

Correspondence

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

Brendan Kelly's editorial¹ 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.^{2,3} 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,^{4,5} 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 Kelly¹ 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,

the Convention is not legally binding on UK domestic legislation but places obligations on the government to ensure its laws are compliant.² Complaints can be made to the UN commissioner where people with a disability feel that the Convention is not being appropriately implemented. It was not possible to determine whether any complaints had been received as a result of this definition.

In conclusion, the UK, in the sense of all three legislative areas, may receive a similar criticism to Spain from the UN Committee on the Rights of Persons with Disabilities when it reports,³ but it remains to be seen whether this will lead to widespread change in mental health legislation.

- 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 Office for Disability Issues, HM Government. *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities*. Office for Disability Issues, 2011.
- 3 Committee on the Rights of Persons with Disabilities. *Concluding Observations of the Committee on the Rights of Persons with Disabilities: Spain*. United Nations, 2011.

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Author's reply: I agree with Szmukler that the 'fusion law' proposal would help shift detention criteria from the presence of mental disorder to the absence of decision-making capacity, and that a revised version of 'best interests' would be useful. In this context, it is interesting that the expert committee charged with advising the government on revising the Mental Health Act 1983 found that only a 'small minority' believed that 'a mental health act should authorise treatment in the absence of consent only for those who lack capacity' and 'if a person with a mental disorder who refused treatment was thought to pose a serious risk to others then he or she should be dealt with through the criminal justice system, not through a health provision'.¹ There was, however, 'a much larger body of opinion which was prepared to accept the overriding of a capable refusal in a health provision on grounds of public safety in certain circumstances'. Notwithstanding this matter, I broadly agree with Szmukler that the 'fusion law' proposal would help move matters in the direction of greater compliance with the UN Convention on the Rights of Persons with Disabilities (CRPD).

Bennett's letter is also very constructive. His consideration of mental health legislation in Scotland and Northern Ireland clearly indicates that neither of those jurisdictions meets some of the apparent requirements of the CRPD, and provides further support for my conclusion that there is little evidence that the UK 'is ready for such profound change'.² Ireland, incidentally, has recently made some progress towards greater compliance with the CRPD, with the publication of the Assisted Decision-Making (Capacity) Bill in 2013.³ There is, nonetheless, more work to be done in Ireland, as there is in England, Wales, Scotland, Northern Ireland and elsewhere, if the robust declarations of the CRPD are to generate meaningful and realistic protections for the full range of rights of people with mental illness.

- 1 Expert Committee. *Review of the Mental Health Act 1983*. Department of Health, 1999.
- 2 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.

- 3 Kelly BD. The Assisted Decision-Making (Capacity) Bill 2013: content, commentary, controversy. *Ir J Med Sci* 2014. Epub ahead of print (<http://dx.doi.org/10.1007/s11845-014-1096-1>).

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The significance of copy number variations in schizophrenia

Rees *et al*¹ seek to replicate the association with schizophrenia of copy number variants (CNVs) involving putative schizophrenia loci in a large case-control study. They conclude that 11 of the 15 previously implicated loci were strongly associated with schizophrenia. The odds ratios of these CNVs relative to schizophrenia range between around 2 and >50. The authors suggest that the findings now indicate a need for routine screening for CNVs.

However, I think there are grounds for reservations about the implication of these findings for the generality of cases of schizophrenia, both at the population level and in terms of public health initiatives. The authors report that one or more of the identified CNVs was present in 2.5% of the case group and in 0.9% of the control group. Let us assume that the prevalence of schizophrenia in the general population is around 0.5%, as reported in the British National Psychiatric Morbidity Surveys.^{2–4} From this it is possible to calculate that, for every one person with schizophrenia who has one of these CNVs, there would be around 72 in the unaffected population. The positive predictive value (PPV) is the proportion of positive results of a test that are truly positive, and the PPV equivalent to these data can be calculated at 1.37%: in other words, this is the probability that someone with one of the identified CNVs has schizophrenia. If we change the assumed prevalence of schizophrenia to 1%, the PPV rises to 2.73%. The authors say: '[g]iven their frequency, these findings therefore suggest that routine screening for CNVs should be made available and that the results will have immediate implications for genetic counselling, and given their comorbidity with other medical disorders, for patient management as well'. However, in my view, these values for PPVs make this conclusion questionable.

It is also of interest to use the authors' data to calculate the population attributable fraction (PAF): this is the notional amount by which the prevalence of an outcome would be reduced if the particular exposure were completely removed from the population. It reflects both the frequency of the given exposure and the strength of its effect. Using these data and, as before, assuming a prevalence of 0.5%, the PAF is 0.618%. If we assume a prevalence for schizophrenia of 1%, this index changes very little, to 0.622%. This is not a large value: we found a PAF of 14% for the link between psychosis and non-consensual sexual intercourse before the age of 16,⁵ whereas a meta-analysis by Varese *et al*⁶ suggests that the PAF for all forms of childhood adversity in schizophrenia is 33%.

The practical implications of CNVs in schizophrenia are thus in some doubt.

- 1 Rees E, Walters JTR, Georgieva L, Isles AR, Chambert KD, Richards AL, et al. Analysis of copy number variations at 15 schizophrenia-associated loci. *Br J Psychiatry* 2014; **204**: 108–14.
- 2 Meltzer H, Gill B, Petticrew M. *The Prevalence of Psychiatric Morbidity among Adults Aged 16–64, Living in Private Households, in Great Britain*. Office of Population Censuses and Surveys, Social Surveys Division, 1994.
- 3 Singleton N, Bumpstead R, O'Brien M. Psychiatric morbidity among adults living in private households, 2000. TSO (The Stationery Office), 2001.
- 4 McManus S, Meltzer H, Brugha TS, Bebbington PE, Jenkins R (eds) *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*. NHS Information Centre for Health and Social Care, 2009.