

## Correspondence

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### The UN Convention on the Rights of Persons with Disabilities and UK mental health legislation

Brendan Kelly's editorial<sup>1</sup> on the United Nations Convention on the Rights of Persons with Disabilities (CRPD) is opportune. Like him, I welcome the Convention's uncompromising support for the rights of persons with disabilities and its articulation of key forms of discrimination.

As Kelly points out, when it comes to persons with a 'mental illness' (or a 'psychosocial disability' in the language of the Convention) there are major challenges. Although there will be debate about who has a 'disability', the majority of those with a mental illness likely to be severe enough to be candidates for involuntary treatment are almost certainly included. Thus a 'disability-neutral' mental health law becomes necessary. The Mental Health Act 1983 (amended in 2007) does not comply with the terms of the Convention. It fails the test proposed by the UN High Commissioner for Human Rights by having as a necessary criterion the presence of a 'mental disorder' (i.e. a disability). Thus it is taken to violate Article 14, that 'the existence of a disability shall in no case justify a deprivation of liberty'.

With colleagues, I have argued that mental health law fails to respect the 'autonomy' or right to 'self-determination' of the patient in psychiatry in the same way as capacity-based law does for all other patients.<sup>2,3</sup> Mental health law is thus discriminatory. This discrimination seems to be based on deeply embedded (but clearly false) and persistent stereotypes of mental illness being inextricably linked with incompetence (and dangerousness).

To eliminate the discrimination there must be a generic law covering all persons who lack decision-making capability, whatever its cause (whether it be a psychiatric, medical, surgical or other cause, e.g. a head injury, schizophrenia, dementia, stroke, post-operative confusion) and whatever the setting. The criteria for involuntary treatment under our 'fusion law' proposal do not require a diagnosis of a 'disability'. They are based squarely on an impairment of 'decision-making capability' (whether the person has a pre-existing disability or not) and the treatment must be in the person's 'best interests'. Both criteria are controversial and require elaboration. The concept of 'will and preferences', used frequently in the CRPD, could be helpful. 'Involuntary' (if that remains the right term) interventions could be justified when a person is unable to express their will and preferences or when their currently expressed will and preferences are not their 'enduring' or 'authentic' will and preferences (as might occur during a confusional state). The appropriate 'best interests' intervention in such cases would be to give expression to what has been determined to be the person's 'authentic' will and preferences. An advance statement made when the patient did

have decision-making capability (was able to express his preferences) would provide good evidence of what they would be.

Obviously there will be difficult cases. A 'tick-box', 'objective' or procedural approach will not be adequate to the task. Some form of 'interpretation' will be required,<sup>4,5</sup> but this can be tested by consulting others who know the person's values well, with recourse to a tribunal in the face of disagreements.

- 1 Kelly BD. An end to psychiatric detention? Implications of the United Nations Convention on the Rights of Persons with Disabilities. *Br J Psychiatry* 2014; **204**: 174–5.
- 2 Dawson J, Szmukler G. Fusion of mental health and incapacity legislation. *Br J Psychiatry* 2006; **188**: 504–9.
- 3 Szmukler G, Daw R, Callard F. Mental health law and the UN Convention on the rights of persons with disabilities. *Int J Law Psychiatry* 2014; **37**: 245–52.
- 4 Banner NF, Szmukler G. 'Radical interpretation' and the assessment of decision-making capacity. *J Appl Philos* 2014; **30**: 379–94.
- 5 Bach M, Kerzner L. *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*. Law Commission of Ontario, 2010 (<http://www.lco-cdo.org/en/disabilities-call-for-papers-bach-kerzner>).

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The editorial by Kelly<sup>1</sup> was thought-provoking for two reasons: the implication that the United Nations Convention on the Rights of Persons with Disabilities might prevent the detention and treatment of patients who are ill, and that there was a 'UK' Mental Health Act 1983 modified in 2007.

Fortunately, I had not missed a major legislative change. It remains the case that in Scotland the Mental Health (Care and Treatment) (Scotland) Act 2003 is the legislation under which care is given to those with mental disorder. The Mental Health (Northern Ireland) Order 1986 also remains. Thus there is no 'UK' mental health legislation. This may appear parochial but it is critically important when considering care and treatment in these legislative areas of the UK. As Kelly does not address the criteria for detention in Scotland or Northern Ireland, his attempt to raise the relevance of the UN Convention to UK mental health legislation is undermined: these criteria are considered here.

In Scotland there are broadly five criteria for civil detention: mental disorder; significant impairment of decision-making ability about medical treatment for mental disorder; a significant risk to the health, safety or welfare of the patient or the safety of any other person; it is necessary to detain the patient in hospital and medical treatment is available. There is thus a specific 'mental disorder' criterion which is defined in Section 328 of the Act as any: mental illness, personality disorder or learning (intellectual) disability 'however caused or manifested'. As mental disorder is a criterion, the UN Convention may require the Scottish Government to remove it in order to be compliant in the same manner as the UK Government would be required to do so for the legislation critiqued by Kelly.

Similarly in Northern Ireland the criteria for detention, although varying with different 'forms', include mental disorder of a nature or degree which warrants detention of the patient in hospital and when failure to detain would create a substantial likelihood of serious physical harm to the patient or to other persons. Thus in Northern Ireland the criteria for detention also include a mental disorder criterion which may be considered a disability under the UN Convention.

In view of the argument that neither of these acts comply with the definition of disability in Article 1 of the UN Convention, could this be used as grounds to challenge detention? At present,