatively small number of regions have a functioning community forensic learning disability team (21), a service clearly defined in national service standards (22), raises a particular concern that any associated hospital closures which followed the proposed changes would mean that some areas may be left with no functioning services with relevant professional expertise in risk management of learning disability, thus increasing the likelihood of risks escalating without effective intervention and support. There are particular concerns about people awaiting trial in the community, who might otherwise be managed via detention under Section 3 (14).

It is important to emphasise the potential impact on public protection based on unmanaged risks. Of course, most autistic people or people with a learning disability present no wider risk to others. However, in some cases there are risks including fire-setting, sexual violence and stalking. Some 'special interests' in autism can also cause concern (e.g., poisons or explosives). These behaviours occur for a complex range of reasons and effective risk management is important to assure public safety, including that of carers. When such risks begin to escalate, a detention under Section 3 is a key mechanism to prevent further development with more serious consequences.

Beazley et al (11) highlighted a particularly concerning scenario for people who commit a serious offence but who are unable to be prosecuted for it for any reason. A 'hospital order' under Section 37 of the MHA generally[2] relies on a successful prosecution occurring. Plenty of prosecutions are not pursued for evidential reasons, or because the Crown Prosecution Service judge them not to be in the public interest. For people with profound impairments, their likely unfitness to plead or wider difficulties in engaging in trial proceedings may also be relevant, and even if such proceedings are brought, the underlying cognitive impairment may cause a failure in the underlying *mens rea,* meaning that charges are dropped. This could leave a person with no prison sentence, no access to the MHA, and, if the person objects, no access to DoLS. If the underlying behaviour means that the person also loses their residence (this might occur if the initial incident is, for example, an assault on a staff member in a residential home), it could leave a group of people with literally nowhere to go.

Finally, if increased numbers of autistic people or people with a learning disability move into community residential or care settings, it will be vital to improve the capacity, governance and quality of housing and care provision at these locations, as well as associated community NHS services. The joint committee indicated they had 'serious concerns that the deficit in community care provision has the potential to derail these reforms and lead to worse outcomes for this group' (15). One key factor is that

[2] The word 'generally' is intentional. There is an alternative process via s.5 of the Criminal Procedure Insanity Act (1964) which could result in a Hospital Order disposal for a person who is not Fit to Plead or who is found 'Not Guilty by Reason of Insanity'. However, this procedure is presently very infrequently used.

whilst care homes will typically be registered with the CQC, many supported living environments are not. One of our carer authors, reflecting on their son's experience, noted that 'the level of squalor and misery that was deemed acceptable is unbelievable when I look back on it now'. Echoing this, a pilot study which reviewed stakeholder views concerning supported living and residential care settings highlighted a large range in the quality of care provided (23).

The definition of 'autism' is too broad (and so the definition of 'psychiatric disorder' is consequently too narrow)

Beazley (24) has highlighted a specific concern about the breadth of the proposed definition of 'legal autism' in the Bill, noting that this is much broader in scope than any clinical conceptualisation. This paper raises the concern that because 'psychiatric disorder' is 'defined primarily by what it is not (i.e. legal autism or learning disability)', there is a risk that conditions other than autism (including, but by no means limited to personality disorder) could be argued to meet the definition of 'legal autism' and thus be excluded from the scope of a Section 3 detention. The paper raises a particular concern about the resultant necessity for Tribunals to have an increased focus on 'mental disorder' (as opposed simply to 'nature' or 'degree'), particularly given the fact that presenting an autism diagnosis that subsumes or overlaps with 'nature' might become a compelling line of argument for advocates arguing for discharge. This is a particular concern given that autistic people are known to have high rates of co-occurring psychiatric conditions (25). The briefing by the Parliamentary Office of Science and Technology (26) acknowledges that '[m]ental health disorders can present differently in autistic people, and combined with communication difficulties this can make disorders harder to diagnose'. In a situation with comorbid or overlapping features, who determines where the boundaries of the excluded 'legal autism' and remaining 'psychiatric disorder' begin and end?

Wong (27) has argued for the need for 'definitional width' more generally from a legal standpoint, concluding that 'a wide definition allows for requisitely flexible approaches to treatment administration under practical complexities'. Certainly, creating legal definitions of clinical problems, disorders or conditions is an inherently complex process, with lessons to be drawn from the 'Dangerous and Severe Personality Disorder' concept introduced following the last set of MHA reform (11). If legislators wish to avoid the unintended consequences arising from adopting a broad clinical definition for a legal purpose (particularly one with an exclusionary function), it is important that development of the corresponding definitions and conceptualizations is underpinned by additional research.

Conclusion

The summary of concerns we have identified speaks to key issues of fairness and justice. We note that our concerns mirror many of those identified by Tromans et al (6) who considered the views in a sample of 82 psychiatrists. In this sample, over half reported disagreement with the proposed changes, with greater concerns being noted by more senior psychiatrists and those working in inpatient settings.

It is also important to note that other jurisdictions which have implemented such changes have at least partially rolled them back. Several authors (6-9, 11, 17, 27, 28) highlighted the experience in New Zealand, which is the only common-law jurisdiction to have implemented such changes. Taylor and Burrell (7, 9, 17) describe the resultant 'legislative gap' where people with a learning disability were left with no effective community care, and as a result, an increased number went on to commit serious offences, resulting in an increased number being sent to prison. Subsequent legislative changes to address these issues have resulted in 'net widening, with more rather than fewer people with intellectual disabilities becoming subject to compulsory care in detention'.

The authors of this statement are united in their desire to see improvements in the care and treatment of autistic people and people with a learning disability. We recognise that the use of detention under Section 3 is a significant intervention with a person's civil liberties and rights, but this is no less the case for an autistic person or somebody with a learning disability as it is for somebody with another condition that gives rise to a need for care and treatment in a restricted setting. All of us would prefer to live in a world where detention under the MHA was unnecessary entirely, but this desire does not reflect the nature of reality where such detentions can be often viewed as the 'least worst' of a range of pragmatic solutions to manage high levels of risks to self and/or others.

What are the answers or alternatives? Whilst the answers to this question lie beyond the scope of this paper, we collectively agree that such detentions are likely to become less necessary if increased resourcing is allocated to appropriate community support for autistic people and people with a learning disability, and that such support is characterised by a qualified and competent workforce, suitable supported accommodation and meaningful occupational activities. However, better community care will not entirely remove the need for assessment and treatment in hospital of a relatively small proportion of autistic people and people with a learning disability who present with ambiguous or unclear clinical presentations, or significant risks, and where proper assessment and treatment will take longer than 28 days. Presently, therefore, we advocate keeping autism and learning disability within the scope of Section 3, because of the likely unintended consequences and adverse impact on people affecting their quality of life, liberty, and access to treatment and care.

Key points

- The Mental Health Bill (2025), as drafted, will remove autistic people and people with a learning disability from the scope of Section 3 of the Mental Health Act, 1983. This will limit civil detentions to 28 days, under Section 2 only.
- A number of authors have expressed concerns about these changes. A range of potential unintended consequences have been identified. This paper provides a consensus statement from professionals and carers who are concerned about such proposals.
- It seems unlikely that the changes will result in their anticipated aims: autistic people and people with a learning disability may instead be more likely to be sent to prison more frequently and be more likely to be detained under regimes affording fewer safeguards.
- Alternatively, autistic people or people with a learning disability who present with significant risks and are supported in the community may be more likely to act on these risks, leading to increased police involvement and risks to the public.
- People who do not have autism or a learning disability may also be impacted, because the proposed legal definitions of 'autism' and 'learning disability' are so broad.
- Significant legal complications may arise where there is a need to detain someone who has another condition which overlaps or intersects with their autism or learning disability. This is expected to occur relatively frequently.

Appendix 1: Expert by Experience Perspective

As a parent of a learning-disabled adult with autism and mental health issues, I have had some considerable experience in this area. I have seen my son in both a mental hospital and in 'Care in the Community'.

It is a common assumption, and one that I held myself before my son spent time in hospital, that any living situation is preferable to hospital and that hospital is not just a deprivation of freedom, but a last resort, end of hope option when everything else fails. Instead, and in my son's case, it has been a temporary place of safety and genuine care, which has enabled him to recover mentally to a level whereby he is now able to continue his life back in the community.

What I feel is not often appreciated is that the enormous levels of fear and anxiety that some autistic, learning disabled people feel, through trying to live in the community, can be so overwhelming that their behaviours escalate and they tip over into mental illness, and sometimes offending behaviour. Having watched this happen to my son, I can absolutely attest that this amounts to no quality of life whatsoever.

Community placements are great when they work, but in my experience, they are often woefully inadequate. My son's last placement was abusive and unsafe. He was dirty, undernourished, angry, sad, confused and desperate. It is in this environment that the autistic, learning disabled person is asked to make sense of a staggering complex world. This makes them not only desperate in themselves but very, very vulnerable. I bless the day that my son was rescued from that cruel living environment (via the criminal justice system) and transferred to a medium secure mental health clinic. Through proper mental health assessments, and insightful person-centred care, the hospital has brought him back to the person he was.

I am very aware that the fear is that, in some cases, autistic or learning disabled people can be in hospital for too long, as in 'shut away and forgotten', but I feel that this is a separate issue and one which should not mean that they have no access at all to the help that they sometimes need in a hospital setting. These people shouldn't have to descend so far that they become involved with of the Criminal Justice System before they get the help that they need.

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