Detained for Being Different: A Critique of the Mental Health Act's Approach to People with Autism and Learning Disabilities

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Introduction

The Mental Health Act 1983 (MHA) is the primary legislation governing when the state can detain and treat people for mental health reasons in England and Wales. It gives doctors, approved mental health professionals, and the police the power to detain individuals and keep them in hospital if they are judged to be at risk of harming themselves or others. The purpose of the Act is, in principle, to provide care and protect the community. However, the scope of who can be detained under the MHA is broad: the law defines "mental disorder" widely, and this includes autism and learning disabilities, even where there is no co-occurring mental illness (Mental Health Act 1983, s.1(2); s.1(2A)).

NHS Digital's Assuring Transformation (2024) datasets consistently show that around 2,000–2,500 autistic and learning-disabled people are detained in inpatient mental health units in England at any given time, with new admissions continuing every month. Evidence from government reviews and academic research suggests that these detentions often occur not because hospitalisation is clinically necessary, but because suitable community services and supported placements are unavailable, creating systemic barriers to discharge (Glasby et al., 2024; DHSC, Building the Right Support Action Plan, 2022).

As a result, many people remain in hospital for years, including in secure units far from home, with data showing significant proportions of inpatients detained for over two, five, or even ten years (NHS Digital, 2024). Conditions in these settings have repeatedly been found to exacerbate distress through restrictive practices, including restraint, seclusion, and long-term segregation, particularly for autistic people (CQC, 2020). These problems have been repeatedly exposed by major inquiries and abuse scandals, including Winterbourne View (2011) and Whorlton Hall (2019), raising profound ethical, human rights, and policy concerns about the continued use of inpatient detention for people with autism and learning disabilities.

The government has proposed reforms through the Mental Health Bill, which seeks to limit the use of detention for people with autism and learning disabilities. While this marks an important shift, it does not address the wider structural problem: institutionalisation persists because community provision is inadequate and under-funded. This article examines how the current system enables long-term detention, the harms it produces, and whether the proposed reforms are likely to deliver meaningful change.

Background and Legal Context

The Mental Health Act 1983 (MHA) sets out when a person can be detained and treated in hospital without consent. Detention applies where professionals consider that an individual has a "mental disorder" and that hospital admission is necessary for their health or safety or for the protection of others (MHA 1983, ss. 2(2)(a),(c)). The Act defines "mental disorder" broadly as "any disorder or disability of the mind" (s. 1(2)), a definition which expressly includes both learning disability (s. 1(4)) and autism, as confirmed by the MHA Code of Practice (2015, para 2.14). As a result, autistic and learning-disabled people fall within the scope of the Act even where they do not have a co-occurring mental illness.

The Policy Problem: Detention as a Response to System Failure, instead of Clinical Need

Although the Mental Health Act was intended to provide care and protect people from harming themselves or others, its current operation has resulted in the routine institutionalisation of autistic and learning-disabled people. The central policy problem is that detention is being used as a substitute for adequate community support, rather than as a last resort in cases of acute mental illness.

Research and government evidence consistently show that autistic and learning-disabled people are often admitted to, or kept in, inpatient units because the community infrastructure required to support them safely is missing or insufficient. The Department of Health and Social Care's *Building the Right Support Action Plan* (2022) reports that almost half of all delayed discharges (48%) occur due to a lack of suitable housing or supported living placements.

It also identifies shortages in social-care packages, specialist autism-appropriate accommodation, and skilled staff able to deliver community-based support. Research reinforces this: Glasby et al. study (2024) found that long-stay hospitalisation is frequently driven by the breakdown or absence of community placements, insufficient Positive Behaviour Support (PBS) provision, and the lack of step-down services needed for safe discharge. Regulatory findings echo these patterns. The Care Quality Commission's thematic review, *Out of Sight – Who Cares?* (2020) concludes that people with learning disabilities and autism are often admitted because "community alternatives are not available," and that the absence of crisis services contributes directly to avoidable admissions and prolonged detention. Together, these sources demonstrate that the core policy failure is structural: the MHA is being used as a backstop to compensate for chronic gaps in housing, social care, crisis support, and specialised community provision for neurodivergent people, meaning detention routinely occurs for social-care reasons rather than clinical need.

Alongside gaps in housing, social care, and crisis support, there is also a structural funding problem that reinforces the use of detention. Local authorities are responsible for commissioning and paying for community support for autistic and learning-disabled adults, whereas the NHS funds inpatient care under the MHA (Challenging Behaviour Foundation, 2024). This creates a perverse incentive: hospital detention becomes the financially "easier" option compared to building costly, long-term community support packages.

Although the Mental Health Act's Code of Practice sets out a "least restrictive option and maximising independence" principle, the statutory detention criteria do not impose an express duty on professionals to demonstrate that all appropriate community alternatives have been tried before admission. Detention is lawful where hospital treatment is judged "necessary" for the person's health or safety or for the protection of others, even if community support has not been fully developed or provided (MHA 1983, ss.2–3; Code of Practice, 2015). Therefore, the "least restrictive" principle in the Code of Practice cannot be realised if there are no practical alternatives available in the community. This reinforces the structural problem: where community support is absent, detention becomes the path of least resistance rather than a clinically necessary last resort.

The Consequences of Detention: Harm, Deterioration, and Human Rights Violations

The reliance on hospital detention for autistic and learning-disabled people has profound and well-documented consequences. CQC (2020) found that inpatient environments routinely expose neurodivergent people to restrictive practices, including restraint, seclusion, and long-term segregation, that can escalate distress rather than alleviate it. Many units are noisy, unpredictable, and sensory-intense, making them fundamentally unsuitable for autistic individuals whose distress behaviours are often misinterpreted as risks requiring further restriction. Far from providing therapeutic benefit, these environments frequently cause deterioration in mental and physical wellbeing (CQC, 2020). These findings demonstrate how inpatient care under the MHA frequently exacerbates rather than alleviates distress for autistic and learning-disabled people, contributing to poorer mental and physical well-being outcomes for patients. Long-stay hospitalisation also entrenches institutionalisation. NHS Digital (2024) data shows that a substantial proportion of autistic and learning-disabled inpatients remain detained for multiple years, with significant numbers staying over two years in detention.

In addition, Glasby et al. (2024) found that long-stay settings can create institutional dependency, making individuals less prepared for discharge and more reliant on hospital routines. The study describes delayed discharge as part of a wider "circular" system in which the absence of suitable community

placements prevents people from leaving the hospital, and the resulting long stay then reinforces professional perceptions that they require inpatient care (Glasby et al., 2024). Together, these findings show that extended stays in hospital do not provide therapeutic benefit; instead, they contribute to deterioration in wellbeing and embed the very dependency and risk factors that justify continued detention.

These harms raise serious human rights concerns. The Equality and Human Rights Commission (2023) has highlighted that prolonged and unnecessary detention risks violating Article 5 ECHR (the right to liberty and security) and Article 8 (respect for private and family life), particularly where people are placed far from home or subjected to long-term segregation. Repeated abuse scandals Winterbourne View (2011), Whorlton Hall (2019), demonstrate the systemic vulnerabilities created by institutional settings and the heightened risk of neglect, ill-treatment, and inhumane or degrading treatment, which also contravenes Article 3 of the ECHR (prohibition of torture).

The consequences of detention, therefore, extend beyond poor outcomes; they reflect a structural failure to protect the rights, dignity, and autonomy of neurodivergent people. These harms underline the urgency of reform and the need to replace inpatient reliance with adequately resourced community alternatives.

Are the Mental Health Bill Reforms Sufficient? A Critical Evaluation

The government's proposed Mental Health Bill is the most significant attempt in decades to change how the MHA applies to autistic people and those with learning disabilities. A central reform is that autism and learning disability would no longer be valid reasons for detaining someone for treatment under section 3 of the Act. Detention would instead be lawful only where the individual has a co-occurring mental illness that genuinely requires hospital care, for example, an autistic person experiencing an acute psychotic episode requiring inpatient treatment. The reform intends to prevent hospital detention where the primary driver is a lack of community support rather than clinical necessity.

The Bill also introduces several wider changes. It strengthens the criteria for detention by requiring clearer evidence of therapeutic benefit; places new statutory principles in the Act, including choice, autonomy, and the least-restrictive option; expands access to Independent Mental Health Advocates (IMHAs); and increases oversight of practices such as long-term segregation. These reforms follow key recommendations from the Independent Review of the MHA (2018), and together represent a

shift away from the longstanding assumption that autism and learning disability, on their own, justify hospital admission.

After evaluating the current impacts of the MHA, it can be argued that these proposals are necessary. Removing autism and learning disability as grounds for detention helps restore the original purpose of the Act: treating acute mental illness, not managing unmet social care needs. By raising the detention threshold and emphasising therapeutic benefit, the Bill attempts to ensure that hospital admission occurs only when clinically appropriate. Additional rights-based reforms, such as improved advocacy, may help to reduce overly restrictive practices and enhance scrutiny of detention decisions. In this sense, the Bill represents meaningful progress from an arguably outdated Act.

However, despite these strengths, the reforms do not address the core structural drivers of institutionalisation identified in this article. The most significant limitation is that the Bill does not create, nor require investment in, the community infrastructure necessary to support autistic and learning-disabled people outside the hospital. As the DHSC's *Building the Right Support Action Plan* (2022) demonstrates, delays in discharge are overwhelmingly linked to a lack of suitable housing, underfunded social care packages, limited crisis services, and shortages of skilled staff and specialist placements. Glasby et al.'s NIHR study (2024) similarly shows that people remain in hospital for years because community placements either do not exist or are not adequately funded. Nothing in the Bill imposes a statutory duty on local authorities or the NHS to provide these missing services. As a result, even if the legal criteria narrow, the structural pressures that push people into the hospital and keep them there will remain largely intact.

A second major limitation is that the Bill does not resolve the funding split that contributes to the overuse of detention. Community support for autistic and learning-disabled adults is commissioned and paid for by local authorities, while inpatient care under the MHA is funded by the NHS. Challenging Behaviour Foundation (2024) highlights how this arrangement creates a perverse incentive: when community placements break down or become too costly, detention shifts financial responsibility away from local authority budgets and onto the NHS. The Bill leaves this system unchanged and therefore does little to disrupt the economic pressures that make detention an "easier" option.

Third, without investment in community support, there is a risk that the reforms will result in unintended consequences. If autism and learning disability are excluded as grounds for detention, clinicians may feel compelled to label behaviours of distress as symptoms of a mental illness in order to justify admission, particularly when no safe alternative exists. This concern has been raised in evidence to parliamentary committees, which emphasise that the Bill's success depends on parallel investment in

social care and specialist community services. Without such investment, the Bill risks becoming symbolic, altering legal definitions without changing the underlying system.

Policy Recommendations and Conclusion

The limitations of the Mental Health Bill highlight the need for reform that extends beyond legislative change and confronts the structural causes of inappropriate detention. The first priority is a significant expansion of community-based provision. This requires sustained investment in supported living, specialist autism accommodation, crisis intervention teams, and Positive Behaviour Support (PBS) services, areas repeatedly identified as critical gaps by the DHSC (2022), CQC (2020), and NIHR research (Glasby et al., 2024). Without these services, detention will continue to function as the default response to unmet support needs. A statutory duty on local authorities and the NHS to provide adequate community alternatives would help ensure that individuals are not detained simply because no other support is available.

Second, the government must address the structural funding split that creates a perverse incentive to rely on inpatient care. Responsibility for social care would remain with local authorities under the Care Act 2014, but funding for community provision for autistic and learning-disabled adults should be provided through a ring-fenced national allocation, pooled with NHS Integrated Care Boards for joint commissioning. This would prevent the current situation in which community support represents a direct financial burden for local authorities, while detention shifts costs to the NHS. By retaining local delivery while nationalising financial responsibility, this model would align institutional incentives with the Bill's stated aim of reducing unnecessary detention.

Third, there must be stronger safeguards around restrictive practices and long-term segregation. While the Bill introduces some oversight measures, it does not impose enforceable expectations on inpatient units to reduce the use of restraint, seclusion, or segregation. Responsibility for monitoring and reporting should rest primarily with the Care Quality Commission, supported by a statutory requirement for inpatient units to collect and publish standardised data on the use and duration of restrictive interventions. This data should be routinely reviewed as part of CQC inspections and linked to enforcement powers where persistent or unjustified use is identified. Independent monitoring by the CQC, combined with mandatory reporting, would help address the human rights concerns highlighted by the CQC (2020) and the Equality and Human Rights Commission (2023).

In the end, the Mental Health Bill acknowledges the injustice at the heart of the current system, but refuses to confront its policy roots. As long as community support remains patchy, underfunded, and

optional, the hospital will continue to function as the state's fallback for social care failures. If ending unnecessary detention is the goal, rewriting the Act is the easy part. The hard part is confronting the structural drivers that make detention the easiest option: chronic underfunding, fragmented commissioning, and the absence of safe, properly resourced community support. Until these are addressed, the Mental Health Act's promise of protection is symbolic at best.

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