The independent review of
Learning Disability and Autism
in the Mental Health Act

# Evidence resource

January 2020

## What is in this resource

# What this resource is

The final report from this review made recommendations. The report is available here. The final report is based on evidence and includes references to important findings and articles.

This evidence resource is for people who work to develop law, policy and practice in this area, with a focus on Scotland. The resource is for people with lived experience and for professionals. The evidence comes from people with lived experience and from professionals.

The resource focuses on other sources of information that we think will be helpful in further developments.

This resource gives you more evidence that is relevant to the recommendations in the final report. It is not a report of all of the evidence that we saw in this review. We saw far more evidence than we could report on in total, including new evidence and existing reports.

### New evidence from this review

A lot of relevant evidence can be found in other reports from this review, especially the stage 1 report here, the stage 3 consultation document here, and the review's final report here.

Organisations, experts and advisors who contributed to the review are listed in the report on how we did the review, which is available here.

In stage 1 of the review, 103 individuals and 4 organisations with lived experience took part. 76 professionals and 17 professional organisations took part.

In stage 2, 18 lived experience organisations, 26 professional organisations and 33 experts took part.

In stage 3, 120 individuals and 19 organisations with lived experience took part, in a meeting, in consultation or both. 37 professionals and 35 professional organisations took part, in a meeting, in consultation or both. A further 16 respondents took part in the online consultation.

# What this resource is

**Please note** that our website will be archived and will be taken down in 2020. Web addresses will change. You will be able to find out how to get to our archived website here.

**Acknowledgements**

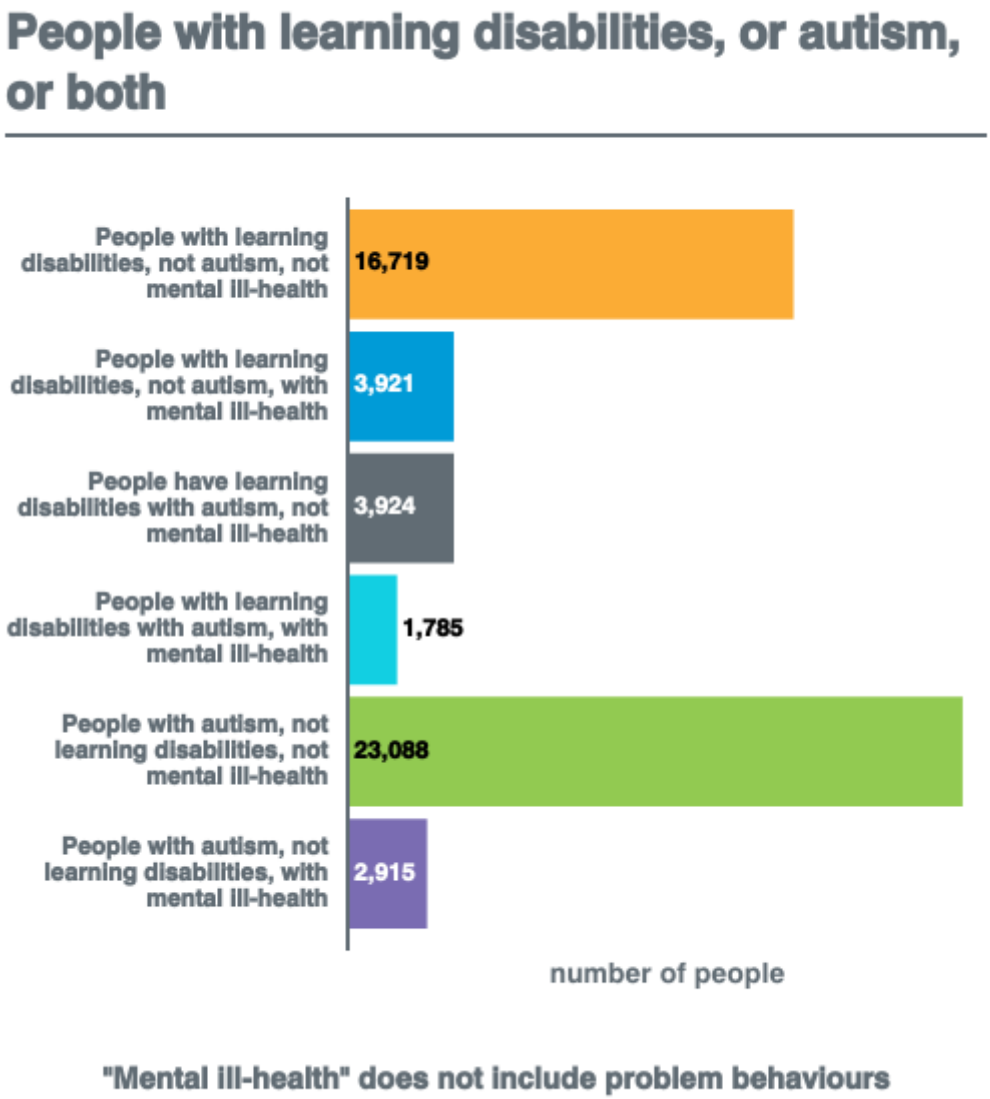
We thank Scottish Learning Disability Observatory (SLDO) for infographics that they created for this report. These are on pages 5 to 10. They were provided by Angela Henderson, Director of Policy and Impact (Angela.Henderson@glasgow.ac.uk).

For the literature review in section 10, we thank Professor Jill Stavert and Aisha MacGregor of the Centre for Mental Health and Capacity Law, School of Health and Social Care, Edinburgh Napier University. The independent review commissioned Edinburgh Napier University to produce the literature review. Later, Jill Stavert offered to act as an advisor to the review on a voluntary basis.

# Numbers of people


**5,295,403 people live in Scotland (data from Scotland Census, 2011)**

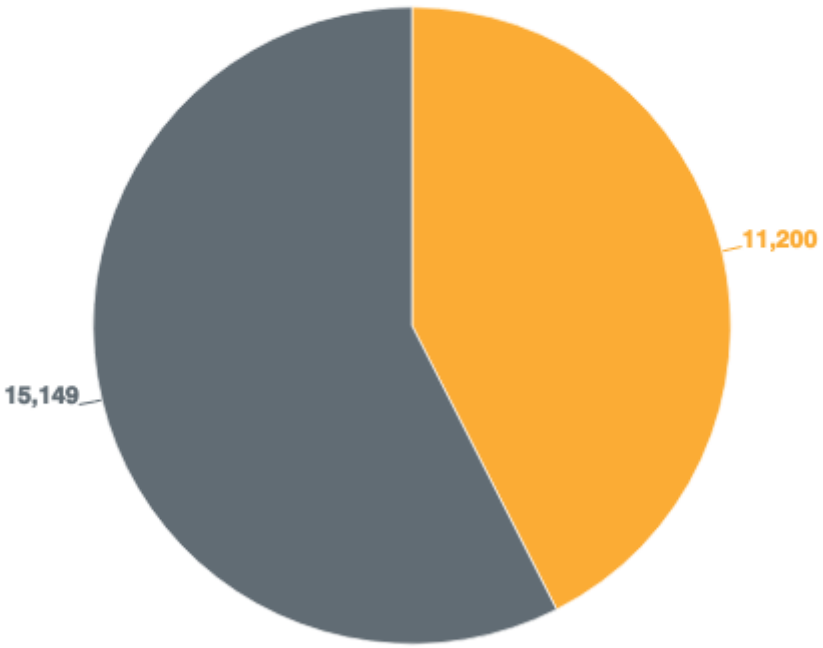
# Numbers of people



# Numbers of people with intellectual disability

## Learning disabilities


All people with learning disabilities
Children 0-15 yrs
Adults 16-64 yrs
Older adults 65+ yrs

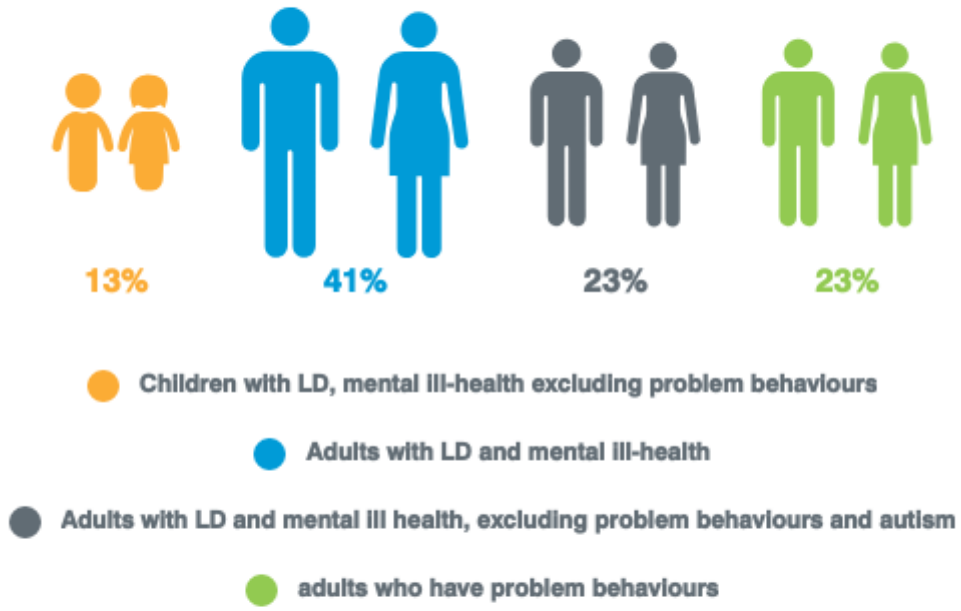



Females (43%)
Males (57%)

**22% of people with learning disabilities have autism**

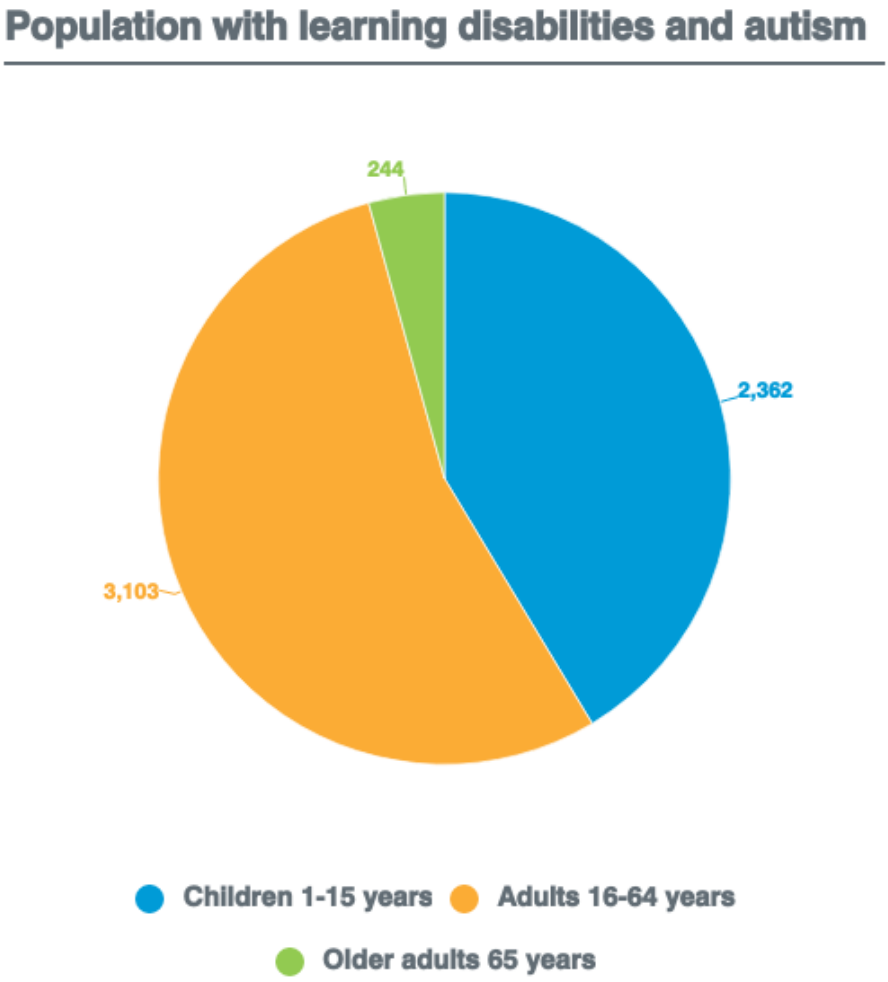
# Numbers of people with intellectual disability

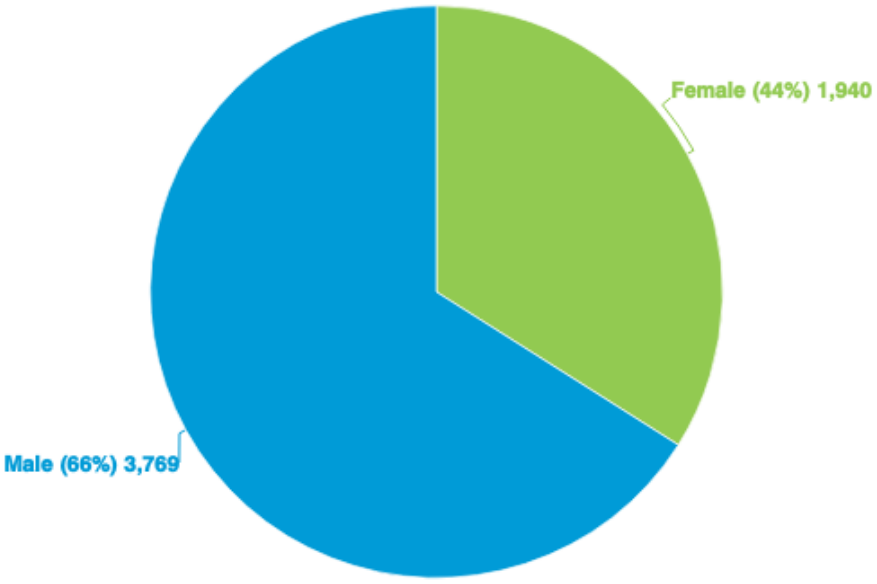
## Mental health and learning disabilities



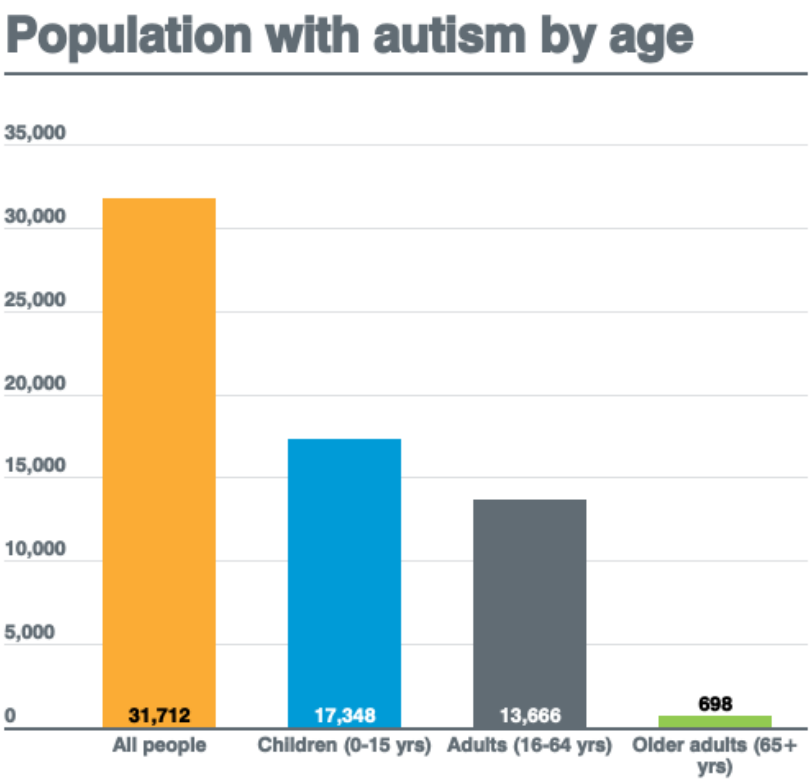

**Mental ill-health is 7 times more common in people with learning disabilities than in other people. Schizophrenia (and psychosis in general), bipolar disorder, dementia, autism, and ADHD are more common in people with learning disabilities than in other people.**

# Numbers of autistic people with intellectual disability

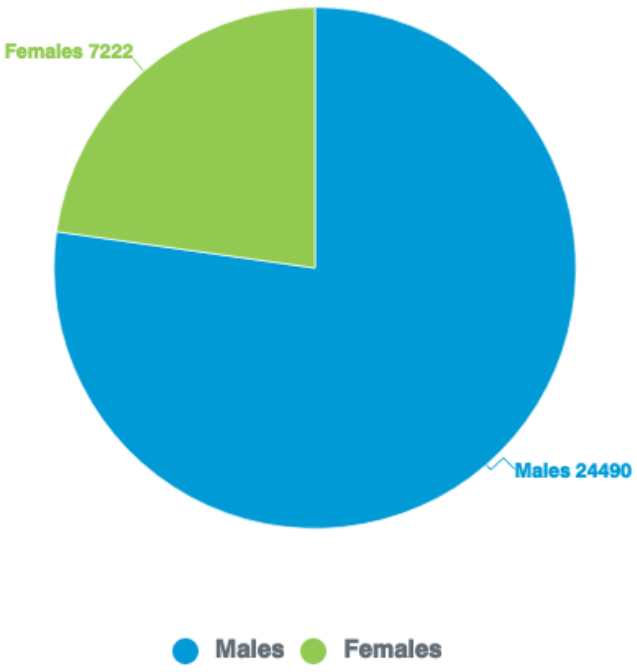


# Numbers of autistic people




**NB: Diagnostic criteria for autism has broadened in recent times. Therefore, over the age of 24 years there is a lower proportion of people with autism.**



# 1 What Scotland has to do

Headings within the following sections are from the review's final report.

## 1.1 About this review

Further reading:

The Millan Review, which called for this review. link, from page 30.

Mental Health (Scotland) Bill: Stage 3. link, from column 29.

## 1.2 The challenge for Scotland

### Complying with the Convention on the Rights of Persons with Disabilities

Legal experts confirmed to us that the United Nations Convention on the Rights of Persons with Disabilities and others international treaties should guide this law reform process. Scottish Government has devolved responsibility for international law. The UK has ratified (accepted) the Convention on the Rights of Persons with Disabilities, and the Scottish Parliament voted in 2016 for full implementation of that convention.

By ratifying this convention, we have agreed that, wherever possible, our laws will fit with the standards and values of this convention. Article 4.1 of the convention gives Scotland general obligations which include adopting 'all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention', and taking 'all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'.

Also, Scotland's judiciary (judges) can consider the Convention on the Rights of Persons with Disabilities in their decisions (link, for example).

This convention is not justiciable in the domestic courts as it has not been directly incorporated into Scots law and United Kingdom law (domestic law). This means that a person cannot 'go to court' only because their rights under this Convention may have been breached. However, the European Convention on Human Rights is directly incorporated into our domestic law, and the European Court of Human

Rights would itself take the Convention on the Rights of Persons with Disabilities into account when interpreting European Convention rights (link, paragraph 27).

**Interpreting the Convention on the Rights of Persons with Disabilities**

The Committee on the Rights of Persons with Disabilities creates general comments, some of which have been particularly challenging. To address this, we are taking a similar position to Scottish and UK legal experts who lead in this area. We aim to demonstrate that we are taking the Committee's comments and observations seriously, but we understand that Scotland is obliged to implement the convention itself rather than the observations and comments from the Committee. Our proposals are substantially based on published work by these legal experts.

This review also considers how Scotland can fully comply with the European Convention on Human Rights in mental health law. The European Court of Human Rights' interpretation of the European Convention changes over time. That court's clarification of some principles in its judgment on Rooman v. Belgium of 2019 is particularly relevant link. In stage 3, we began to work through some implications of that judgment for law and practice in Scotland.

Our stage 1 evidence told us that the Mental Health Act can be used to authorise the detention of people with intellectual disability who enter hospital for reasons such as placement breakdown, who may then remain in hospital for years due to the absence of community resources. Some of those individuals may have been highly distressed but may have no mental illness. Their circumstances and environments may have been, and may still be, major factors in their distress.

The evidence also told us that the Mental Health Act can be used to authorise the detention of autistic people in hospital environments that are harmfully stressful for them, with compulsory care and treatment from staff who do not have a specialist understanding of autism, and that this can lead to trauma.

The European Court's judgment in Rooman clarifies that "the administration of suitable therapy is a requirement for deprivation of liberty to be lawful, and that irrespective of the facility in which a person

is placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures with a view to preparing them for their eventual release". The judgment clarifies that "the level of care required must go beyond basic care and that access to health professionals, consultations and the provision of medication is not sufficient for a treatment to be considered appropriate. Also, deprivation of liberty has to take place in an appropriate institution. A specialised psychiatric institution which, by definition, ought to be appropriate may prove incapable of providing the necessary treatment." We understand that where these conditions are not met, the lawfulness of the deprivation of liberty in relation to Article 5 of the European Convention is questionable.

Further reading

Paradigm Shift or Paradigm Paralysis? National Mental Health and Capacity Law and Implementing the CRPD in Scotland. Jill Stavert, 2018 (link)

### 1.3 Autism and learning disability redefined

Further reading: See 2.1

### 1.4 A law for people with learning disability and autistic people

Further reading: see references within the tables in this section of the main report

### 1.5 Criminal law

Further reading: See sections 8 and 9

# 1 What Scotland has to do

## 1.6 Law for mental health and for disability rights

This review proposed specific changes for autistic people and people with intellectual disability in law, including changes in law that would lead to rights and duties for service provision for these groups of people. We understand that if a change in the law or a new service could equally benefit other groups of persons with disabilities, then law reform should not discriminate against those groups by excluding them from those changes.

We do think that people with other forms of disability could benefit from some of the changes that we proposed. Some of our recommendations may be considered for mental health law in general. Also, some of our recommendations might benefit people with physical or sensory disabilities, and those recommendations might be considered for disability rights law.

However, this review presented evidence that there has been some substantial and specific harm to the human rights of autistic people and people with intellectual disability under the current Mental Health Act. The review advises against continuing with 'general' mental health law for all people with 'mental disorder' which takes no account of the specific needs of people with intellectual disability, or the specific needs of autistic people. The Millan report of 2001 recognised that applying the Mental Health Act in the same way for everyone with 'mental disorder' might not work well for people with intellectual disability and autistic people (link, pages 34 to 36).

Further reading

A new paradigm for protecting autonomy and the right to legal capacity: advancing substantive equality for persons with disabilities through law, Policy and Practice. Michael Bach and Lana Kerzner, for the Law Commission of Ontario, 2010 (link).

Scotland's Mental Health and Capacity Law: A Case for Reform. Report of joint Mental Welfare Commission for Scotland and Centre for Mental Health and Capacity Law law reform scoping exercise. Jill Stavert and Colin McKay, 2017 (link).

# 2 How we understand autism, intellectual disability and mental health

## 2.1 Disability

Further reading

A human rights model of disability. Theresia Degener, 2014 (link)

Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities. Rosemary Kayess, P. J. French, 2008 (link)

## 2.2 Human rights

Further reading

Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland. Committee on the Rights of Persons with Disabilities, United Nations, 2017 (link)

The UN Convention on the Rights of Persons with Disabilities: A Commentary. Ilias Bantekas, Michael Ashley Stein, and Dimitris Anastasiou, 2018 (link)

Police Scotland: Equality and Human Rights Impact Assessments (link)

Code of Ethics for Policing in Scotland (link)

## 2.3 Legal capacity

In practice, ‘mental capacity’ may often be incorrectly called ‘legal capacity’. These concepts are sometimes conflated (link, paragraph 15).

‘Mental capacity’ is already found in Scots law as a concept. Mental capacity is about a person’s decision-making skills. Those skills vary according to the person and their situation.

‘Legal capacity’ is already found in Scots law, in these words and as a concept (link, for example). Legal capacity is the ability to hold rights and duties (legal standing) and the ability to exercise rights and duties (legal agency). In some circumstances, it may be easier or harder to exercise legal agency.

Further reading

Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK. Wayne Martin, Sabine Michalowski, Jill Stavert, Adrian Ward, Alex Ruck Keene, Colin Caughey, Alison Hempsey, Rebecca McGregor, 2017 (link)

# 3 Support for decision making

It would also be accurate to describe this section as being about 'support for the exercise of legal capacity', using the language of the Convention on the Rights of Persons with Disabilities.

General reading:

Supported decision making - experiences, approaches and preferences Gavin Davidson et al, 2018 (link)

### 3.6 Decisions about psychological interventions

Further reading

A critique of the use of Applied Behavioural Analysis (ABA): on behalf of the Neurodiversity Manifesto Steering Group. Damian Milton, 2018 (link)

### 3.7 Decisions about prescribing psychotropic medication

Further reading

Winterbourne Medicines Review – improving the use of medicines in people with learning disabilities. NHS Improving Quality, 2015 (link)

Stopping over medication of people with a learning disability, autism or both (STOMP). NHS England (link)

# 4 Support, care and treatment

### 4.2 Intellectual disability

For research on the health of persons with intellectual disability in Scotland, see the Scottish Learning Disability Observatory here.

### 4.3 Autism

An independent guide to quality care for autistic people. National Autistic Taskforce, 2019 (link)

Also see the Scottish Learning Disability Observatory here

# 5 Where support, care and treatment happens

## 5.1 Independent living

Further reading

England:

Transforming care: A national response to Winterbourne View Hospital. Department of Health Review: Final Report, 2012 (link).

Delivering the Transforming Care programme: a case of smoke and mirrors? John L.Taylor, British Journal of Psychiatry Bulletin, 2019 (link)

## 5.4 Hospital admissions for mental illness or crisis

The right to health does give autistic people and people with intellectual disability a right of access to hospital. Unfortunately, there is clear evidence of serious adverse effects of hospital admission on the human rights of some autistic people and people with intellectual disability.

For these groups of people, hospital admission has been linked with harm to human rights. Relevant reports have come from people with lived experience in stage 1 of this review link, the Mental Welfare Commission for Scotland link, research for Scottish Government link and the Joint Committee on Human Rights at the UK parliament link.

# 6 How professionals make decisions

## 6.1 Human rights assessments

The term ‘dangerousness’ is not used in Scots law, but the concept is current within judgments of the European Court of Human Rights (link at 117). One problem with dangerousness as a concept is the stigma that it encourages. The review did not see evidence that autism or intellectual disability generally cause people to be more ‘dangerous’ than other people.

Considering risk in relation to human rights may help to reduce this stigma. The human rights model of disability includes an understanding of disability as being dynamic and open to reduction by changes in the person’s environment, with responsibilities on the state to act to reduce this disability.

## 6.2 Authorising limits on human rights

We understand that all of the human rights treaties which apply to Scotland do allow for restrictions on liberty for autistic people and people with intellectual disability.

To meet their duties on human rights, public services have to be able to act to protect rights such as the right to life. They may also have to act against a person’s will to stop the person’s serious self-neglect, for example. Governments must be able to give some public bodies and professionals the authority to restrict a person’s liberty and to use medical treatment without a person’s consent.

Unlike the European Convention on Human Rights, the Convention on the Rights of Persons with Disabilities requires that any limits to human rights are made on the same basis for all persons including persons for disabilities.

‘Disability’ in the context of the Convention on the Rights of Persons with Disabilities includes mental illness, along with intellectual disability (‘intellectual impairment’), autism and other conditions. This means that an autistic person or person with intellectual disability who is detained on the basis of mental illness is still detained on the basis of disability.

# 6 How professionals make decisions

### 6.3 Professional roles in decisions

Care co-ordinator: It would be most important for each person to have a consistent care co-ordinator. The role requires the care co-ordinator to be available to attend Tribunal. In the final consultation, we used the term ‘care manager’ for this role, but that term has existing meanings.

In this model, a care co-ordinator who is a social worker would not be independent of a responsible officer who is their Chief Social Work Officer. If a human rights officer was a social worker under the same Chief Social Work Officer, there would not be enough independence in this model. With health and social care integration, this lack of independence could be more likely to happen even when different professionals are care coordinators. Human rights officers could carry out human rights assessments independently in other local areas. Human rights assessments could be independently reviewed (see 7.4).

Lead clinicians: This role involves the clinician using their ‘objective medical expertise’ to give an opinion on whether the person is of ‘unsound mind’. We are not suggesting that these terms should be used in law, but a key judgment for interpreting the European Convention on Human Rights (Winterwerp v. the Netherlands - link) requires our mental health law to include these concepts. We also proposed nurses for this role. We recommended that it be possible for nurses to be both care co-ordinators and lead clinicians, but not at the same time for one person. This approach would be needed to make sure that expertise can be made available in rural and remote areas such as island communities. Nurses are the largest NHS workforce. In some areas, it may be impossible to have psychologists and psychiatrists with expertise in autism or intellectual disability routinely available.

Responsible officer: The responsible officer’s decisions would show how they took account of the person’s will and preferences, the human rights assessment, the care co-ordinator’s perspective, the perspective from unpaid carers, and the lead clinician’s perspective. The role is about professional decisions, not budget decisions.

We expect that there would be opportunities for Chief Social Work Officers to advocate for appropriate resources for the people for whom they are responsible, within Health and Social Care Partnerships. Chief Social Work Officers would need to take a holistic view of the person’s human rights overall, not just a social work perspective.

# 7 How decisions are monitored

### 7.1 Disabled persons organisations

The United Nations now refers to these as ‘organisations of persons with disabilities’ (link). This subject is also discussed in the report on how we did the review, here.

We have found that in Scotland, autistic people refer to their organisations as autistic people’s organisations. Not all autistic people identify as being disabled.

### 7.3 How decisions are made and reviewed

This proposal was modelled on the authority of Scotland’s additional support needs tribunal. A fairly similar proposal was made in England’s recent review of mental health law, based on the model of authority that exists with their education tribunal (link, page 123).

We asked the Mental Health Tribunal for Scotland for information on who the general members of the tribunal are at present. This information was not available. In our view, a broader range of clinical (medical) members and general members would strengthen the tribunal’s ability to make effective decisions, in the context of the new approach that this report recommendations.

### 7.4 Professional review

In section 4.3 we recommend a national autism service. To avoid conflicts of interest, that service would not host an independent professional review service.

### 7.7 Monitoring compulsory treatment

In human rights terms, disproportionate use of compulsory care and treatment in Scotland includes the use of the Mental Health Act to justify compulsory care and treatment for people with intellectual disability, in hospital and the community. Data shows that people with intellectual disability tend to be subject to compulsory care and treatment for longer than other groups of people (link, link). This may be authorised in the context of a breakdown in the person’s social environment, not for health reasons. In at least some cases, this will be disproportionate in terms of human rights. The long term use of antipsychotic medication to manage behaviour in people with intellectual disability in Scotland also appears to be disproportionate, in terms of human rights (link).

# 8 Offenders

## 8.1 Fair trials

Our proposals on legal capacity in section 2.2. Legal capacity consists of legal standing and legal agency. We are recommending that it should continue to not be possible to challenge a person's legal standing (their ability to hold rights and duties). We are recommending that it should only be possible to limit a person's exercise of their legal agency in the context of a human rights assessment which shows that it is necessary and proportionate for the state to limit the person's legal agency in that way.

The Committee on the Rights of Persons with Disabilities has said that there should be no 'declarations of unfitness to stand trial' (link, paragraph 16).. This would mean that every person would be held able to stand trial, with support of necessary. It may be that a legal representative could test the Crown (prosecution) case thoroughly for the person, but we do not think that it would be possible or legally sound for legal representatives to interpret the will and preferences of an individual in the context of criminal proceedings.

We discuss in the report our view that even with all support and other reasonable adjustments, some people will still not be able to participate in a trial in a way that is fair. No trial would be deemed fair for any person who did not understand the proceedings against them. In this context, a judge would be faced with a decision on how to proceed. A range of human rights would have to be taken into account in a proportionate decision, including the right to a fair hearing.

## 8.2 Fairness in responsibility

The United Nations Committee on the Rights of Persons with Disabilities has called for an end to declarations of 'incapacity to be found criminally responsible' within criminal justice systems (link, paragraph 16).

Here, we discuss disability as a mitigating factor in the sense of a defence. The next section on 'fairness in punishment' deals with disability as a plea in mitigation in the context of sentencing.

Following the Millan report of 2001, the Scottish Law Commission considered the criminal defences associated with mental disorder as defined by the Mental Health (Care and Treatment) (Scotland) Act 2003 (link). Following that work, the Criminal Justice and Licensing (Scotland)

Act 2010 brought in amendments to the Criminal Procedure (Scotland) Act 1995. These changes reflected the Scottish Law Commission's recommendations (link). These changes created new defences of mental disorder and of diminished responsibility and created procedures for these defences in criminal law. The same work led to a new statutory plea of unfitness based on the person's mental or physical condition.

We suggest that new defences based on 'disability' could make it possible for the person to be held responsible for their actions, and also to take into account factors that were not the person's responsibility. Those factors could include autistic impairments, intellectual impairments, and failures of public services to give support or education that the person needed to be able to follow the law. This would be an area for further development.

### 8.3 Fair punishment

Disability can be raised in mitigation of consequences. A very recent Scottish court judgment shows this clearly (link). The judgment reflects the European Convention on Human Rights and the Convention on the Rights of Persons with Disabilities. This judgment highlights that:

An accused person who has a severe disability is not automatically exempt from punishment.

An accused person is not, by reason of disability, automatically entitled to a lesser sentence than would otherwise be appropriate.

An alteration or reduction in sentence is appropriate in certain circumstances.

The effects of disability may be relevant to sentence, insofar as they impact on the risk posed by a particular individual, in assessing the relative merits of potential disposals, and in cases of very severe disability where it may be that imprisonment would inevitably and immediately be incompatible with the accused's rights.

The State should take special care in guaranteeing conditions that correspond to the special needs of the individual's disability.

Sentencing should adequately allow for the difference between the person's likely experience and treatment in prison and that of other inmates.

# 8 Offenders

For these offenders who are detained after an offence that they chose to commit, punishment through detention is appropriate in principle. The Convention on the Rights of Persons with Disabilities requires this as part of equal treatment.

Some autistic offenders and offenders with intellectual disability are put on orders under the Criminal Procedure (Scotland) Act 1995. These orders can allow for restrictions on liberty and for compulsory care and treatment. Punishment is not recognised under these orders or within forensic services. There is currently no defined punishment element in any forensic order. In our view, it is important to not punish offenders who did not understand that they were offending (who lacked *mens rea,* criminal intent). However, many individuals who are within forensic intellectual disability services were criminally responsible, in that they knew that their actions were wrong.

We understand restriction on a person's liberty as a consequence of an offence to be punishment when that person had criminal intent for that offence. We met with people with intellectual disability or autism under forensic orders across the forensic estate. It is clear to us that at least some of these individuals experience their detention as punishment. It also appeared to us that the absence of a clearly defined end to detention was an issue for at least some of these offenders. For some people, it was 'the worst thing'. This is consistent with the reported experiences of intellectually disabled offenders in another jurisdiction, New Zealand (link, concept of 'doing time').

These orders can allow detention for much longer than offenders with mental disorder would experience. We saw unpublished data which indicates that offenders with intellectual disability in Scotland tend to be on forensic orders for longer than other offenders with 'mental disorder'. The data was being considered for publication so could be shared at the time of writing. Data on the duration of inpatient stays for people with intellectual disability was consistent with this.

We did not recommend that people 'with challenging behaviour' should be in any part of the criminal justice system because of that behaviour, nor that people should simply be discharged at the end of fixed terms with no support.

We were not certain that Orders for Lifelong Restriction were being used proportionately with the very small number of autistic offenders and

offenders with intellectual disability on these orders. We understand that individuals may get ‘stuck’ in the prison system with no opportunity to demonstrate a reduction in risk. Release from custody on these orders, when appropriate, would require very robust support packages and risk management plans. To implement our recommendations, work would be needed to develop approaches to support and risk management in the community for a broad range of offenders.

### 8.6 Public safety and victims’ rights

Pre-emptive detention can be when someone is detained before committing an offence, or continued detention after the end of a sentence to prevent possible offences in future. All forms of pre-emptive detention can raise human rights issues. In this context, discrimination on the basis of disability can be an additional factor.

There would be a risk of indirect discrimination in any approach to risk assessment that mainly associates risk with an individual’s impairments. A person may be disabled by an absence of adequate support. A strong focus on impairments could tend to lead to continued detention in hospital, with risk from individuals being seen as high.

On risk assessment, there has been work in Scotland and the UK in recent years to develop tools and approaches for risk assessment and risk management of offenders with intellectual disability. There is evidence that more emphasis should be placed on social and environmental factors associated with offending, for people with intellectual disability (link, page 636).

Further reading

Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment. Bernadette McSherry, 2013.

# 9 Where support, care and treatment happens for offenders

## 9.1 Habilitation in the community

We spoke with experts in New Zealand with experience of community-based rehabilitation services for offenders with intellectual disability. Despite some issues in early implementation of New Zealand's approach to learning disability in law (link), experts viewed current services as effective. Provision in New Zealand is based in the community for many offenders with intellectual disability. The review did recommend that intellectual disability be removed from the definition of 'mental disorder' in Scotland's Mental Health Act, but with a different approach to that taken in New Zealand

## 9.3 Prison

Our recommendations on prison aim for appropriate provision for the autistic people and people with intellectual disability who are already there. Essentially the same human rights apply to people inside and outside prison. In human rights terms, it would not be justifiable to simply accept an inappropriate and disproportionate impact on significant numbers of autistic people and people with intellectual disability in prison. In practice, the human rights of these groups of offenders should be clearly and demonstrably promoted, protected and fulfilled

# 10 Literature review

In 2018, the review commissioned a literature review to analyse information that details experiences of other jurisdictions in relation to their care and treatment legislation for autistic people, people with intellectual disability, and autistic people with intellectual disability.

The report was to indicate how care and treatment legislation in each jurisdiction promotes and protects the right to mental health for autistic people and people with intellectual disability. The authors were asked to apply a definition of the right to mental health consistent with terms expressed in instruments of the United Nations such as the ICESCR and CRPD. The authors were to determine what jurisdictions were considered.

---

**Centre for Mental Health and Capacity Law, School of Health and Social Care, Edinburgh Napier University[1]**

## 1 Introduction

### 1.1 Scope of review

This literature review is provided in pursuance of the Independent Review of the Mental Health (Care and Treatment) (Scotland) Act 2003 for people with learning disability and/or autism (the Independent Review). It captures literature from 2008 to date with information on experiences of care and treatment legislation for autistic people, people with learning disability, and autistic people with learning disability in selected jurisdictions other than Scotland.

Given the remit of the Independent Review this literature review has concentrated on those jurisdictions which wholly or partly exclude persons with autism or learning disability from the remit of mental health legislation.

### 1.2 Search criteria

A search of the literature was conducted using the databases: MEDLINE, CINAHL, PsychINFO, ASSIA, Web of Science, Westlaw, LexisNexis and Heinonline for articles, legislation and other literature published from 2008 until September 2018. Additional searches for other

[1] This review was conducted by Professor Jill Stavert and Aisha MacGregor of the Centre for Mental Health and Capacity Law, School of Health and Social Care, Edinburgh Napier University.

available published and grey literature were conducted using Google Scholar and Google.

The literature search included reference to persons with “autism”, “learning disability” and “intellectual disability”, “mental health legislation”, “legislation” and Mental Health Act”.

### 1.3 The right to mental health defined

It has been requested that this review adopts the definition of the right to mental health which is consistent with that of both the UN International Covenant on Economic Social and Cultural Rights (ICESCR) and UN Convention on the Rights of Persons with Disabilities (CRPD).

For the avoidance of doubt, “mental health” and the right to mental health has thus been interpreted in its widest sense. It is an integral component of one’s overall health and is a state of well-being in which an individual realises his or her own abilities. This means that individuals have the right to the highest attainable standard of mental health and “mental health” is not seen as simply encompassing mental illness or disease. It also requires the provision of adequate support and safeguards for those with mental disorder and a framework which preferably prevents its occurrence but which, at the very least, minimises the impact of mental disorder on those who suffer from it. An appreciation that certain social, cultural, economic, political and environmental factors impact on mental health and its attainment, and the need, therefore, to realise accompanying enforceable, relevant rights is integral to this approach.[2]

Moreover, it is a well-established international human rights requirement that human rights are enjoyed by all on an equal and non-discriminatory basis and the CRPD (Articles 3[3] and 5[4] and 25[5]), in adopting a social model of disability, makes it clear that disability must not be used as the basis of denial or limitation of enjoyment of such rights – including the right to mental health - and all obstacles to the equal and non-discriminatory enjoyment of must be removed. The ICESCR General

---

[2] See J Stavert and R McGregor, ‘Domestic legislation and international human rights standards: the case of mental health and incapacity” 22(1) *International Journal of Human Rights* 70-89, 72, for more detail regarding such rights.
[3] General Principles.
[4] Equality and non-discrimination.
[5] Health.

comment No 14 (paras 18 and 19)[6] - interpreting Article 2(2)[7] and 3[8] ICESCR in conjunction with Article 12[9] ICESCR- also makes it clear that there must be no discrimination in relation to accessing health care and the underlying determinants of health, as well as to the means and entitlements for their procurement, on the basis of, inter alia, mental disability.

### 1.4 Structure of findings in this report

Given the remit of the Independent Review, this review will start by identifying those jurisdictions where legislation allowing for involuntary psychiatric care and treatment (mental health legislation) specifically excludes intellectual or learning disability. It will then provide the specific jurisdiction information.

[6] Office of the High Commissioner on Human Rights *Convention on the Economic Social Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)* adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) http://www.refworld.org/pdfid/4538838d0.pdf (accessed September 28, 2018).

[7] This requires that ICESCR rights will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

[8] This requires the equal right of men and women to the enjoyment of all economic, social and cultural rights.

[9] The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

**2 Jurisdictions identified where mental health legislation specifically excludes intellectual disability or learning disability**

(a) Canada
   a. Northwest Territories
   b. Princes Edward Island
   c. New Brunswick
   d. Manitoba

(b) Australia
   a. New South Wales
   b. Australian Capital territory
   c. Tasmania
   d. Western Australia
   e. Queensland
   f. Victoria
   g. Northern Territory

(c) New Zealand

(d) England and Wales

Additional notes:

(1) South African mental health legislation includes both mental illness and intellectual disabilities but relevant sections where only one or other applicable.[10]
(2) In some jurisdictions, for example India, it is not altogether clear whether or not learning disability or intellectual disability is included under mental health legislation.[11]

---

[10] Mental Health Care Act 17 of 2002 http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/mental_health_care_act_17_of_2002.pdf (accessed September 29th, 2018).

[11] See Mental Healthcare Act 2017 (which came into force on 7 July 2018)http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf (accessed 29 September 2018); RM Duffy and BD Kelly 'Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation' (2017) 11 *International Journal of Mental Health Systems* 48

(3) Sometimes there is no explicit exclusion of intellectual disability or learning disability under mental health legislation, but capacity and/or treatability tests are criteria for compulsory care and treatment. This, particularly where a human rights-based approach must be adopted (as required either constitutionally, or as principles incorporated in the mental health legislation itself or in other legislation), implies that involuntary care and treatment in the case of persons with autism and learning disabilities should be limited only to those who lack capacity and/or require psychiatric care and treatment under such legislation.

(4) The Mental Capacity (Northern Ireland) Act 2016 unifies mental health and capacity legislation. Persons who fall within its remit will be determined by a capacity test based on decision-making ability rather than diagnosis. The Act is not yet in force and so literature on experiences of its operation is unavailable. Information on the Bamford Review of Mental Health and Learning Disability and its reports, which informed the 2016 Act is, however, available.[12] Essentially, the Bamford Review did not recommend that learning disability be excluded from the remit of the ensuing legislation but, very similar to the recent review of the Mental Health Act 1983 in England and Wales[13] rather that it should operate with specific requirements of persons with learning disabilities firmly in mind.

(5) EC Fistein et al 'A comparison of mental health legislation from diverse Commonwealth jurisdictions' (2009 May) 32(3) *International Journal of Law and Psychiatry* 147–155. This article looks at mental health legislation in various Commonwealth countries and identifies those which do and do not

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5563026/ (accessed September 29th, 2018).

[12] Northern Ireland Department of Health *Bamford Published Reports* https://www.health-ni.gov.uk/publications/bamford-published-reports (accessed 18th January 2019)

[13] UK Government *Modernising the Mental Health Act, Increasing choice, reducing compulsion: Final report of the Independent Review of the Mental Health Act 1983* (December 2018) available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf (accessed 18th January 2019)

include learning disability within the remit of such legislation. It does not, however, specifically consider experiences of such legislation for autistic people and people with learning disability.

## 3. Specific jurisdictions

### 3.1 Choice of jurisdictions for this review

It became apparent during the literature search that there is a relatively small body of literature specifically relating to the experiences of care and treatment legislation for autistic persons and persons with learning disability across the jurisdictions mentioned in Section 2 above. Moreover, no literature could in fact be located that explicitly referred to autistic persons for any of the jurisdictions. The identified jurisdictions – New Zealand, Victoria and England and Wales - have therefore been selected on the basis of there being the most available relevant literature for these countries. The ease of availability of individual experts and expert bodies also influenced the choice of jurisdictions. Other jurisdictions have not been included owing to the dearth of such literature.

As this literature review concentrates on experiences of the relevant legislation for autistic persons and persons with learning disability it does not include:

(a) Full summaries of types of, and criteria for, care and treatment and safeguards under this legislation; or

(b) Details of the wider body of literature concerning the relevant legislation which extends beyond the experiences of care and treatment which are particular to persons with autism and learning disability. This wider body of literature encompasses, for example, issues surrounding capacity and risk assessments, sufficiency of available support and supported decision-making, coercion under mental health legislation in general, service provision and, in England and Wales, the operation of the Deprivation of Liberty Safeguards.

## 3.2 New Zealand

### 3.2.1 Legislation

#### *3.2.1.1 Mental Health (Compulsory Assessment and Treatment) Act 1992*[14]

Prior to 1992 individuals with an intellectual disability fell within the scope of the Mental Health Act 1969. The 1969 Act was linked to the Criminal Justice Act 1985 which allowed the courts to make orders placing individuals with an intellectual disability under the 1969 Act (rather than in prison) or for community care. In 1992 the 1969 Act was replaced by the Mental Health (Compulsory Assessment and Treatment) Act. The 1992 Act introduced a new definition 'mental disorder' which excluded individuals with an intellectual disability only from the Act's compulsory measures.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 defines 'mental disorder' as an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:

(a) poses a serious danger to the health or safety of that person or of others; or
(b) seriously diminishes the capacity of that person to take care of himself or herself.[15]

Section 4(e) of the Act specifically excludes intellectual disability as a sole basis for the application of the Act. The presence of intellectual disability does not, however, preclude use of the Act if the criteria for 'mental disorder' are otherwise met (in other words, where comorbidity exists).

Any powers under the 1992 Act must be exercised in accordance with both the New Zealand Bill of Rights 1990[16] - section 11 of which includes

[14] Mental Health (Compulsory Assessment and Treatment) Act 1992 http://www.legislation.govt.nz/act/public/1992/0046/latest/whole.html
[15] Section 2(1) Mental Health (Compulsory Assessment and Treatment) Act 1992.
[16] New Zealand Bill of Rights http://legislation.govt.nz/act/public/1990/0109/latest/whole.html

the right to refuse to undergo any medical treatment – and the Human Rights Act 1993[17] which prohibits discrimination on a number of grounds including disability (incorporating mental illness). New Zealand has also ratified the CRPD thus further strengthening these rights.

In 2003 the Intellectual Disability (Compulsory Care and Rehabilitation) Act was enacted. The objective of this legislation was to fill the legislative gap left by the 1992 Act which had led to some persons with intellectual disabilities who were thought to present a risk not being cared for under the mental health legislation and being discharged into the community.

#### *3.2.1.2 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003[18]*

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides for the compulsory care of intellectually disabled persons (as defined under section 7 of the Act) who have been charged with, or convicted of, an offence. Responsibility is placed on the disability sector as opposed to mental health or criminal justice system.

Section 8 of the Act provides that an individual will not have an intellectual disability for the purposes of the Act simply because they:

(a) Have a mental disorder; personality disorder; or acquired brain injury; or
(b) Feel neither shame nor remorse for harm they have caused to others.

An individual with an intellectual disability may become subject to the Act and the scheme established by it either:

(a) Through an order made in the course of criminal proceedings bought against the individual; or
(b) By being transferred from prison (where they have been serving a prison sentence): or
(c) By being transferred from the Mental Health (Compulsory Assessment and Treatment) Act 1992, where they were subject to

[17] Human Rights Act 1993 http://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html

[18] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 http://legislation.govt.nz/act/public/2003/0116/30.0/DLM224578.html

the 1992 Act after being charged with or convicted of an imprisonable offence.

The Act creates two categories of care recipient:

(a) Special care recipients (who must always receive care and rehabilitation in a secure facility and are similar to special patients under the 1992 Act); and
(b) Care recipients who may either receive care and rehabilitation in a secure facility or in a supervised setting.

The 2003 Act contains various rights and safeguards for individuals who are receiving care and rehabilitation under it.

#### *3.2.1.3 Protection of Personal and Property Rights Act 1988*[19]

The Protection of Personal and Property Rights Act 1988 provides a legislative basis for care decisions to be made on behalf of an incapacitated person by a welfare guardian appointed by a court for that purpose, or by an order of a court.

#### *3.2.1.4 New Zealand Public Health and Disability Act 2000*[20]

The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations. This is in order to pursue certain objectives including, amongst other things, to improve, promote and protect the health of New Zealanders and to promote the inclusion and participation in society and independence of people with disabilities.

#### *3.2.1.5 Health and Disability Commissioners Act 1994*[21]

The Health and Disability Commissioners Act 1994 protects the rights of patients to be treated with respect, dignity and independence, to be free of discrimination, to have proper standards of care, to be fully informed, to make informed choices and to give informed consent, to have protection of privacy, and to have the right to receive support.

---

[19] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
http://www.legislation.govt.nz/act/public/1988/0004/67.0/DLM126528.html
[20] New Zealand Public Health and Disability Act 2000
http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html
[21] Health and Disability Commissioners Act 1994
http://www.legislation.govt.nz/act/public/1994/0088/49.0/DLM333584.html

### 3.2.2 Relevant literature

***Mental health legislation***

(a) J Dawson and K Gledhill (eds) *New Zealand's Mental Health Act in Practice*, Victoria University Press, 2013.

(b) EC Fistein et al 'A comparison of mental health legislation from diverse Commonwealth jurisdictions' (2009) 32(3) *International Journal of Law and Psychiatry* 147–155. See commentary in Section 2 above.

(c) Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, 2012.[22]

(d) I Soosay and R Kydd 'Mental health law in New Zealand' (2016) 13(2) BJPsych International 43-45.

This provides a brief history of mental health legislation in New Zealand since 1840 and describes the use of the 1992 Act in clinical practice and the wider legal and constitutional context.

***Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003***

(e) K Prebble et al 'The Care Manager's Dilemma: Balancing Human Rights with Risk Management under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003' (2012) 28(1) *Disability & Society* 110-124.

The article describes a study which sought to ascertain how a care manager's role functions in each type of care setting, identify issues related to statutory requirements of the role and explore how the role relates to care recipient outcomes. In particular, it identified conflicts between (i) the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and ethos underpinning disability organisations; (ii) risk management and rehabilitation and protecting human rights; and (iii) an unclear articulation of rehabilitation which impacted on implementation of the Act.

[22] Ministry of Health Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, 2012 https://www.health.govt.nz/system/files/documents/publications/guide-to-mental-health-act.pdf

(f) A Smith *Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003: A Discourse Analysis*, Doctorate in Health Science thesis, 2015.[23]

Although an academic thesis, this provides an interesting insight into the operation of the 2003 Act.

***General***

(f) UN Committee on the Rights of Persons with Disabilities *Concluding Observations on the initial report of New Zealand,* 31 October 2014, CRPD/C/NZL/CO/1.[24]

These observations noted (i) a lack of specific judicial training regarding the CRPD or the requirement that there be access to justice for persons with disabilities, including those with intellectual and psychosocial disabilities;[25] and (ii) that there are barriers to persons with disabilities, especially persons with intellectual disabilities, from fully accessing healthcare services, including sexual and reproduce health care.[26]

[23] UN Committee on the Rights of Persons with Disabilities Concluding Observations on the initial report of New Zealand. https://core.ac.uk/download/pdf/56365324.pdf

[24] UN Committee on the Rights of Persons with Disabilities Concluding Observations on the initial report of New Zealand https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fNZL%2fCO%2f1&Lang=en

[25] Paras 27-28 UN Committee on the Rights of Persons with Disabilities Concluding Observations on the initial report of New Zealand.

[26] Paras 51-51 UN Committee on the Rights of Persons with Disabilities Concluding Observations on the initial report of New Zealand.

### 3.3 Victoria, Australia

#### 3.3.1 Legislation

In Victoria individuals with intellectual disability do not fall within the remit of the Mental Health Act 2014.[27]. The two pieces of legislation that govern the care and treatment of individuals with intellectual disability are the Disability Act 2006 and the Medical Treatment Planning and Decisions Act 2015.

##### 3.3.1.1 *Disability Act 2006*[28]

The Disability Act 2006 replaced the previous situation of informal detention for persons with intellectual disabilities. The Act specifies the circumstances where individuals with intellectual disabilities may be subject to restrictive interventions and compulsory treatment. Restrictive interventions, which include the use of seclusion and restraint, can only be employed where an individual is a resident in a service provided by an approved disability provider, where this is specifically included in their behaviour management plan, and where an independent person has explained the right to review.

Individuals with intellectual disability can also be subject to compulsory treatment through a Supervised Treatment Order (STO) granted by the Victoria Civil and Administrative Tribunal. The tribunal may grant a STO where there is a pattern of violent or dangerous behaviour that has caused significant harm, no less restrictive option is available to reduce the risk of harm, compulsory treatment must be beneficial and reduce the risk of harm, there is an unwillingness to accept treatment voluntarily and the order is necessary to ensure compliance and prevent a risk of serious harm to others.[29] A STO can be applied for a period of up to 12 months and, subject to the tribunal's approval, can be renewed thereafter.

---

[27] Section 4(k) Mental Health Act 2014 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/0001F48EE2422A10CA257CB4001D32FB/$FILE/14-026abookmarked.pdf

[28] Disability Act 2006 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/51dea49770555ea6ca256da4001b90cd/0B82C05270E27961CA25717000216104/$FILE/06-023a.pdf

[29] Section 191(6)(a) -(e) Disability Act 2006.

The role of a Senior Practitioner Role was introduced by the 2006 Act to enhance safeguards. Senior Practitioners monitor the use of restrictive and compulsory treatment and to approve treatment plans, and these can only progress to an STO where Special Practitioner approval has been granted. It would appear that STOs are used for the purpose of risk management and are predominantly used for men who commit sexual offences (Office of the Public Advocate, 2010).

#### 3.3.1.2 *Medical Treatment Planning and Decisions Act 2016*[30]

The Medical Treatment Planning and Decisions Act 2016 came into force in March 2018 and provides the framework for medical treatment decisions where individuals lack capacity. The Act is underpinned by guiding principles designed to ensure the promotion of the exercise of capacity, that the individual's preferences are central to all decisions made and that supported decision-making should take place as opposed to substituted decision-making. The Act stipulates that individuals must be provided with accessible supports for decision-making and introduces measures to strengthen choice and control over medical treatment, including advance care directives, medical treatment decision-makers and support persons.

Whilst these mechanisms are designed to enhance autonomy over medical treatment it is, however, too early to tell whether the objectives of this legislation are being achieved in practice. To date there is a lack of evidence around implementation.

#### 3.3.1.3 *Victoria Charter of Human Rights and Responsibilities 2006*[31]

Laws in Victoria must take account of and be implemented in accordance with its Charter of Human Rights and Responsibilities 2006. The rights identified in the Charter are only civil and political rights. However, it should be noted that they must be enjoyed on an equal

[30] Medical Treatment Planning and Decisions Act 2016http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B4D3EBB66E52E98CCA25807A0014F70D/$FILE/16-069aa%20authorised.pdf

[31] Victoria Charter of Human Rights and Responsibilities 2006 http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt8.nsf/DDE300B846EED9C7CA257616000A3571/87318807B8E7A33ACA257D0700052646/$FILE/06-43aa013%20authorised.pdf

basis by all and, as indicated in 1.3 above, the realisation of the right to mental health requires that a number of other rights, including civil and political rights, are given effect.

#### 3.3.1.4 *Guardianship and Administration Act 1986*[32]

The Guardianship and Administration Act 1986 allows for guardians or administrators to be appointed and for the authorisation of certain medical procedures for persons with intellectual disabilities, cognitive disability, and psychosocial disabilities/ mental health conditions.

### 3.3.2 Relevant literature

***Disability Act 2006***

(a) Department of Health and Human Services. Senior Practitioner Report 2016-2017, 2017.[33]

(b) Office of the Public Advocate. *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected? Victoria: Office of the Public Advocate*, 2010.[34]

This study looked at STOs in order to ascertain whether these are operating in accordance with human rights standards. Its findings can be summarised as follows:

(a) Men were most likely to be on STOs with a comorbidity of intellectual disability and mental illness, and prior contact with the criminal justice system.

---

[32] Guardianship and Administration Act 1986 https://jade.io/article/282099

[33] Department of Health and Human Services. Senior Practitioner Report 2016-2017, 2017 https://dhhs.vic.gov.au/sites/default/files/documents/201805/DHHS%20Senior%20Practitioner%20report%202016-17%20Plain%20English.pdf

[34] Office of the Public Advocate. Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected? Victoria: Office of the Public Advocate, 2010 https://www.publicadvocate.vic.gov.au/our-services/publications-forms/52-supervised-treatment-orders-in-practice-how-are-the-human-rights-of-people-detained-under-the-disability-act-2006-protected?path=

(b) Risk was most likely to have been related to a sexual offence conviction.
(c) Individuals on STOs were subject to both detention and restrictive interventions.
(d) Individuals had restrictions placed in terms of access to media, who they engaged with and where they could visit.
(e) Individuals on STOs described being subject to continuous observation with an impact of their freedom and ability to maintain relationships.
(f) Professionals, however, identified STOs as improving quality of life by enhancing relationships and increasing choice and control.
(g) Both professionals and individuals noted the benefits of treatment under STOs in terms of reducing reoffending.

(c) Spivakovsky, C. 'Making Risk and Dangerousness Intelligible in Intellectual Disability' (2014) 23(3) *Griffith Law Review* 389-404.

This article reports on an analysis of 10 STO decisions made by the Victoria Civil and Administrative Tribunal, nine of which were used in relation to men and for the purpose of detention, restricting contact with the community, and to administer medication. The study found that:

a. Tribunal reliance on criminal records to demonstrate a risk of violent behaviour and on reoffending screenings to show a risk of serious harm.
b. A medical diagnosis of an intellectual disability influences risk assessments.
c. A willingness to comply with the treatment plan was undermined by incapacity assessments.

***Medical Treatment Planning and Decisions Act 2016***

(d) Department of Health and Human Services (2017). A Guide to the Medical Treatment Planning and Decisions Act 2016, Melbourne: Victoria State Government.

***General***

(e) National Disability Services. (2008). Disability Act 2008: A Guide for Boards of Management of Disability Service Providers, available at: http://www.daru.org.au/wp/wp-content/uploads/2013/08/DisabilityACT2006-booklet-2.pdf

### 3.4 England and Wales

#### 3.4.1 Legislation

The English and Welsh Mental Health Act 1983 (as amended by the Mental Health Act 2007) excludes learning disability from the definition of mental disorder, except in circumstances where there is evidence of abnormally aggressive or seriously irresponsible behaviour.[35]

There is a lack of literature specifically examining the experiences of the Mental Health Act 1983 for people with a learning disability and/or autism. However, it would appear that the interaction between the Mental Health Act and Mental Capacity Act is complex and issues arise as to whether the more often used Mental Health Act (even where individuals have capacity to refuse treatment) is appropriate. Amongst other things, the recent review of the Mental Health Act 1983 highlighted issues surrounding the treatability of people with learning disabilities and autism, particularly in relation to the appropriateness of hospital environments in meeting individual needs.[36] It did not recommend that people with learning disabilities and autism be removed from the scope of the legislation but did emphasis the need to ensure that proper regard is made to the specific individual needs of all patients including those within this particular cohort.[37]

#### 3.4.2 Relevant Literature

(a) Department of Health. (2015). No Voice Unheard, No Right Ignored - A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions.[38] Highlights the mixed response about

---

[35] Sections 1(1)(2) and (2A). 'learning disability' is defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning' (section 1(4)).

[36] Department of Health and Social Care. (2018). Independent Review of the Mental Health Act: Interim Report, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703919/The_independent_Mental_Health_Act_review__interim_report_01_05_2018.pdf

[37] *Ibid* pp177-184.

[38] Department of Health. (2015). No Voice Unheard, No Right Ignored - A Consultation for People with Learning Disabilities, Autism and Mental Health Conditions

removing people with learning disability and autism from the scope of Mental Health Act.

(b) Department of Health and Social Care. (2018). Independent Review of the Mental Health Act: Interim Report.[39] Please see comments in 3.4.1 above. Key issue that has been raised is whether learning disability should be completely removed from the Mental Health Act.

(c) EC Fistein et al 'A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions' (2009) 32(3) International Journal of Law and Psychiatry 47-155. See commentary above.

(d) Mental Health Foundation and Foundation for People with Intellectual Disabilities *Mental Capacity and the Mental Capacity Act 2005: A literature review* 2012.[40]

The Mental Health Foundation and the Foundation for People with Learning Disabilities reviewed 77 papers in relation to Mental Capacity Act, including 15 relating to people with learning disabilities. Amongst various key issues it noted was included the fact that a widespread lack of understanding, particularly amongst health and care professionals existed particularly in relation to the presumption of capacity principle, where assumptions were made about persons having learning disability and a lack of capacity. Conversely, a presumption of capacity was also used by some local authorities to justify non-intervention to avoid taking responsibilities for individuals. There was also poor evidence of supported decision-making.

(e) Sawhney, I et al 'Patients with Learning Disabilities who Lack Capacity Detained under the Mental Health Act in the UK: A Case Study' (2017) 45(2) *British Journal of Leaning Disability* 138-141.

Notes that individuals detained under section 2 of the Mental Health Act can appeal to a tribunal but the difficulties in effectively pursuing this remedy where the individual lacks capacity.

---

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf

[39] See note 35 above.

[40] Mental Health Foundation and Foundation for People with Learning Disabilities Mental Capacity and the Mental Capacity Act 2005: A literature review 2012 http://www.mentalhealth.org.uk/publications/mca-lit-review

**4 Compatibility of mental health legislation with international human rights standards**

In order to assess the extent to which the mental health legislation of a particular state is compatible with international human rights standards it is necessary to be clear as to (a) which human rights standards are being examined; and (b) whether it is the legislative content and/or its implementation is being evaluated.

A state may be a party to both regional and international human rights treaties[41] each of which impose obligations on that state and the nature and extent of such obligations may differ between treaties. The approach to human rights enjoyment promoted to by the CRPD, for example, is radically different to any preceding international and regional treaties thus challenging states in terms of which and how human rights standards apply nationally.[42] For instance, the Mental Health (Care and Treatment) (Scotland) Act 2003 remains largely compatible with European Convention but issues arise concerning its compatibility with the CRPD.

It is also important to appreciate the difference between, on the one hand, human rights compliance of the content of legislative provisions and objectives underlying such legislation and, on the other, human rights compliance the implementation of the legislation.

Amended version January 2019

---

[41] See WHO *International human rights treaties relevant to the rights of people with mental disabilities* https://www.who.int/mental_health/policy/legislation/un_and_regional_human_rights_instruments.pdf?ua=1 (accessed 21 January 2019)

[42] Different national approaches to human rights implementation, including (but not limited to) the legal status of international and regional treaties within a status will influence this. For example, the UK is a state party to the European Convention on Human Rights (ECHR) and the CRPD. The UK Human Rights Act 1998 allows for ECHR rights to be enforced throughout the UK. In Scotland, all devolved legislation and its implementation must be compatible with ECHR rights (section 29(2)(d) Scotland Act 1998; sections 2, 3 and 6 Human Rights Act 1998). The CRPD is not incorporated in the UK or Scottish law in the same way (although proposed Scottish legislation may be prevented if it is incompatible with the CRPD (section 35(1)(a) Scotland Act 1998)).

# 11 Current proposals for English law

After Professor Jill Stavert and Aisha MacGregor provided the literature review in section 10, several recommendations and proposals were made in relation to intellectual disability, autism and mental health and mental capacity law in England.

**Modernising the Mental Health Act – final report from the independent review.**

Professor Sir Simon Wesselly, updated 2019 (link, page 183)

“These recommendations should be read in conjunction with the wider recommendations for all patients that will be of particular benefit to people with learning disabilities, autism or both.

- Health and social care commissioners should have a duty to collaborate to ensure provision of community-based support and treatment for people with an learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community.
- Amend the MHA Code of Practice to clarify best practice when the MHA is used for people with autism, learning disability or both.
- Care and Treatment Reviews should be given statutory force in the MHA.
- The Mental Health Services Dataset should include specific data to monitor the number of detentions and circumstances surrounding that detention of people with autism, learning disabilities or both”

**The detention of young people with learning disabilities and/or autism**

Joint Committee on Human Rights, House of Commons and House of Lords, October 2019 (link, page 28)

The current legislation governing admission, treatment, and discharge from mental health hospitals is failing to protect the Article 5 rights of those with learning disabilities and/or autism. In particular, the requirement of “appropriate medical treatment” contained within the Mental Health Act is constructed far too broadly.

# 11 Current proposals for English law

We endorse the recommendation of the Mental Health Act Review that the criteria for detention under the Mental Health Act must be narrowed[1].

Those with learning disabilities and/or autism must only be detained under the Mental Health Act, in situations where:

a) treatment is necessary;

b) treatment is not available in the community and only available in detention (i.e. the last and only resort);

c) treatment is of benefit to the individual and does not worsen their condition; and

d) without the treatment, there is a significant risk of harm to the individual or others.

We acknowledge that tightening the criteria for detention under the Mental Health Act 1983 could increase the number of detentions under the Mental Capacity Act 2005, with its weaker safeguards. We emphasise that the legal principles set down by the European Court of Human Rights apply irrespective of which regime applies. All persons detained in mental health settings are entitled to individualised, therapeutic treatment. Where this is not happening, the detention of individuals is a violation of Article 5 and may, in some severe cases, violate Article 3. Persons detained under the Mental Capacity Act, and those admitted informally, must be afforded equal protection of their Article 3 and Article 5 rights.

---

1. Detention criteria concerning treatment and risk should be strengthened to require that:

a. treatment is available which would benefit the patient, and not just serve public protection, which cannot be delivered without detention; and

b. there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person without treatment.

# 11 Current proposals for English law

**The case for removing intellectual disability and autism from the Mental Health Act**

Baroness Sheila Hollins, Keri-Michèle Lodge and Paul Lomax. The British Journal of Psychiatry (2019) Volume 215, Issue 5 pp. 633-635 (link, abstract)

“Intellectual disability (also known as learning disability in UK health services) and autism are distinct from the serious mental illnesses for which the Mental Health Act is designed to be used. Their inclusion in the definition of mental disorder is discriminatory, resulting in unjust deprivations of liberty. Intellectual disability and autism should be excluded from the Mental Health Act.”

The independent review of
# Learning Disability and Autism
in the Mental Health Act