Joint Committee on Human Rights report: The detention of young people with learning disabilities and/or autism – 2019

This report was formulated by the joint committee of human rights (JCHR), a group of 12 individuals made up of 6 members of the House of Commons and 6 members of the House of Lords. The scope of the inquiry was the detention of young people with learning disabilities and/or autism within institutions known as Assessment and Treatment Units. These units are designed to be short-term secure placements for people with learning disabilities. However, the report recognised that some people lived in them for years.

Whilst they did recognise that most people were subject to the Mental Capacity Act or Mental Health Act, some remained informally. It is the latter that they had serious concerns about as these individuals told the commission that they feared challenging their situation for fear of being 'sectioned.'

At the time of the report in 2019, 2,270 people remained in institutions, despite an initiative from the Department of Health called 'Transforming Care' to reduce this number as a reaction to the exposure of the abuse scandal at Winterbourne View, an initiative which pledged that everyone inappropriately in hospital would move to community-based support as quickly as possible and no later than 1June 2014. Of the 2,270, 57% had a total length of stay of over 2 years and 28% of those individuals had a care plan which stated that they did not require inpatient care.

Following on from the end of the Transforming Care programme, the NHS Long Term plan was published in January 2019 which has set a revised target for reducing the number of those with learning disabilities and/or autism to less than half of 2015 levels (2,395) by March 2023/24. Concerns have been raised and outlined in the report that this is not ambitious enough and that the target should be zero and the exception justified.

The report recognised that a major barrier preventing successful discharge is the lack of flexible support in the community, and that where they are available, the quality of the services is a barrier by being too prescriptive or not being designed alongside the individual and their family.

The detention of those with learning disabilities and/or autism was often inappropriate causing suffering and frequently making their conditions worse. Despite their being a consensus among families, professionals and commissioners that the individual did not require detention, it was found to have continued. The right housing, social care and health services which were found to be needed to prevent people being detained inappropriately, were not being commissioned.

The report recognised that it was wholly unacceptable that professionals should attempt to prevent parents speaking out when they disagree with the way that their children are being treated.

It was highlighted that 29% of under 18's were being treated 100km or more from home and this undermined their right to family life under Article 8 ECHR. The report stated that this must stop and until it does, families should be given the financial support they need to visit their loved ones.

The report recommended that:

1. A legal duty be introduced on local authorities and Clinical Commissioning Groups to ensure the availability of sufficient community-based services
2. A legal duty be introduced on local authorities and Clinical Commissioning Groups to pool budgets for care services for people with learning disabilities and/or autism
3. Families are recognised as human rights defenders and, other than in exceptional circumstances, be fully involved in all relevant discussions and decisions.
4. The rights of individuals and their families to advocacy must be enhanced and enforced, including for those who are considered informal patients and these services should be funded seperately from care and support services.
5. Measures be taken in respect of the Care Quality Commission (CQC) to use more unannounced visits, weekend visits and those late in the evening as well as using covert surveillance methods to better inform inspection judgments, changes to legislation to ensure the CQC can act more swiftly when needed and a review of their rating system.

If you would like to read the full report, please click on the link
https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/121.pdf