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


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 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. 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 have.

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, 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.


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