individuals and communities to plan their activities. Indeed, this changing landscape can seriously disrupt regular daily routines, incurring a further burden on mental health.[5]

Following major disasters only around a tenth of effected populations are chronically distressed.[6] Even for those who are initially distressed psychological health returns to pre-disaster levels within a relatively short period. Yet, unlike an earthquake or terror attack, COVID-19 threatens to pose a particularly sustained threat, with enduring health and economic consequences. During 'usual' disasters particular groups are especially vulnerable (such as women, the unemployed, those with pre-existing psychological disorders, those who have to relocate). With COVID-19 it is the young that seem particularly at risk of mental illness,[4] as well as those who have to spend time in isolation/quarantine.[2] Practitioners may need to be particularly mindful of their particular needs as the pandemic unfolds.

Declaration of interest

None.

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Potential unintended consequences of removal of intellectual disability and autism from the Mental Health Act

Hollins et al argue for the removal of autism and intellectual disability from the Mental Health Act,[1] on the basis that they are not the same as the serious mental illnesses for which the Act is intended for. Although we would agree with the suggestion that both autism and intellectual disability are phenomenologically different from forms of serious mental illness such as affective and psychotic disorders, it is clear that such individuals can present with symptoms that present a substantial risk to themselves and/or others, without the need for a co-occurring mental health condition.[2]

Also of relevance is a recent article by McCarthy & Duff,[3] which details changes to mental health legislation in New Zealand, where the introduction of the Mental Health (Compulsory Assessment and Treatment) Act (MH (CAT) Act) 1992[4] intentionally excluded people with an intellectual disability and no co-occurring mental health problems. However, the unintended consequences of the legislative chasm left by this change was that it significantly limited the options for people with intellectual disability and offending behaviours, or indeed those with high-risk behaviours not qualifying as criminal offences. This led to such individuals being sent to prison, left in the community or in some individuals with very high levels of offending, being admitted to a forensic hospital. In order to correct for this issue, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 was introduced in 2004.[5] This enabled provision of compulsory care to people with an intellectual disability who had been charged or convicted of an imprisonable offence.

We would be concerned that removal of autism and intellectual disability from the Mental Health Act in the UK would have a similar impact to the introduction of the MH (CAT) Act 1992, leading to such individuals presenting with high risks to themselves and/or others potentially facing imprisonment or remaining in community placements that are unsuited for their complex needs. One suspects that this issue could be at least partially addressed by significantly increased investment in community infrastructure for individuals with intellectual disability and/or autism and particularly complex needs, but for as long as such infrastructure is lacking, many such individuals would be at risk of imprisonment or remaining in community placements that are inadequate for their needs.

Declaration of interest

Dr Tromans is the chief investigator on a National Institute of Health Research supported research study investigating adult autism prevalence within acute inpatient psychiatric settings, among both patients with and without intellectual disability. Dr Tromans is also a co-investigator on a National Health Service Small Business Research Initiative study investigating the utility of an autism tool.

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