



# How mental health law discriminates unfairly against people with mental illness

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### Conclusions

- Mental health law, as conventionally conceived, discriminates against those with a mental illness
- Its underlying assumptions stigmatise those people
- By building on the complementary strengths of capacity-based and civil commitment law, a 'fusion' model is proposed that applies to all persons who lack capacity, whatever the cause, or healthcare setting
- This proposal, unlike the MHA, I argue, is compliant with the UN Convention on the Rights of Persons with Disabilities



# How mental health legislation discriminates unfairly against people with mental illness

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## Summary

*Mental health legislation, as currently conceived in most jurisdictions, discriminates against people with a mental illness. It carries underlying assumptions that people with such illnesses are not fully autonomous and that they are dangerous to others. Thus such legislation reinforces damaging stereotypes of people with a mental illness. By building on the complementary strengths of capacity-based and civil commitment legislation, we propose a 'fusion' of legal principles into a model law which has decision-making capacity at its centre, but which clearly defines how the use of detention and force are to be governed. This comprehensive law is designed to apply to all persons who lack capacity, from whatever cause and in whatever healthcare setting. We have drafted a model law that demonstrates these principles can be given practical expression<sup>11</sup>. The model law, unlike the current MHA is, I would argue, compliant with the UN Convention on the Rights of Persons with Disabilities.*

## Introduction

There is probably no more unpleasant task for a psychiatrist than imposing treatment on an unwilling patient; and probably no experience for the patient that is more humiliating.

Yet, few would argue that involuntary treatment can never be justified. It is the nature of such justifications that I will talk about. I will argue that conventional forms of mental health legislation that govern involuntary treatment, such as we have in the Mental Health Act in England and Wales, discriminate unfairly against people with a mental illness. Indeed, I will maintain that there is no reason for any form of legislation specifically formulated for people with a 'mental illness'.

## How involuntary treatment is governed

In many jurisdictions, the circumstances in which medical treatment may be provided without the consent of the patient are governed, not by one set of legal principles, but by several distinct legal regimes. These different legal regimes tend to operate in parallel with different legal standards governing their use, and drawing upon different principles and rules.

England and Wales is an example. The involuntary treatment of so-called 'physical' conditions and the involuntary treatment of 'mental' conditions are governed quite differently – the former under the Mental Capacity Act 2005 (MCA), the latter under the Mental Health Act 1983 (MHA).

## Consider these two patients:

*Ms A is a 47 year old lady with Stage II cancer of the cervix. Her doctor recommends treatment involving radiotherapy combined with chemotherapy. He informs her that the likelihood of survival with treatment is around 60% at five years; without treatment it is less than 20%. Ms B decides that she could not tolerate the adverse effects following treatment, especially the nausea and vomiting, symptoms she has since childhood dreaded, and the fairly high likelihood of genitourinary complications, which she finds abhorrent. She rejects the treatment after a full discussion, where she clearly understands the consequences of not having treatment. Although, her life may be at stake, Ms B cannot be involuntarily treated.*

*Ms B is a 47 year old lady who has a 20 year history of schizophrenia. When ill, she has the delusion that she is related to the Queen and this leads her to some bizarre actions. She also neglects her physical care, to the point that her hair becomes so matted it cannot be combed out. She has had over 5 admissions in the past, always following discontinuation of her anti-psychotic medication; this, despite the fact that the medication is effective in alleviating her symptoms. On her last admission, following a good recovery from her illness, medication was discussed. She said she did not want to take it on a continuing basis. She understood the consequences of not taking it - the likelihood of relapse, the severity of the symptoms, and the likelihood of readmission, probably on an involuntary treatment order. However, she said that her sole social activity was membership of a sewing group, where she excelled in embroidery. All the antipsychotic medication she had tried, at least four different drugs, because of their neuromuscular side-effects, made it difficult for her to sew. She said she valued the social interaction more than remaining symptom-free. Under the MHA, she could nevertheless be lawfully placed on an involuntary treatment order.*

In the common law world, as in England, a mental incapacity (or adult guardianship) scheme, such as our MCA, tends to be the preferred legal vehicle for authorising involuntary treatment of general medical conditions. On the other hand, mental health legislation (or 'civil commitment') such as our MHA, tends to be the preferred regime covering the involuntary treatment of psychiatric disorders. Quite different legal criteria apply to use of the two schemes. The law governing involuntary treatment of general medical conditions usually relies mainly on the concept of the 'incapacity' or 'incompetence' of the patient to make necessary treatment decisions (a 'functional' criterion), plus the notion of the 'best interests' of the patient. The criteria governing involuntary treatment under mental health legislation will usually incorporate some concept of 'mental disorder' or 'mental illness', (a 'status' criterion) plus some notion of 'dangerousness' or 'risk' (to the patient or others).

I will argue these arrangements discriminate unfairly against people with mental disorders, by subjecting them to less favourable treatment under the law, and that this situation should be remedied.

### **How does mental health legislation discriminate?**

A patient with a 'physical disorder' such as Ms A may refuse treatment even if the disease is life-threatening. UK courts, and other common-law jurisdictions in western countries, set a very high value on the 'autonomy' of the individual (in the sense of being able to determine what shall be done to one's body). A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason even where the decision may lead to death. We accept this decision unless there is reason to believe that the patient's decision-making capacity is impaired. Paternalistic interventions in medicine (with the notable exception of psychiatry) that override the individual's autonomy are only allowed when 1. A patient lacks the mental capacity to make treatment decisions for himself or herself, and 2. Treatment is in the person's 'best interests'.

Capacity involves the patient's ability to understand and retain information about the nature of the treatment, why it is being proposed, and the consequences of accepting it or not, and to use and weigh up that information so as to arrive at a choice. The patient accepts that the information is relevant to his or her predicament, and is able to consider the consequences for his or her life, in the light of what is important for that person, of accepting or rejecting the proposed treatment. 'Best interests' attempts to determine what the patient might have chosen in this situation if he or she had capacity, based on past statements (as in an advance statement) or according to those who know the patient well. When a future period of incapacity is predictable, a patient may also appoint a person to take healthcare decisions on his or her behalf according to stated preferences or principles. The patient's values are thus accorded special weight.

### *The anomalous position of mental illness*

In contrast to the key role of impairment in decision-making capacity by patients with 'physical disorder', civil commitment or mental health legislation in most jurisdictions permits the detention and non-consensual treatment of those with 'mental disorder', such as Ms B, with the patient's capacity playing no role in decisions to initiate psychiatric treatment against a patient's wishes. The MHA allows involuntary treatment if the person is suffering from a mental disorder (very broadly defined); the disorder is of 'a nature or degree which makes it appropriate...to receive medical treatment'; and, treatment is 'necessary in the interests of the health or safety

of the patient or for the protection of other persons' (section 3).

Staying with the 'health or safety' of the patient for the moment, compared with the tests for those with 'physical disorders', the criteria for the involuntary treatment of 'mental disorders' fail to respect the autonomy of the patient. The patient's reasons for rejecting the treatment are not required to be explored (as they must be in determining capacity), nor, explicitly, is the question of whether treatment is in the best interests of the patient. The key considerations are the presence of a mental disorder and risks to the patient's 'health or safety', presumably from the perspective of the clinician or treatment team (or other representatives of society), not the patient's. But we accept that patients with physical disorders, provided they have capacity, can make decisions that may be seriously detrimental to their health or safety. For persons with capacity, their personal values are given dominion. Those with mental disorder are not accorded this privilege.

Why is this so? Why are there different rules? There seems to be an underlying assumption in legislation of this kind that 'mental disorder' necessarily entails mental incapacity or incompetence, so the question does not need to be asked, and that the values espoused by a person with a 'disordered mind' are not to be taken seriously in determining where their best interests lie. However, we know from excellent research studies that decision-making capacity is not necessarily impaired. Even in patients who are in a state of relapse and are at their most ill, that is who are admitted to a psychiatric hospital around half retain decision-making capacity.

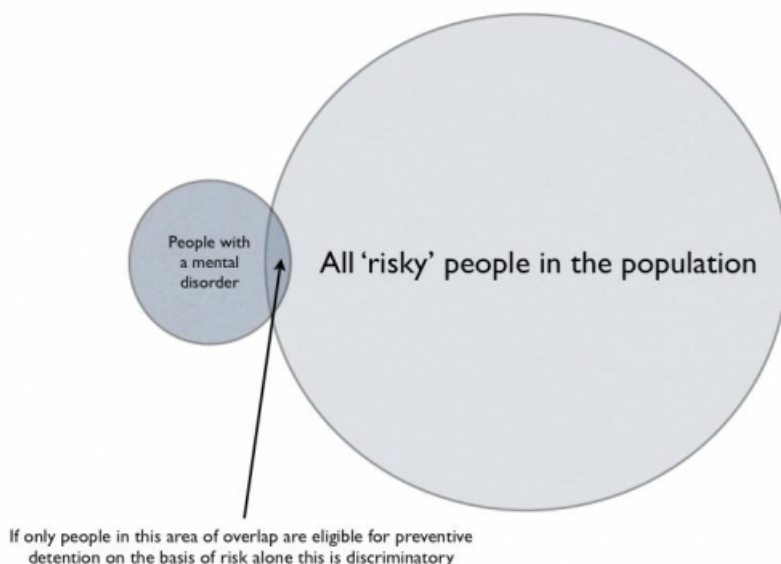
By failing to respect the mentally disordered patient's autonomy; by not presuming capacity unless there is reason for doubt; by assuming that mental disorder entails incapacity; and by enshrining these prejudices in legislation which applies uniquely to those with 'mental disorder', current mental health legislation discriminates against those with mental disorders and serves to stigmatise them. They are assumed to be not 'fully' persons with agency (or the capacity for self-determination).

## ***Treatment for the protection of others***

Mental health legislation usually confuses paternalism and the protection of others. They are quite separate ends; the former is concerned with the health interests of the patient and empowers others to act when the patient cannot act in his or her best health interests. On the other hand, protection of others turns on the risk of harm. This risk may not have much to do a patient's capacity to make treatment decisions.

Where does the discrimination lie in relation to the 'protection of others'? People with mental disorders are unusual in being liable to detention (in hospital) because they are assessed as presenting a *risk* of harm to others, but without having actually committed an offending act. This is best illustrated diagrammatically in Fig 1. Those in the larger circle might include, for example, habitual spouse abusers, those with short tempers - especially when intoxicated or provoked, or those who drive recklessly. Only those people in the area of overlap between the circles representing those with mental disorders and those who are judged 'risky' can be detained under legislation such as the MHA on the basis of risk, not on the basis of an offence. This constitutes a form of preventive detention to which our society, in other contexts, has had an aversion on civil liberty grounds. Such hospital disposals are available both under civil and forensic provisions of the legislation.

Fig 1 The relationship between mental disorder, risk and liability to preventive detention



Returning to Fig 1, let us imagine that everyone in the larger circle presents an equal level of risk – assuming that this can be accurately judged (which, incidentally, in reality it can't <sup>1</sup>). Why, as is commonly the case, should the person with a mental disorder in the overlap zone (who has capacity) be more liable to be detained on the basis of that risk than the person without a mental disorder? If preventive detention is to be allowed for the mentally disordered solely on account of their risk to others, if we are to avoid discrimination, so should it be for all of us. Thus fairness demands that all those presenting an equal level of risk to others (that is, all those in the larger circle in Fig 1) should be equally liable to detention. This of course amounts to a generic dangerousness or preventive detention provision against which many will recoil. But the principle of non-discrimination requires that either we have generic legislation applicable to all of us; or that we have no preventive detention for anyone, including those with mental disorder. Under such a form of legislation, once having exceeded the acceptable threshold of 'risk', an intervention would occur, which might be psychiatric treatment, if appropriate, for those with a mental disorder, or other interventions including a custodial sentence for those are not.

A mentally ill person *with* capacity should not be treated involuntarily on account of risk to others. By definition, such a person understands the consequences and risks that their illness entails and takes responsibility for them. But I am not arguing that risk to others is not important. If a patient *lacks* capacity and treatment is in his or her 'best interests', non-consensual treatment is, on the account I am giving, entirely justified. For such a person without capacity the risk to others would be taken into account in a 'best interests' consideration and might prompt particularly urgent action to ensure the safety of the patient and others.

Why has this discriminatory situation in relation to the protection of others arisen and why is it so rarely challenged? It presumably reflects deeply ingrained fears of the mentally ill and stereotypes of dangerousness that are so inherent in 'folk' notions of mental illness that their uncoupling is not even thought about.

But this is a dangerous situation. There is a tendency for societies to try to expand the 'mental disorder' circle to include people with various socially undesirable behaviours. This potential was clearly demonstrated in Home Office proposals under which the application of a state-defined, not medically defined, 'diagnosis' ('dangerous severe personality disorder'<sup>2</sup>) and an ascription of risk was argued to be sufficient to detain someone, even in the absence of a previous violent offence or the possibility of effective treatment. Persons with mental disorder do not receive the protections from preventive detention that the rest of us do. In a risk-averse society like ours, the potential for broadening the scope of 'mental disorder' and 'risk' is troubling.

*What about violence and mental illness?*

Some people suggest that the association of mental disorder with violence makes mental illness not comparable

to physical illness when thinking about appropriate laws. At this point let me digress slightly and make some comments on the relationship between mental illness and violence. Dangerousness may be a consequence in a small minority of patients of having a mental illness. The risk, in the absence of alcohol or substance misuse, or of an antisocial personality – that is, someone who has a propensity to commit antisocial acts - is modestly, if at all, raised<sup>3,4</sup>. People with severe mental disorder perpetrate only a small fraction of serious violence in our society, less than 5%<sup>5,6</sup>. Violence is no more predictable in those with a mental illness than in those without. Nor is the propensity for violence clearly more ‘treatable’ in those with a mental illness. It is quite possible, for example, that psychological or group interventions to reduce violence, such as ‘anger management’ for violent persons who are not mentally ill, such as spouse abusers, may be more effective than interventions for violence in those who are mentally ill. Justice demands that all people who are equally risky should be treated equally, and be equally subject to preventive measures that a society may see as appropriate.

## ***Compulsory treatment in the community***

As the locus of treatment has shifted from hospital to community and concerns about non-adherence to treatment have grown, many jurisdictions have introduced involuntary treatment in the community. This has been a controversial measure. If a patient lacks capacity and treatment is in his or her best interests (and can be given effectively and safely), my analysis suggests no ethical objection to the treatment being given in the community rather than in a hospital. But non-consensual treatment should end when the patient recovers capacity.

Following on from the earlier discussion of ‘protection of others’, involuntary treatment in the community for patients with capacity for the protection of others is unjustified on any health interest basis. This is especially important given increasing expectations from the public that they should be protected from disturbing persons whom they see as threatening.

Thus I conclude that conventional mental health legislation, as in England, discriminates against people with mental disorders. It reflects stigmatising stereotypes. Autonomy (or the right to self-determination) is not respected; preventive detention is unfairly applied to this group. The ‘two-track’ approach, one set of rules for the mentally disordered and another for the rest of medicine is inconsistent with the principles of health care ethics and with basic notions of human rights, especially freedom from unnecessary discrimination in the law. Some other form of legislation is thus required.

## **Recent history of mental health legislation in England and Wales**

Given the case that I have presented, it is bitterly disappointing that the reform of mental health legislation under the stewardship of the previous government paid scant regard to the discriminatory nature of mental health legislation in this country. An important opportunity for significant reform was lost.

A protracted process, commencing in 1998 and lasting almost decade, saw an important and potentially ground-breaking initial report from the Richardson Committee<sup>7</sup> whose recommendations were nearly all rejected. Then followed Green and White Papers and two Draft Mental Health Bills, both of which were eventually withdrawn. The final result was, in 2007, the passing of a number of amendments to the existing Mental Health Act 1983, the most significant of which was the introduction of an order enabling compulsory treatment in the community. Criticisms of the Government’s proposals were vociferous and sustained, uniting in opposition virtually every stakeholder group in the mental health field – including patients, the Royal College of Psychiatrists, lawyers, nurses, and social workers: a feat probably never achieved previously anywhere in the world! Most critics saw the proposals, draft bills and amendments as privileging public protection at the expense of promoting the health interests of patients.

The inclusion of a capacity or impaired-decision-making criterion received strong support from most of the stakeholders and two parliamentary committees but was resisted by the government. The issue of capacity was highlighted by a fortuitous circumstance. At the same time as the mental health law reform process was progressing, so was legislation governing the treatment of people who lacked the capacity to make decisions for

themselves, culminating in the passing of the Mental Capacity Act 2005 (MCA). As the name indicates, the central requirement justifying involuntary treatment is impaired mental capacity, but for those with a mental disorder, its application is 'trumped' by the MHA.

So we now have two forms of legislation governing the involuntary treatment of people with a disturbance or impairment of mental functioning, which embody entirely different principles and rules. The MCA covers all persons with impaired decision-making capacity - including that due to 'mental disorder' - except those with 'mental disorder' who fall under the MHA, where the MHA 'trumps' the MCA. As I have already mentioned, why mental capacity should be central to one legal scheme but not the other, has never been made clear. Furthermore, deciding which legal regime is appropriate for a particular patient at a particular time can be very confusing. A patient who lacks capacity and has both a mental disorder and a physical disorder will come under both regimes with one set of rules governing the treatment of the mental disorder and another the physical disorder. You can imagine how even more confusing the situation can become when the physical disorder contributes to the mental disorder, or vice-versa, not uncommon situations.

### **A solution to the discrimination: the 'Fusion Law' proposal**

It is because mental health legislation discriminates in the manner I have discussed, that Professor John Dawson, a professor of mental health law in New Zealand and I have proposed a single law in which there would be no need for specific reference to 'mental disorder'<sup>8</sup>. Nor would there be any need for a separate legal regime focused solely on involuntary psychiatric treatment. We propose one comprehensive involuntary treatment regime based on a capacity test like that in the MCA; one that requires us to assess the ability of a person to understand, recall, use, and weigh relevant treatment information, and to communicate a treatment decision.

In our view, there is little evidence that impairment of patients' capacity differs in any essential respect in mental and physical disorders. In both cases, some impairment or disturbance of mental functioning is the cause of the patient's incapacity, and we believe legal criteria that are sufficiently inclusive to cover the full range of situations can be devised. We have therefore made proposals for the design of such a comprehensive involuntary treatment statute for England and Wales, and (with Dr Rowena Daw) we have now drafted a model law to show that those proposals can be given practical expression<sup>9</sup>.

This scheme would govern the treatment without consent of all medical conditions, in all healthcare settings, avoiding the problematic distinction between 'physical' and 'mental' disorders. These proposals recognise that many people with mental disorders retain their capacity to consent to treatment; and that the law already requires the capacity of people with mental disorders to be assessed for many purposes, including their capacity to manage property, make a will, drive a car, stand trial, and so on. Our aim is to reduce discrimination against people with mental disorders by not making psychiatric treatment, unnecessarily, the subject of special legislation, and, instead, to apply consistent principles concerning involuntary treatment across all fields of medical law.

One might think that something like the MCA, alone, might suffice for all patients who lack decision-making capacity. However, it is not adequate in its current form. The MCA's strength in giving due weight to the patient's autonomy when capacity is retained is, however, counterbalanced by a number of weaknesses. These lie in the lack of sufficient attention to powers governing emergency treatment, forced treatment and detention in hospital. For example, in the MCA, one section only (out of 69 in total) deals with the use of force: 'restraint' is permitted when it is a 'proportionate response' to the 'likelihood of the patient suffering harm' and the 'seriousness of that harm'. But detention and the use of force are exactly those areas in which civil commitment schemes, such as the MHA, are strong. The use of force and the detention in relation to objecting patients is clearly authorised and regulated by mental health legislation - who can authorise the detention, for how long, where it may occur, how it should be monitored, appeals, and so on - but not in the MCA.

It is rarely pointed out that the lack of clarity in these areas in capacity-based legislation may pose a problem for the treatment of patients with non-psychiatric 'physical disorders' who object to treatment. Patients who object to treatment but who do not suffer from a 'mental disorder' (as defined under the MHA) are not uncommonly treated under the MHA - wholly inappropriately - because of a reluctance by clinicians to use force unless they can rely on clear statutory authority of this kind. Psychiatrists are not uncommonly pressured by police,

ambulance, or surgeons to use the MHA on objecting patients where the treatment is for a physical disorder. Other objecting patients with a physical illness who lack capacity and who might benefit from a treatment may not be treated at all. This lack of clarity around the use of force may in such instances incline clinicians to use a low threshold for concluding the patient retains capacity to refuse treatment. We therefore advocate a legal regime that retains the strengths of both incapacity and civil commitment, but still relies squarely on the incapacity of the person to make necessary care or treatment decisions, in association with a 'best interests' test, as the key justification for intervention in their life. The 'fusion' proposal thus builds on the strengths of the two existing regimes.

It may have occurred to you that Dawson and I could have proposed an alternative form of non-discriminatory legislation - that is, the application of the rules governing mental health legislation to all persons with any kind of medical disorder. But, imagine your reaction to being told by your doctor that although you have elected (with capacity) not to have a proposed treatment for a physical disorder, he or she has decided that you will have that treatment because in his or her opinion your illness warrants treatment and that it is in the interests of your health or safety or for the protection of others that you have it. I doubt that many, if any, would find that an acceptable state of affairs.

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

I believe that our 'fusion' proposal is consistent with another set of considerations, not yet clearly articulated when we originally proposed the Fusion Law. These concern the rights of persons with disabilities.

The UN Convention on the Rights of Persons with Disabilities (CRPD) was passed by the General Assembly of the United Nations in December 2006. It has now been signed by 140 countries and ratified by 60, including the UK.

The CRPD comprises the classic set of liberal or political rights - such as the right to liberty (art 14), integrity of the person (art 17), and freedom from torture and inhuman treatment (art 15) - and it also includes the human rights that have come into prominence since WW2 - such as the right to home and family life (art 23), and rights to health (art 25). But also included are more recently elaborated 'socio-economic rights', especially relevant to people with disabilities: the right to independent living and community inclusion (art 19), the right to work and employment (art 27), and the right to be free from exploitation and abuse (art 16).

Long-term mental illness, at least, is clearly included under the rubric of a disability. The CRPD is especially challenging (through articles 12 and 14 concerning 'legal capacity' and the right to liberty) in its implications for involuntary treatment. The Office of the UN High Commissioner for Human Rights sees the implications, as applying to psychiatric detention, thus:

*[48.] ... Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". Proposals made during the drafting of the Convention to limit the prohibition of detention to cases "solely" determined by disability were rejected. As a result, unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14.<sup>10</sup>*

Some commentators maintain that involuntary treatment of a person with a disability is effectively excluded under the CPRD even for those whose capacity is impaired, and that support for the person in clarifying and achieving their preferences is the appropriate model. However, it is difficult to see how one could entirely eliminate the need for involuntary treatment for those who lack decision-making capacity and where it would be clearly in their best interests. I know of no society that does not accept this position as morally justified.

What conditions then would need to be met for involuntary treatment to be justified under the terms of the



CRPD? The following appear key:

1. There must be 'respect for inherent dignity and individual autonomy including the freedom to make one's own choices' (as stated in Art 3).
2. There must be no 'discrimination of any kind on the basis of disability' (Art 4).
3. Persons must 'enjoy legal capacity on an equal basis with others in all aspects of life' (Art 12).

Clearly mental health legislation as exemplified by MHA does not meet the requirements of the CRPD. Involuntary treatment is based on 'status', that is, suffering from a 'mental disorder' – that is, a form of disability under the terms of the CRPD, coupled with a 'risk' criterion - posing a danger to himself or herself or to others. Furthermore, involuntary treatment can be given without taking into account the patient's autonomy (or decision-making capacity). It is precisely this form of legislation that the UN High Commissioner for Human Rights was referring to when he went on to call for:

*[49] "..... the repeal of ..... provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness".*

Recall that under the comprehensive legal scheme we propose in the Fusion Law, that the loss of decision-making capacity is the necessary entry criterion to consideration for involuntary treatment. But how does such an impairment in capacity relate to the notion of 'disability'?

An impairment of decision-making capacity is in the vast majority of cases specific to a particular decision, and is not long-term. It may occur in any person, whether they have a (pre-existing) disorder causing a disability or not. A fit young person who suffers a head injury causing a confusional state following a road traffic accident may lack capacity to make treatment decisions; as may an elderly person with normally good cognitive functioning but suffering from a chest infection. To term the lack of capacity in these cases, a 'disability' stretches the meaning of the term well beyond common usage. There is thus good reason to separate impaired capacity from 'disability' even though both may be present at the same time. The key point is that in most cases, they occur separately, and are conceptually distinct.

Important in relation to the CRPD is the fact that the 'fusion law' applies to all persons, no matter what the cause of the impairment of capacity, whether it is a 'mental disorder' or 'physical disorder'. You will recall that our proposal for a single statute is driven by the intention to avoid discrimination. An impairment of capacity is an event that may be suffered by any person, whether they have a pre-existing disability or not.

I do not have the time to discuss the Fusion Law proposal further. A more detailed account can be found in the references below, including a draft of a 'model law' to demonstrate that it is possible to give practical expression to the principles underlying the fusion concept and its applicability across all patient groups and settings <sup>8,9</sup>.

## **Conclusions**

Mental health legislation, as currently conceived in most jurisdictions, discriminates against people with a mental illness. It carries underlying assumptions that people with such illnesses are not fully autonomous and that they are dangerous to others. Thus such legislation reinforces damaging stereotypes of people with a mental illness. By building on the complementary strengths of capacity-based and civil commitment legislation, we propose a 'fusion' of legal principles into a model law which has decision-making capacity at its centre, but which clearly defines how the use of detention and force are to be governed. This comprehensive law is designed to apply to all persons who lack capacity, from whatever cause and in whatever healthcare setting. We have drafted a model law that demonstrates these principles can be given practical expression<sup>11</sup>. The model law, unlike the current MHA is, I would argue, compliant with the UN Convention on the Rights of Persons with Disabilities.

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