“The Fusion Hypothesis: A Panacea for Mental Health Law? A critical investigation into the proposals for combined mental health and mental capacity legislation.”

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Contents

ABSTRACT:....4
DECLARATION:....5
COPYRIGHT STATEMENT....5
Dedication....6
Acknowledgements....6
The Author....6
Introduction....7
Chapter One: The Fusion Hypothesis....13
1.1 Introduction....13
1.2 The Broad Fusion Approach....14
1.3 Capacity relevant legislation....16
1.4 Discrimination in Mental Health Law....24
1.4. (i) The Need for Separate Legislation....26
1.5. Is Fusion the way forward?....29
1.6. Specific Models of the Fusion Approach....32
1.6. (i) Northern Ireland: The Bamford Review....32
1.6. (ii) Szmukler, Daw and Dawson's 'Model Law'....35
1.7. Limitations of Fusion on a Broader Scale....38
1.7. (i) Forensic Patients....38
1.8. Conclusion:....45
Chapter Two: The Relationship between Autonomy, Capacity and Fusion. Will autonomy be enhanced?....47
2.1. Introduction....47
2.2. What is autonomy?....48
2.3. What do fusionists say about autonomy and capacity?....52
2.4. Decisional Capabilities....54
2.4.(i): Appreciation....55
2.4.(ii) Communicating....59
2.4.(iii) Understanding....63
2.5. When can autonomy and capacity be trumped?....64
2.5.(i) The Interests of Others....67
2.5(ii) Patients are 'Not Fully Autonomous'....71
2.5.(iii) Maximisation of Individual's Long Term Interests....74
2.6. Conclusion....78

Chapter 3: The Fusion Hypothesis and Discrimination 81
3.1 Introduction 81
3.2. What are fusionists arguing for? 82
3.3. What is equality? 84
3.3.(i) Should mental health legislation be aiming for formal equality? 85
3.4 What are the justifications for not upholding formal equality? 91
3.4(i) Differential treatment 92
3.4 (ii) The 'Harm' Argument: 94
3.4(iii) Not all decisions deserve respect 104
3.5. Conclusion 108
Conclusion: Moving Forward with Fusion 110
A Cautionary Tale from the CRPD? 111
BIBLIOGRAPHY 123
Articles**:** 123
Books: 130
Statutes: 135
Government Reports 135
Cases 137

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ABSTRACT:

"The Fusion Hypothesis: A Panacea for Mental Health Law? A critical investigation into the proposals for combined mental health and mental capacity legislation."

The current mental health legislation continues to be criticised due to the lack of relevant decision-making criterion, such as the use of capacity assessments in regards to compulsory treatment of persons with mental illness and the continued discriminatory nature of the legal frameworks towards those with mental illness. This has lead to increased attention from the proposals of those wishing to reform the law. One such approach that has gained momentum is that of the fusion hypothesis. A fusionist approach to mental health law reform would signal the start of a major paradigm shift in the way in which patients with mental illnesses were to be treated. Fusionist suggestions offers to enhance patient autonomy and eradicate discrimination by introducing capacity-based thresholds into a single piece of legislation allowing both persons with mental illness and those with physical illness to be treated under the same legal framework. This approach would therefore combine mental health legislation with mental capacity legislation to create a unified decision-making legal regime.

Fusion offers a patient with mental illness the opportunity to decide for themselves how to be treated using non-discriminatory mental health law and could be particularly attractive to patients, who are liable to be detained under the current mental health legislation, as this approach would seek to give them decision-making rights which they currently do not have.

The fusion hypothesis is therefore in need of further investigation; focussing on its claims that it will indeed enhance autonomy and reduce discrimination. To do this capacity relevant legislation will be assessed and its links to autonomy will be discovered. It will be shown that the relationship between these two concepts are not as straightforward as fusionists purport.

Following this it will be established that when fusionists talk of non-discrimination what they are really arguing for is 'formal equality' and it will be established that in certain circumstances it may be legitimate to continue with differential treatment of even those with capacity.

The thesis will conclude with an examination of the impact of the United Nations Convention on the Rights of Persons with Disabilities providing the fusion hypothesis with a caution as it moves forward.

DECLARATION:

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Dedication

To my Mum and Dad, who have helped me immensely throughout the last three years.

Acknowledgements

I am very grateful to the people who have helped me complete this thesis.

Firstly I would like to say a massive thank you to Kirsty Keywood and Neil Allen for helping me throughout what has been a very tough three years. I would never have got this finished if it wasn't for your guidance, advice and belief in me that I could get it done.

Secondly, I would like to thank my partner, Matthew who has had to put up with me for the last three years, toiling away and especially for looking after me so well when I spent six weeks in bed due to a badly broken ankle in the latter stages of my research.

And finally, my Mum and Dad who have helped me every step of the way, not just in this thesis but in every aspect of my life. Thank you. I just hope you have space on your bookshelves for this.

The Author

My interest in law began at college where I studied for my A Level in Law. This continued at the University of Leicester where I gained my Law LLB and this is also where I began to study the law surrounding health care. I received my Health Care Ethics and Law MA at the University of Manchester a few years later, which stoked my interest in mental health law. Thus why I began the journey into research into the mental health legislation. This thesis is my only piece of research other than my dissertation into Involuntary Sterilisation for my MA.

Introduction

The notion underpinning the fusion approach to mental health care is that instead of continuing with two pieces of legislation, in the form of a separate Mental Health Act 1983(MHA 83) as amended by Mental Health Act 2007 (MHA 07) and the Mental Capacity Act 2005 (MCA 05) there should be an amalgamation, or fusion, of them into a single piece of legislation. Despite decades of consultation[1] and reform[2] it is still felt by fusionists that the mental health legislation is out dated and does not give people with mental illnesses the same chances to exercise their autonomy. This has lead to increasing interest in suggestions to fuse mental health and mental incapacity legislation by introducing capacity-based threshold into medical decision-making which not only governs general medicine but also the psychiatric sphere.[3] The fusionist approaches suggest current mental health legislation restricts patient autonomy and unjustly discriminates against patients with mental illness and thus believe their vision of law making will therefore increase patient autonomy, whilst simultaneously reducing discrimination. This thesis will endeavour to determine the validity of these claims.

[1] "*Reform of the Mental Health Act 1983: Proposals for Consultation*," (London: The Stationery Office, 1999).; Genevra. Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*," ed. Department of Health (London1999).; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*," (2007).; "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume I, Report, together with formal minutes and annexes," ed. House of Lords/ House of Commons.; "Joint Committee on Human Rights. Legisaltive Scrutiny: Mental Health Bill. Fourth Report of Session 2006-2007," (2007); "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume II, Oral and Written Evidence," ed. House of Lords House of Commons; "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume III Written Evidence," ed. House of Lords/House of Commons. ."*Mentally Incapacitated Adults and Decision-Making: An Overview*," ed. The Law Commission (London: HMSO, 1991); "Joint Committee on Human Rights. Legisaltive Scrutiny: Mental Health Bill. Fourth Report of Session 2006-2007."; "*Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*," ed. The Law Commission (London: HMSO, 1993).; "*Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*," ed. The Law Commission (London: HMSO, 1993).; "*Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*," ed. Lord Chancellor's Department (London: The Stationery Office, 1997).;

[2] Mental Health Act 1983; Mental Health Act 2007

[3] J. Dawson and G. Szmukler, "Fusion of mental health and incapacity legislation," *British Journal of Psychiatry* 188(2006).; George Szmukler, Rowena Daw, and John Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation," *Journal of Mental Health Law* Special Edition(2010).; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*.";

A concern of fusionist approaches is whilst capacity is becoming a key threshold concept in general medicine through the introduction of the MCA 05; the concept has yet to be fully integrated into the MHA 83.[4] When considering the fusion approach, which includes a capacity-based criterion, assessing capacity relevant legislation becomes essential. The House of Lords Select Committee recently conducted an inquiry looking into whether the MCA 05 had been successful[5] and sheds some light onto how capacity-based tests may be received. Some witnesses felt it was a progressive Act which balanced protections and empowered people[6] and shifted the focus towards patient choice, control and self-determination.[7] They explained the use of capacity as a threshold concept allowed persons with decision-making capacity to make their own decisions without third party interference. However some questioned the use of capacity in its current form. Kirsty Keywood suggested we need to think carefully about how we balance empowerment yet

[4] Dawson and Szmukler, "Fusion of mental health and incapacity legislation.";also, George. Szmukler and Frank. Holloway, "Mental Health Legislation Is Now Harmful Anachronism," *Psychiatric Bulletin* 22(1998). Anthony. Holland, "The model law of Szmukler, Dawson and Daw- the next stage of a long campaign?," *Journal of Mental Health Law* Special Edition(2010).; G.S. Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge," *Inquiry* 52, no. 1 (2009).; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."; G. Richardson, "Balancing autonomy and risk: A failure of nerve in England and Wales?," *International Journal of Law and Psychiatry* 30, no. 1 (2007).; Genevra Richardson, "Mental capacity at the margin: the interface between two acts," *Medical Law Review* 18, no. 1 (2010).

[5] House of Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.1/Heard in Public/Q's 1-24*," ed. Select Committee (2013).; House of Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.2/Heard in Public/ Q's 25-44*," ed. Select Committee (2013).; House of Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence No.3/ Heard in Public/ Q's 45-73*," (2013).; House of Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.4/ Heard in Public/ Q's 74-105*," (2013).; House of Lords, "*Unrevised transcript of evidence taken before the Select committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence No.5/ Heard in Public/ Q's 100-125*," (2013). Neither the Members nor witnesses have had the opportunity to correct the record in any of these reports.

[6] Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.1/Heard in Public/Q's 1-24*." Nick Goodwin p2; see also, Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.2/Heard in Public/ Q's 25-44*." Kirsty Keywood p5

[7] Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.1/Heard in Public/Q's 1-24*." Claire Crawley p4

still provide protection for vulnerable persons;[8] as well as considering the removal of the diagnostic threshold of capacity in order to simplify the MCA 05 test.[9] This illustrates it is increasingly difficult to ignore the value of using the concept of capacity within mental health legislation and adds credence to the calls from fusionists to include such a threshold in subsequent mental health legislation. However coming to a consensus on how the concept should be defined and used in practice still causes problems for academics and clinicians alike and is why this thesis will investigate the use of capacity relevant legislation in a fusionist framework.

It was interesting to see in the evidence of the Select Committee that although questions were raised as to whether the relationship between the MCA 05 and the MHA 83 was fully understood and whether a unified approach would be helpful;[10] there was no mention of a fusion approach being implemented. This may simply be down to lack of time or trying to remain focussed on the intent of the report or it may point to a waning interest in such approaches. Therefore this thesis will endeavour to investigate if fusion is still an appropriate framework to implement.

There is also a pressing need to further understand the various perceptions of capacity-based tests and autonomy that exist amongst fusion approaches. Research to date about medical decision-making has tended to focus on the introduction of capacity-based tests and how this will enhance patient autonomy. Much of this research focuses on patients without mental illnesses and deals more with cognitive based capacity-based tests therefore tending to address problems which may not necessarily be tailored to the psychiatric

[8] Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.2/Heard in Public/ Q's 25-44*." Kirsty Keywood p5
[9] Ibid. Kirsty Keywood p31
[10] Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.1/Heard in Public/Q's 1-24*." Lord Alderdice p38-39 Q23

sphere.[11] The majority of literature discussing the fusion of the law claims it is imperative no-one be treated without consent;[12] however some fusionist approaches continue to provide exceptions to this rule for forensic psychiatric patients.[13]

There has also been little discussion about the concept of discrimination and the fusion approach. Much of the literature regarding fusionist proposals simply state it is discriminatory to treat people differently; without any real explanation as to the definition of discrimination or whether this in itself is justifiable or unlawful. The fusionists tend not to discuss the concept in much detail and this thesis aims to answer what it is the fusionists are actually talking of when they discuss discrimination, and whether ultimately fusion will make legislation fairer for persons with mental illnesses. The importance of "parity of esteem[14]" was highlighted by the Health Committee of the House of Commons who were reporting on and assessing the statutory amendments to the MHA 83 by the MHA 07.[15] They explained the care needs of mental health patients should have equal priority with the needs of patients with physical health needs and concluded unless this was prioritised within the NHS it would "continue to be a meaningless aspiration."[16] This demonstrates the continued need of research into the possibility of a unified non-discriminatory approach to the mental health law.

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[11] Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge."p81; see also, Jacqueline. M. Atkinson and Hilary. J. Patrick, "Balancing autonomy and risk: the Scottish approach," *Journal of Mental Health Law* Special Edition(*2010*). p80; see for further discussion about the ethics of psychiatry, Rem.B. Edwards, *Ethics of Psychiatry: Insanity, Rational Autonomy and, Mental Health Care* (New York: Prometheus Books, 1997).

[12] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."; Eric. Matthews, "Mental and Physical Illness-An Unsustainable Separation?," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing, 1999).; Stephen. Rosenman, "Mental Health Law: An Idea Whose Time Has Passed," *Australian and New Zealand Journal of Psychiatry* 28(1994).

[13] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."p 14; George. Szmukler, Rowena. Daw, and John. Dawson, "Response to the Commentaries," *Journal of Mental Health Law* Special Edition(2010).p 94-96; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."

[14]Health Committee House of Commons, "*Post-legislative scrutiny of the Mental Health Act 2007. First Report of Session 2013-2014: Report, together with formal minutes, oral and written evidence.*," (London2013). p13

[15] Ibid.

[16] Ibid. p14

Overall, the purpose of this thesis is to develop an understanding of the underlying premise of fusion approaches to law reform and to examine whether capacity-based thresholds are appropriate for use in the psychiatric sphere. The thesis will aim to establish the links between capacity and autonomy within mental health law and investigate the concepts of discrimination and equality in relation to fusionist approaches. The central questions this thesis asks are firstly, will capacity-based thresholds in a fused piece of legislation enhance patient autonomy? Secondly, will a fusion law reduce the discrimination patients with mental illnesses face?

To do this the thesis is exploratory in nature, with in-depth analysis of the suggestions of fusionists and capacity advocates in regards to the reform of current mental health legislation. The past reforms have been assessed, along with those of current frameworks in other jurisdictions, along with large amounts of literature from government reports and consultations. Decision-making frameworks in relation to adult patients will be examined as it is beyond the scope of this thesis to examine the decision-making frameworks for children. Further limitations of this study are that a full examination of the principles contained within the Convention on the Rights of Persons with Disabilities (CRPD) cannot be provided as this is also beyond the scope of the thesis. However it has been discussed in the conclusion to provide a caution to fusion as it moves forward.

The overall structure of the study takes the form of five chapters, including this introductory chapter. Each chapter has its own theme. Chapter one is based upon discussions surrounding what the fusion hypothesis is and what their key edicts are. This lays out the theoretical dimensions of the research and sets out the research questions. Chapter two examines the claims of fusion approaches which argue decision-making capacity is strongly linked with autonomy and thus the introduction of such tests into legislation would therefore ensure patient autonomy was not only protected but enhanced.

It continues to question how this would happen and questions whether there are justifiable situations where the autonomy of patients can be overruled. Chapter three examines the concept of discrimination in relation to the fusion approaches and discovers fusionists may in fact be trying to ensure formal equality, rather than any real sense of non-discrimination. A discussion surrounding the risk of harm and separate treatment for those with mental illnesses and those without is also examined in this chapter. Finally, the conclusion gives a brief summary of findings and offers a caution to fusion in regards to the CRPD. If the CRPD is to be followed strictly, the introduction of any sort of fusion approach will need to be modified to be compatible.

Chapter One: The Fusion Hypothesis

1.1 Introduction

Fusion approaches to mental health law would signal the start of a major paradigm shift in the way in which patients with mental illnesses are treated and is borne out of dissatisfaction with current mental health legislation. Fusion offers to enhance patient autonomy and eradicate discrimination by introducing capacity-based thresholds into a single piece of legislation allowing both persons with mental illness and those with physical illness to be treated under the same legal framework. It would be based on the premise that mental capacity would become the legally relevant criterion for intervention.

Fusionists criticise various areas of the current mental health legislation, highlighting the lack of relevant criterion, such as a lack of capacity assessment requirements, in regards to compulsory treatment of persons with mental illness; which they claim exacerbates the discriminatory nature of the legislation.[1] Fusion offers a patient with mental illness the opportunity to decide for themselves how to be treated using non-discriminatory mental health law. This could be particularly attractive to patients, who are liable to be detained under the current mental health legislation, as this approach would seek to give them decision-making rights which they currently do not have.

This chapter explains why and how the concept of fusion has developed and discusses the broad concept behind the approaches whilst examining the ethical concerns and premises it is based upon. An aim of this chapter is to pinpoint key themes picked up by fusion advocates and other commentators that are in need of further resolution. Understanding where fusion has come from and what premises it is based upon allows for a greater level

[1] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume II, Oral and Written Evidence." Ev 120; Genevra Richardson, "Mental capacity at the margin: the interface between two acts," *Med Law Rev* 18, no. 1 (2010).; G. Szmukler, R. Daw, and J. Dawson, "A model law fusing incapacity and mental health legislation " *Special Edition of the Journal of Mental Health Law* (2010); Tom. Campbell and Chris. Heginbotham, *Mental Illness: Prejudice, Discrimination and the Law* (Aldershot: Dartmouth, 1991).; Tom D. Campbell, "Mental Health law: institutionalised discrimination," *Australian and New Zealand Journal of Psychiatry* 28(1994).

of critical assessment. Suggestions a capacity-based threshold needs to be integrated into mental health legislation will also be considered. Finally, the claims current legislation operates in a discriminatory manner will also be assessed, leading to questions in further chapters as to what the term 'discrimination' actually means and whether there is a significant difference between patients with mental illness and those without, which justifies separate treatment.

This chapter will examine specific examples of what a fused system might look like and assess how fusion may operate by looking to the proposed models of reform. The chapter will hope to uncover the origins and influences on the development of the fusion approach and an assessment of the limitations of the fusion hypothesis will be undertaken.

1.2 The Broad Fusion Approach

For many years mental health legislation has been unsettled and has seen many reviews and reforms. The changes in social and medical attitudes to mental ill health, competing ethical and philosophical viewpoints of legal scholars and the increased implementation of rights-based legislation have all contributed to the debates for reform.[2] This shift in

[2] Martin. Roth and Robert. Blugrass, eds., *Psychiatry, Human Rights and the Law* (Cambridge: Cambridge University Press, 1985).; Michael. Cavadino, *Mental Health Law in Context: Doctor's orders?* (Aldershot: Dartmouth Publishing Company, 1989).; Nigel. Eastman and Jill. Peay, eds., *Law without Enforcement: Integrating Mental Health and Justice* (Oxford and Portland, Oregon: Hart Publishing, 1999).; Barbara. Fawcett and Kate. Karban, *Contemporary Mental Health: Theory, Policy and Practice* (Abingdon: Routledge, 2005).;Bernadette. McSherry and Penelope. Weller, eds., *Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon: Hart Publishing, 2010).; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."; Dawn. Fletcher, "Reform of the Mental Health Act 1983: Opportunity or Catastrophe for Social Work?," (Univeristy of East Anglia, Norwich.: School of Social Work and Psychosocial Studies., 2004).; "*Reform of the Mental Health Act 1983: Proposals for Consultation*."; B. Symonds, "The philosophical and sociological context of mental health care legislation," *Journal of Advanced Nursing* 27, no. 5 (1998).; Richard.J. Bonnie, "Afterword: The Evolution of Mental Health Law: A Retrospective Assessment," in *The Evolution of Mental Health Law*, ed. Lynda.E. Frost and Richard.J. Bonnie (Washington: American Psychological Assocation, 2001).p309; "*No Health Without Mental Health: Implementation Framework*," ed. Mental Health Network NHS Confederation (2010); "*No health without mental health: A cross-government mental health outcomes strategy for people of all ages*," ed. Department of Health (2011); "*No health without mental health: A cross-government mental health outcomes straegy for people of all ages. Supplementary note to the 'No health without mental health' Impact Assessment, to accompany publication of an Implementation Framework*," ed. Department of Health (2012); "*No health*

professional and public attitudes towards persons with mental illness has lead to an emphasis on the normalisation and integration of such persons into the mainstream of society.[3]

When the Mental Health Act 1959 was introduced, the vision of mental health was underpinned by paternalism; where doctors had a greater influence on patient decision making.[4] Thus, the introduction of the MHA 83 signalled a "significant departure"[5] from its predecessor and represented a swing towards a 'new legalism' in which the law aimed to improve patient safeguards.[6] This was further reinforced by the inclusion of Part IV of the MHA 83 which defined for the first time the grounds for involuntary treatment and contained provisions relating to patient's consent to treatment.[7] Despite these changes, reform was still deemed necessary due to decreasing confidence in the mental health services by those who felt it was outdated and increasingly out of step with the Human Rights Act 1998.[8]

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without mental health: A cross-governemnt mental health outcomes stragey for people of all ages. A Call for Action," ed. Department of Health (2011).

[3] "*Mentally Incapacitated Adults and Decision-Making: An Overview*."; "*Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*."; "*Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*."; Fiona. Caldicott, Edna. Conlan, and Anthony. Zigmond, "Client and Clinician-Law as an Intrusion," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing, 1999).p76; Graham. Thornicroft, *Shunned: discrimination against people with mental illness* (Oxford: Oxford University Press, 2006).; Cavadino, *Mental Health Law in Context: Doctor's orders?*; Marian. Barnes, Ric. Bowl, and Mike. Fisher, *Sectioned: Social Services and the 1983 Mental Health Act* (London: Routledge, 1990). p127; "*Mentally Incapacitated Adults and Decision-Making: An Overview*."p14

[4] Cavadino, *Mental Health Law in Context: Doctor's orders?* p3

[5] Phil. Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London and New York: Routledge, 1996). p183

[6] Cavadino, *Mental Health Law in Context: Doctor's orders?* p67

[7] Robert. Blugrass, "The recent Mental Health Act in the UK: issues and perspectives," in *Psychiatry, Human Rights and the Law*, ed. Martin. Roth and Robert. Blugrass (Cambridge: Cambridge University Press, 1985).p29

[8] Nigel. Eastman and Jill. Peay, "Law without Enforcement: Theory and Practice," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing).p1, also; Nigel. Eastman and Jill. Peay, "Afterword: Integrating Mental Health and Justice," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing).p211; see also, P. Bartlett and R. Sandland, *Mental Health Law: policy and practice*, 3rd ed. ed. (Oxford: Oxford University Press, 2007).p26; Nick. Bosanquet, "Auditing the Effectiveness of Mental Health Law," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing, 1999).p147-148; Rowena. Daw, "The Mental Health Act 2007- The Defeat of an Ideal," *Journal of Mental Health Law* May(2007).

This section will look at the key issues plaguing the mental health legislation over the years and will look at how others have attempted to deal with these issues and how they have helped to guide the fusion approach to where it is today. By examining capacity relevant legislation and the notion of non-discrimination in detail we begin to get an idea of the theoretical underpinnings and rationales for the fusion approaches.

1.3 Capacity relevant legislation

Furthermore a considerable amount of literature has been published on the inclusion of capacity-based tests in mental health legislation, especially in the form of fusion legislation.[9] By introducing capacity-based tests fusionists hope to remedy what they see is the main criticism of the current mental health legislation which is that small number of patients can be treated involuntarily under the MHA 83 even when they retain capacity.[10] A considerable amount of literature has been published on the use of capacity-based tests

[9] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; Atkinson and Patrick, "Balancing autonomy and risk: the Scottish approach."; Robert. Robinson, "The mental capacity tribunal under the model law: what are we arguing about?," *Journal of Mental Health Law* Special Edition(2010).; Paul.S. Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law," *Journal of Mental Health Law* Special Edition(2010).; Tom. Burns, "Mental illness is different and ignoring its differences profits nobody," *Journal of Mental Health Law* Special Edition(2010).; Kris. Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal," *Journal of Mental Health Law* Special Edition(2010).; Holland, "The model law of Szmukler, Dawson and Daw- the next stage of a long campaign?."; M. McCallion and U. O'Hare, "A New Legislative Framework for Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals," *Journal of Mental Health Law* Special Edition(2010); Szmukler, Daw, and Dawson, "Response to the Commentaries."; Kris. Gledhill, "The role of capacity in mental health laws- recent reviews and legislation," *Journal of Mental Health Law* Special Edition(2010); Aswini. Weereratne, "Safeguards for informal patients," *Journal of Mental Health Law* Special Edition(2010); A. Buchanan, "The Treatment of Mentally Disordered Offenders under Capacity-Based Mental Health Legislation," *Journal of Mental Health Law* Special Edition(2010).; Kris. Gledhill, "Seal v UK: The End of the Story or Time for a Fresh Beginning?," *Journal of Mental Health Law* Special Edition(2010).; T. D. Campbell, "Mental Health Law: Institutionalized Discrimination," *Australian and New Zealand Journal of Psychiatry* 28, no. 4 (1994).; Rosenman, "Mental Health Law: An Idea Whose Time Has Passed."; Matthews, "Mental and Physical Illness-An Unsustainable Separation?."; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism."; Neil. Rees, "The Fusion Proposal: A Next Step?," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010).

[10] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p11-12; see also, G. S. Owen et al., "Mental capacity and psychiatric in-patients, implications for the new mental health law in England and Wales," *British Journal of Psychiatry* 195, no. 3 (2009). p257-258

in medical decision-making.[11] These studies have ranged from discussing the actual decisional abilities one needs to make decisions[12] to the introduction of a statutory capacity assessment.[13] Recent studies have suggested where it was once presumed persons with mental illness automatically lacked capacity; evidence now shows many such patients

[11] M. Hotopf, "The assessment of mental capacity," *Clinical Medicine* 5, no. 6 (2005).; Mary. Donnelly, "Capacity assessment under the Mental Capacity Act 2005: Delivering on the functional approach?," *Legal Studies* 29, no. 3 (2009).; A. J. O'Brien, "Capacity, consent, and mental health legislation: Time for a new standard?," *Contemporary Nurse* 34, no. 2 (2010); John. Bellhouse et al., "Capacity-based mental health legislation and its impact on clincial practice: 1) admission to hospital," *Journal of Mental Health Law*, no. August (2003); John. Bellhouse et al., "Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital," *Journal of Mental Health Law*, no. August (2003); Barry. Edelstein, "Challenges in the Assessment of Decision-Making Capacity," *Journal of Aging Studies* 14, no. 4 (2000); Derek. Chiswick, "Commentary: test of capacity has little practical benefit," *British Medical Journal* 331, no. Education and Debate (2005); E. C. Fistein et al., "A comparison of mental health legislation from diverse Commonwealth jurisdictions," *Int J Law Psychiatry* 32, no. 3 (2009); Philip Bielby, "The conflation of competence and capacity in English medical law: a philosophical critique," *Med Health Care Philos* 8, no. 3 (2005).; Chris. Heginbotham and Mat. Kinton, "Developing a capacity test for compulsion in mental health law," *Journal of Mental Health Law*, no. May (2007).; J. Dawson and A. Kampf, "Incapacity principles in mental health laws in Europe," *Psychology Public Policy and Law* 12, no. 3 (2006).; Christopher. Johnston, ed. *Medical Treatment: Decisions and the Law: The Mental Capacity Act in Action*, 2nd ed. (West Sussex: Bloomsbury Professional Ltd, 2010); Richard Griffith and Cassam Tengnah, "Mental Capacity Act 2005: statutory principles and key concepts," *Br J Community Nurs* 13, no. 5 (2008); Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge."; J. Dawson, "Mental capacity and psychiatric admission," *British Medical Journal* 337, no. 7660 (2008); Owen et al., "Mental capacity and psychiatric in-patients, implications for the new mental health law in England and Wales."; Richardson, "Mental capacity at the margin: the interface between two acts."; G. S. Owen et al., "Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study," *British Medical Journal* 337, no. 7660 (2008); Alec. Buchanan, "Mental Capacity, legal competence and consent to treatment.," *Journal of the Royal Society of Medicine* 97, no. Sept (2004); Len. Doyal and Julian. Sheather, "Mental health legislation should respect decision making capacity," *British Medical Journal* 331, no. 17 Dec (2005); Peter. Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria," *Medical Law Review* 11, no. Autumn (2003).

[12] Paul.S. Appelbaum and Thomas. Grisso, "The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment," *Law and Human Behavior* 19, no. 2 (1995).; Thomas. Grisso et al., "The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment," *Law and Human Behavior* 19, no. 2 (1995).; Thomas. Grisso and Paul.S. Appelbaum, "The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments," *Law and Human Behavior* 19, no. 2 (1995).; Thomas. Grisso, Paul.S. Appelbaum, and Carolyn. Hill-Fotouhi, "The MacCAT-T: A Clinical Tool to Assess Patients' Capacities to Make Treatment Decisions," *Psychiatric Services* 48, no. 11 (1997).; Paul.S. Appelbaum, "Ought We to Require Emotional Capacity as Part of Decisional Competence?," *Kennedy Institute of Ethics and Journal* 8, no. 4 (1998).; Neil. Allen, "Is Capacity "Insight"?," *Journal of Mental Health Law* Winter(2009).;Astrid. Vellinga et al., "Instruments to assess decision-making capacity: an overview," *International Psychogeriatrics* 16, no. 4 (2004); Marshall.B. Kapp and Douglas. Mossman, "Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"," *Psychology, Public Policy and Law* 2, no. 1 (1996); Laura. B. Dunn et al., "Prevalence and correlates of adequate performance on a measure of abilities related to decisional capacity: Differences among three standards for the MacCAT-CR in patients with schizophrenia," *Schizophrenia Research* 89(2007); Ruth. Cairns et al., "Reliability of mental capacity assessments in psychiatric in-patients," *British Journal of Psychiatry* 187(2005); Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria."

[13] "*Mentally Incapacitated Adults and Decision-Making: An Overview*."; "*Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction*."; "*Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*."; "*Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*."; "*Making Decisions: The Government's proposals for making decisions on behalf of mentally incapacitated adults*," ed. Lord Chancellor's Department (London: The Stationery Office, Oct 1999).

retain decision-making capacity.[14] These reports have therefore increased the interest and importance of discussing the relevancy and efficacy of using capacity as a gateway threshold for treatment and care.

It has been asserted by many that in order to promote the principle of patient autonomy in mental health legislation, there is a need to implement some sort of capacity-based test to determine someone's decision-making ability.[15] Advocates of the fusion approach to mental health legislation argue the use of capacity-based tests will bring with it a uniform standard in medical decision-making, which would 'reflect the central role of autonomy'[16] and demonstrates the strength of the fusion approach.[17] Encouraging the use of capacity-based tests in mental health legislation would help promote the exercising of one's autonomy by giving patients the opportunity to consent to or refuse treatment, which currently does not occur for those liable to be detained under the current MHA. This focus has been the driving force behind the call for progressive and non-discriminatory mental health law.[18]

[14] David.J. Moser et al., "Using a Brief Intervention to Improve Decisional Capacity on Schizophrenia Research," *Schizophrenia Bulletin* 32, no. 1 (2006).p116; Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*.p193; "Code of Practice: Mental Health Act 1983," ed. Department of Health.p188; Brenda. Hale, *Mental Health Law*, 5th ed. (London: Sweet & Maxwell, 2010).p69 and 187; Owen et al., "Mental capacity and psychiatric in-patients, implications for the new mental health law in England and Wales."p153.

[15] Richardson Committee, "Report of the Expert Committee: Review of the Mental Health Act 1983," ed. Department of Health (London1999). See also; Richardson, "Mental capacity at the margin: the interface between two acts."p 62; Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; Ian. Bynoe and Anthony. Holland, "Law as a Clinical Tool: Practising within and Outwith the Law," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing, 1999). p106; William. Bingley and Christopher. Heginbotham, "Mental Health Law: Objective and Principles," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing, 1999). p42-43; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."

[16] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."p504

[17] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p18

[18] Peter. Bartlett, "'The necessity must be convincingly shown to exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983," *Medical Law Review* (2011). p28; see also, Penelope. Weller, "Lost in Translation: Human Rights and Mental Health Law," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010).p55

The current legislation allows for a complex set of arrangements determining which treatments patients can and cannot consent to. At the moment for psycho-surgical treatment s.57 MHA requires consent from the patient and a second opinion. If a patient has been given psychiatric drugs for three months without consent, s.58 requires consent from the patient or a second opinion from an independent doctor to establish if the patient should still be taking them. Section 58A requires the consent of the patient if electro-convulsive therapy (ECT) is proposed. If they refuse then it cannot commence.[19] However, if it can be shown the patient is not capable of understanding ECT's nature, purpose and likely effects, and a second opinion doctor agrees it is appropriate, then ECT can be given without the patient's consent. Despite these sections giving detained patients some sense of control over decision-making, s.63 MHA continues to allow all other treatment for the mental disorder one is suffering from to commence without patient consent. However, the Code of Practice to the Act does require capacity to be considered in a number of situations.[20] This is in stark contrast to how people with capacity who are suffering from physical disorders are dealt with. They can refuse treatment which could ultimately hasten their death.[21] It is this discriminatory differential treatment which fusion offers to eradicate by implementing mental health legislation which takes account of people's capacity. The fusion proposals endeavour to change the approach of the legislation and instead of basing it upon the differences between the illnesses one suffers from; they aim to make the law differentiate on the basis of one's capacity status. Therefore treatment could only be given

[19] For discussions about competency to consent for ECT see, Ross Dunne, Adam Kavanagh, and Declan M. McLoughlin, "Electroconvulsive therapy, capacity and the law in Ireland," *Irish Journal of Psychological Medicine* 26, no. 1 (2009); Maria.I. Lapid et al., "Decisional Capacity of Depressed Elderly to Consent to Electroconvulsive Therapy," *J Geriatr Psychiatry Neurol* 17(2004); B. A. Martin and G. J. Bean, "COMPETENCE TO CONSENT TO ELECTROCONVULSIVE-THERAPY," *Convulsive Therapy* 8, no. 2 (1992); M. Hotopf et al., "Capacity, consent and electroconvulsive therapy: A qualitative and cross-sectional study," *Journal of Mental Health* 17, no. 3 (2008).

[20] "*Code of Practice, Mental Health Act 1983*," ed. Department of Health (London: TSO, 2008).Para 4.9-4.24, 23.27-23.29, 23.37-23.41

[21] *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam); *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821; see rhetoric in *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649; *Re MB* (An Adult: Medical Treatment) [1997] 2 FCR 541.

when someone with capacity consents, or be given in their best interests if lacking capacity.

The Expert Committee regarding the reform of MHA 83 focused on the possibility of a principles-based approach to reform and suggested future mental health legislation should be based on general principles.[22] It recommended any new legislation must be concerned with recognising and enhancing patient autonomy and stated it was important to elevate capacity to a central role within the mental health structure and to consider introducing some sort of capacity-based test for the treatment of mental disorder.[23] They felt it would be necessary to introduce a capacity test specifically for treatment for mental disorder, albeit in a separate piece of legislation. They based their recommendations on the Law Commission's Report on Mental Incapacity and suggested that: "a person would lack capacity to consent to care and treatment for mental disorder, if at the time when the decision needs to be made the mental disorder is such that, either:

> i. 'he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision.' (para 3.16 [Law Commission]); or,
>
> ii. 'he or she is unable to make a decision based on the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision.' (para 3.17 [Law Commission])"[24]

The Expert Committee envisaged it may well be appropriate to overrule someone's autonomy and impose involuntary treatment on even a capable patient in certain circumstances.[25] These circumstances include where there is a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if the patient

[22] Committee, "Report of the Expert Committee: Review of the Mental Health Act 1983." p1 and Chapter 2
[23] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*." p88
[24] Citing the paragraphs from Law Comms Report in Ibid.p89 (para 7.5)
[25] Ibid. p94

remains untreated and where effective treatment is available.[26] The Committee advocated the use of a broad model of incapacity which would be more suitable to a mental health setting and would look to ensure a person's decision was a 'true choice'.[27] This acknowledges someone may lack capacity where although able to apply and understand information on an intellectual level, they would still come to a decision they would not have done had they not had the mental disorder.[28] The Committee's justification for this was that subsequent decisions would be as a result of the person's mental disorder, rather than reflecting their true choices.[29]

The Joint Committee on the Draft Mental Health Bill suggested any new legislation should take greater account of a person's ability to make decisions and recommended the use of significantly impaired decision-making criterion before compulsion was used.[30] They suggested that as far as possible people with mental illnesses should be treated the same as people with physical illnesses and only when people lacked capacity could they be treated involuntarily.[31] They suggested a condition be added to the Bill which required a person to have 'significantly impaired decision-making' ability, which related directly to the decision to accept care and treatment and continued stating the reason for the impairment to the patient's decision-making ability would be their mental disorder.[32]

They were not alone in suggesting mental health law should consider the use of some form of capacity-based test. The British Psychological Society strongly recommended conditions for compulsion be amended to reflect the principle that someone whose capacity

[26] Ibid.p70-71 (para 5.95)
[27] Ibid. p88 (para 7.4)
[28] Ibid.
[29] Ibid.
[30] "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume I, Report, together with formal minutes and annexes." p5
[31] Ibid.p53 (para 151)
[32] Ibid.p55 (para 156)

to make decisions is unimpaired, should be able to decide for themselves.[33] The Mental Health Alliance welcomed the idea there should be a test determining if a person's decision-making was impaired in any way[34] and stated the MHA 83 continued to reinforce stigma and discrimination by its refusal to address the issues of capacity.[35] King's College London and the Royal College of Psychiatrists both suggested an appropriate alternative to capacity-based tests might be the introduction of an impaired decision-making test.[36]

In Scotland, the Mental Health (Care and Treatment) Act 2003 promotes the rights of people with mental disorder and has both a status test, which determines if someone has a mental disorder, and a functional test, determining a person's decision-making ability. The Scottish Act relies on the notion of impaired decision-making ability as it must be shown decision-making ability is 'significantly' impaired by a patient's mental disorder. This Act is more patient focussed than the current legislation in England and Wales.[37] Whilst this Act does not embrace a pure capacity-based test as advocated by some fusion supporters, the use of the 'significantly impaired' judgement test and the inclusion of guiding principles attempt to explain why compulsory powers are sometimes necessary.[38] The Millan Committee felt it appropriate for the mental health legislation in Scotland to clearly explain the ethical justifications for the use of compulsory powers.[39] Therefore under this legislation compulsory powers can only be administered in specific circumstances and the law can only intervene if "the person's ability to take decision about treatment is significantly impaired".[40] This clearly takes into account the autonomy rights of persons

[33] "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume II, Oral and Written Evidence." Ev 597
[34] Ibid. Ev 122
[35] Ibid. Ev 120
[36] For King's College London's views see; "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume III Written Evidence."Ev 779, para 2.4.5. For Royal College of Psychiatrists see; "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume III Written Evidence."Ev 81 Q80
[37] Aisling. Boyle, "The Law and Incapacity Determinations: A Conflict of Governance?," *Modern Law Review* 71, no. 3 (2008). p459
[38] Ibid.
[39] B. Millan, "*Report of the Millan Committee, New Directions: Report of the review of the Mental Health (Scotland) Act 1984*," (Edinburgh: Scottish Executive, 2001). Chapter 2.1-24 and 3
[40] S 64 (5) (d) Mental Health (Care and Treatment) (Scotland) Act 2003

with mental illness, and allows those who retain decision-making ability to make their own choices.[41] It throws into question whether the fusion approach is the most appropriate method of law reform as it demonstrates the law is capable of promoting patient autonomy and can be less discriminatory without the need to combine mental health and mental incapacity legislation.

As there is no consensus about the form decision-making ability tests should take, the question remains as to which concepts are appropriate and whether notions such as 'capacity' are even sufficient criterion to exclude all others or whether it is more apt to take other interests into account.[42] As Richardson warns,

> "…such concerns indicate a need to consider the particular dilemmas raised in applying the legal criteria to psychiatric patients…The law's ability to provide useful guidance at the interface between mental disorder and mental capacity will be impaired if the criteria it employs are deficient or irrelevant in the context of psychiatric disorder."[43]

The discussion about capacity relevant legislation clearly illustrates the fusion hypothesis has a valid concern with the current mental health legislation. It is therefore important to investigate the use of capacity-based tests in more detail. At the moment the MHA does not include capacity relevant provisions for *all* treatment and admission decisions. Therefore fusionist discussions support the proposals for the introduction of capacity-relevant criterions and demonstrates, that in contemporary healthcare, patient decision-making should be given a more central role in the operation of the legislation in regards to all treatment and admission decisions. If it is found such legislation is not relevant to mental health law or fusion, then the fusion approach on the whole will fail. The investigation into capacity relevant legislation will also uncover the links between

[41] Boyle, "The Law and Incapacity Determinations: A Conflict of Governance?."p 461
[42] Bartlett and Sandland, *Mental Health Law: policy and practice*.p527; also, Chiswick, "Commentary: test of capacity has little practical benefit." p1469; also, G. Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions," *Modern Law Review* 65(2002). p720; see also, the House of Lords Select Committee discussions, especially Kirsty Keywood's comments in Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.2/Heard in Public/ Q's 25-44*."p31
[43] Richardson, "Mental capacity at the margin: the interface between two acts."p 65

autonomy and capacity that the fusionists highlight. Therefore this thesis will also assess these links and try to uncover if in fact by using capacity relevant legislation fusion will achieve its goal of increasing patient autonomy. Despite this, these discussions do not necessarily fully support the idea that fusion is the most appropriate mechanism for introducing such an approach and it is the aim of this thesis to uncover if in fact the fusionist hypotheses are the best way to reform the law.

1.4 Discrimination in Mental Health Law

The use of capacity-based tests is an important aspect of the development of fusion approaches because they argue the continuance of legislation that does not take capacity into consideration is discriminatory. Testing decision-making ability is seen as a mechanism allowing people who are capable of deciding for themselves, regardless of their illness, to do so.[44] Whilst at the same time, ensuring those who are incapable of doing so would still be able to be treated.[45] Therefore the notion of decision-making capacity may allow the complexities and nuances of mental ill health to be taken into account and could provide an appropriate test to be included into fusion approaches. The use of such tests also answers the criticism for the lack of capacity-based tests, however raises concerns in regards to the promotion of non-discrimination within the mental health legislation. Therefore it is necessary for this thesis to investigate the notion of discrimination within mental health law and to evaluate if fusion would be a suitable approach to implement.

[44] Bielby, "The conflation of competence and capacity in English medical law: a philosophical critique."p359-360; Sascha. Callaghan and Christoper. James. Ryan, "Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case," *JLM* 18(2011).p817

[45] Bielby, "The conflation of competence and capacity in English medical law: a philosophical critique." p360

Fusionists argue the current mental health legislation is discriminatory because under certain provisions of the Mental Health Act 1983 (MHA 83)[46] patients with mental illness, even when retaining decision-making capacity, can be subjected to compulsory treatment. Fusion legislation would therefore be less discriminatory as it would deal with issues of both mental capacity and mental health under the same statutory framework[47]; using incapacity as the gateway criterion on which to determine psychiatric admission and treatment. Section 3 of the MHA 83 allows for the involuntary admission for treatment of those who meet the criteria that they are;

> "(a)... suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

This section does not mention the capacity status of patients, focussing rather on mental disorder and risk of harm. These sections are in stark contrast to how physically ill people who retain capacity are treated. Patients with physical illnesses cannot be forced to accept detention or treatment against their wishes under any circumstances. The only way compulsory treatment can be administered for an unconnected physical illness, is if the patient is deemed to lack capacity under s.3 of the Mental Capacity Act 2005. It is therefore this continued distinction between the way patients with mental illness and those with physical illness are treated that is seen as discriminatory and is fuelling the development of fusion approaches. The proposed fusion legislation would operate whether treatment was for mental or physical ill health and would mean treatment could only be given with consent and as such, would simultaneously give *all* patients the right to refuse any treatment proposed.

[46] As amended by the Mental Health Act 2007

[47] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; Szmukler, Daw, and Dawson, "Response to the Commentaries."; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."

1.4. (i) The Need for Separate Legislation

Persons with mental illness have often found themselves excluded from society due to many reasons. They are seen as more risky, because of concerns about displaying behaviour which may be harmful to themselves or others. This is often regarded as anti-social, or more dangerous and irrational than the same behaviour displayed by those who do not have a mental illness.[48] Matthews suggests people with mental illness are seen as being 'mad' and are "set[s] apart from the community of normal human beings" and so 'normal' people feel they need to protect them, rather than treat them as equals who deserve the same respect.[49] He suggests the stigma that still attaches itself to people with mental ill health is a relic of the exclusion of mad people from normal society.[50] The assumption people with mental illness are somehow different to the physically ill and need care whether they wish to receive it or not now needs to be challenged.

Recommendations to abandon stigmatising terminology and practice along with continued efforts to encourage self determination and respect for individual rights surfaced in the early 1990s in the Law Commission's consultations into medical decision-making for the incapacitated.[51] Despite these recommendations it can be argued stigma and discrimination is still a problem for persons with mental illness and the continuance of legislation which legitimises the assumption of differences needs to be questioned.

Closely linked to the exclusion of the persons with mental illness are the debates regarding the differences between persons with mental illness and those with physical illness, which subsequently lead to concerns surrounding the continued need for separate legislation. The continuing use of a 'Mental Health Act' implies the domain of illness can be legitimately

[48] Bingley and Heginbotham, "Mental Health Law: Objective and Principles." p43.
[49] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." pg 47 and 50
[50] Ibid.p48
[51] "*Mentally Incapacitated Adults and Decision-Making: An Overview*." p14

divided into mental and physical ill health.[52] As Matthews argues, this assumes every mental illness has similar symptoms and common features and can therefore clearly justify the need for special and separate legislative frameworks.[53] Similarly the public health legislation justifies the differential legal treatment of patients with physical illnesses that are infectious or contaminated and pose significant harm to human health.[54] The MHA 83 requires differing levels of consent from patients depending on their treatment. Consent is not required for the administration of medication for the first three months; however s.58A MHA provides a new capacity threshold for electro-convulsive therapy (ECT). This provision demonstrates that although patients with capacity may be capable of making decisions about ECT, they may remain unable to make decisions about medication, which may have more detrimental side effects than ECT. This also presumes patients who present with illnesses that can be treated by ECT, are more capable of making decisions than those patients who can only be treated by medication. A further section of the MHA 83/07 illustrating the assumption of the need for differential treatment is s.63, which does not require consent or a second opinion and allows involuntary administration of medical treatment in order to treat the mental disorder the patient is suffering from. In regard to the treatment of other non-connected medical issues, if the patient has the required capacity to refuse, then this refusal must be respected. This leaves the peculiar situation whereby a formally detained patient will be allowed to refuse life saving treatment for a heart condition, yet will be unable to refuse anti-depressants.

There may be pragmatic reasons why one type of illness is better dealt with by a psychiatrist rather than a cardiologist but Matthews argues this should not and does not justify any real significant difference for the need for differential legal treatment.[55] Others

[52] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p47
[53] Ibid.
[54] S. 45G, Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008
[55] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p50

disagree.[56] Some believe that although the notion of treating persons with mental illness the same as those with general medical disorders has undoubted appeal by serving both the principle of fairness and non-discrimination,[57] fairness does not require everyone to be treated the same. It only requires those similarly situated, be treated the same.[58] However, when we look to the classifications of mental disorder there are a wide variety of symptoms and disorders. For example, when you compare dementia, anxiety, schizophrenia and eating disorders, they do not look like a homogenous group.[59] It is true to say in many cases any deficiency in mental capacity is the result of physical causes and could be classified as a physical illness, just as physical conditions such as cancer can interfere with mental functioning.[60] It is this distinction, or lack of it, that is the cornerstone of the fusion hypothesis. The fusion approach aims to treat all patients the same under a combined Act and so would be based upon the premise there are no significant differences justifying a separation.

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[56] Burns, "Mental illness is different and ignoring its differences profits nobody."; Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law.";Robinson, "The mental capacity tribunal under the model law: what are we arguing about?."

[57]P.S. Appelbaum, "Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law," *Special Edition of the Journal of Mental Health Law* (2010).p25

[58] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law."p32

[59] Example given by Matthews, "Mental and Physical Illness-An Unsustainable Separation?." pg 51; Barton.W. Palmer et al., "Treatment-Related Decision-Making Capacity in Middle-Ages and Older Patients with Psychosis: A Preliminary Study Using the MacCAT-T and HCAT," *Am J Geriatr Psychiatry* 10, no. 2 (2002); Barton.W. Palmer et al., "Correlates of Treatment-Related Decision-Making Capacity Among Middle-Aged and Older Patients with Schizophrenia," *Arch Gen Psychiatry* 61(2004).; Ashley.S. Roseman et al., "Insight, quality of life, and functional capacity in middle-aged and olders adults with schizophrenia," *Int J Geriatr Psychiatry* 23(2008); Delphine. Capdevielle et al., "Competence to consent and insight in schizophrenia: Is there an association? A pilot study," *Schizophrenia Research* 108(2009).; Scott.Y.H. Kim et al., "Assessing the Competence of Persons with Alzheimer's Disease in Providing Informed Consent for Participation in Research," *Am J Psychiatry* 158(2001).; Jeffrey.A. Kovnick et al., "Competence to Consent to Research Among Long-Stay Inpatients With Chronic Schizophrenia," *Psychiatric Services* 54, no. 9 (2003).; Dilip.V. Jeste, Colin.A. Depp, and Barton.W. Palmer, "Magnitude of Impairment in Decisional Capacity in People with Schizophrenia Compared to Normal Subjects: An Overview," *Schizophrenia Bulletin* 32, no. 1 (2006); Scott.Y.H. Kim, Christopher. Cox, and Eric.D. Caine, "Impaired Decision-Making Ability in Subjects With Alzheimer's Disease and Willingness to Participate in Research," *Am J Psychiatry* 159, no. 5 (2002).; Lapid et al., "Decisional Capacity of Depressed Elderly to Consent to Electroconvulsive Therapy."; Jacinta O. A. Tan et al., "Psychiatrists' attitudes towards autonomy, best interests and compulsory treatment in anorexia nervosa: a questionnaire survey," *Child Adolesc Psychiatry Ment Health* 2, no. 1 (2008); E. Winburn and R. Mullen, "Personlaity disorder and competence to refuse treatment," *Journal of Medical Ethics* (2008); Kate Maxmin et al., "Mental capacity to consent to treatment and admission decisions in older adult psychiatric inpatients," *International Journal of Geriatric Psychiatry* 24, no. 12 (2009).; Christoper. James. Ryan, "One Flew Over the Cukoo's Nest: Comparing Legislated Coercive Treatment for Mental Illness with that for Other Illness," *Bioethical Inquiry* 8(2011).

[60]Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p51

This debate has left open the question whether a fusion approach would necessarily be the most appropriate method of law reform in this area, because although it is a "laudable drive to reduce stigma and discrimination",[61] it risks obscuring the already limited understanding of the nature of mental illness by treating all illnesses the same. Thus illustrating it may be naive to conclude at this time that a fusion approach will reduce discrimination and is therefore in need of further investigation later in the thesis. As mentioned above the discussion surrounding the distinctions between persons with mental illness and those with a physical illness is important to the debates regarding the need for separate legislation because if it cannot be justified as to why persons with mental illness need to be treated differently, then the need for separate legislation disappears.

1.5. Is Fusion the way forward?

Commentators, such as Dawson, Szmukler and Matthews, advocate for the introduction of generic legislation. They agree it is impossible to draw a clear distinction between those who suffer with mental illnesses and those who suffer with physical illnesses.[62] Others concur claiming there are simply no justifications to allow the continuation of separate legislation, based upon someone having a mental illness.[63] Matthews explains one reason for the assumed need for separate legislation is the idea the ills of the body are somehow separate from the ills of the mind, and this assumption ultimately leads to those with mental illness receiving different legal and clinical treatment.[64] This is evidenced by the continued use of special legal rules which only apply to patients with mental illnesses.[65]

[61] Burns, "Mental illness is different and ignoring its differences profits nobody."p38
[62] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p50; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."
[63] Paul. Barber, Robert. Brown, and Debbie. Martin, *Mental Health Law in England and Wales: A Guide for Mental Health Professionals* (Exeter: Learning Matters Ltd, 2009). p1; also, Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."
[64] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p50
[65] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p507

The need for specific mental health legislation would become less obvious, if the notion there is a significant difference between mental illness and physical illness was abandoned.[66] It is this abandonment the fusion approach supports and has allowed the hypothesis to develop on the basis that generic legislation is not only called for, but is the only way forward. Matthews suggests it is essential a general legal framework allowing for decision-making on behalf of all patients regardless of their illness is implemented.[67] He believes this would provide a more holistic approach to healthcare for all illnesses.[68] Similarly Dawson and Szmukler suggest fusion legislation governing both physical and mental illnesses would reduce 'unjustified legal discrimination' by not making psychiatry the subject of separate and special legislation.[69] Therefore fusionists believe the only available solution will be to reform the legislation because if legislation continues to treat patients with mental illness differently than physically ill patients, then stigma and discrimination will remain.

Campbell agrees a fairer policy objective may be to introduce generic legislation which would govern both mental ill health and physical ill health.[70] However, he proposed it should cover the degree of acceptable intervention in relation to compulsory control and treatment of *all* people in need of protection, or to control those who posed a risk to others.[71] This would eradicate what he termed the "institutional discrimination which is manifest in the existence of special Mental Health Acts…for those who have a mental illness or mental disorder."[72] Rosenman agrees, stating the justification for generic

[66] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p55; see also, Basant.K. Puri et al., *Mental Health Law: A Practical Guide* (London: Hodder Arnold, 2005).p204; Michael. Freeman, *WHO Resource Book on Mental Health, Human Rights and Legislation.* (Geneva: World Health Organisation, 2005).p5-7
[67] Matthews, "Mental and Physical Illness-An Unsustainable Separation?."p57
[68] Ibid.p55; see also, Ian. Bynoe and Anthony Holland, "Law as a Clinical Tool: Practising Within and Outwith the Law," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon: Hart Publishing). p106.
[69] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."p504
[70] Campbell, "Mental Health law: institutionalised discrimination." Also, Bynoe and Holland, "Law as a Clinical Tool: Practising within and Outwith the Law."p105
[71] Campbell, "Mental Health law: institutionalised discrimination."p554. My emphasis.
[72] Ibid.

guardianship laws is due to the discriminatory nature of the current mental health legislation.[73] He argues regulation of psychiatric treatment should be placed alongside provisions available for general laws governing all medical treatment in order to avoid the discrimination against persons with mental illness. [74] Szmukler and Holloway take this further stating "there is no logical reason to discriminate between mental incapacity occasioned by mental disorder and physical disorder"[75] and claim dismantling the mental health legislation is possibly the most important action one can take to provide persons with mental illness with equal rights and to eliminate stigma.[76]

These debates illustrate a shift in focus from the paternalistic, segregated mental health system, to a more modern approach looking at the principle of non-discrimination and further highlight the endemic problems blighting mental health legislation. Critics have begun to challenge the current legal system and as such have allowed the fusion advocates to develop an approach which may provide an appropriate legal framework for all patients. Some academics argue for the abolition of specific mental health legislation[77], whilst others argue for modified mental health legislation[78], which would also take into account the issues of risk and harm prevention and offers reasons as to why the fusion proposals are in need of greater investigation and exemplifies why as an approach it is attaining increased academic attention. The key issue to be brought up by this section is that in order for a fusion approach to be valid, it needs to definitively demonstrate why separate legislation is no longer justifiable.

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[73] Rosenman, "Mental Health Law: An Idea Whose Time Has Passed."
[74] Ibid. p565
[75] George. Szmukler and Frank Holloway, "Mental health legislation is now a harmful anachronism " *Psychiatric Bulletin* 22(1998). p663
[76] Ibid. p665; see also Bynoe and Holland, "Law as a Clinical Tool: Practising Within and Outwith the Law."p106
[77] Thomas.S. Szasz, "The Myth of Mental Illness," *American Psychologist* 15, no. 2 (1960). See for further discussion, David. Pilgrim, *Key Concepts in Mental Health*, 2nd ed. (London: SAGE Publications Ltd, 2009).p17-18
[78] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."; Christopher. J. Ryan, "Capacity as a Determinant of Non-Consensual Treatment of the Mentally Ill in Australia," *Psychiatry, Psychology and Law* 18, no. 2 (2011).

1.6. Specific Models of the Fusion Approach

1.6. (i) Northern Ireland: The Bamford Review

The Bamford Review concluded years of extensive consultation and analysis of the law and mental health and learning disability services in Northern Ireland.[79] The Review in 2007 suggested the need for the introduction of a single, comprehensive legislative framework for Northern Ireland and proposed an Act should apply to all persons requiring substitute decision-making.[80] The legislative reviews in Northern Ireland extended their discussions to the need for mental health law and the introduction of mental capacity law[81] and established an intrinsic link between the two types of provision.[82] The 2007 Review considered "having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust"[83] clearly preferring a fusion approach. They further suggested "Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches" and should "look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory."[84] The 2007 Review were unhappy the current law allowed people's autonomy to be overridden in the interests of their own or other's

[79] McCallion and O'Hare, "A New Legislative Framework for Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals." p84; "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*.";
[80] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."p 84 para 8.7.
[81] McCallion and O'Hare, "A New Legislative Framework for Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals." p84.
[82] "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*," ed. Social Services and Public Safety (NI) Department for Health (June 2008). p26
[83] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p49 para 4.64
[84] Ibid. p49 para 4.65

safety and were dissatisfied the current law focused too much on compulsion rather than ensuring appropriate treatment.[85]

In the following year, in "Delivering the Bamford Vision" it was suggested the provisions proposed in the original Bamford Review would be best delivered in two separate pieces of legislation.[86] It was argued that to do so in a single piece would lead to the implementation of a very complex piece of law which would be difficult to introduce. The report felt it was necessary for the mental health legislation to be enacted first as a matter of urgency.[87] Further consultation followed with many commentators suggesting the correct approach would in fact be to introduce a single piece of legislation.[88] Arguments for a single Act to provide separate laws would be stigmatizing[89]; it would be missing the unique opportunity to set international standards by not going forward with a single Act;[90] and the use of two bills would be confusing and would overlap on a range of issues.[91] The Northern Irish lawmakers have since prepared a single Act to cover both mental health and mental capacity in the form of the Mental Capacity (Health, Welfare and Finance) Bill and it is hoped this will be enacted in 2014.[92]

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[85] Ibid. p25 para 4.2
[86] "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*." p26
[87] Ibid.
[88] Ibid.; see also,"*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Reivew of Mental Health and Learning Disability. Action Plan 2009-2011*," ed. Social Services and Public Safety (NI) Department of Health (Oct 2009); "*Annual Report of the Bamford Monitoring Group*," ed. Patient and Client Council (August 2011).;"*Bamford Taskforce Annual Report 2011*," ed. Health and Social Care Board and Public Health Agency (2011).; "*Is Bamford making a difference? Report from Open Dialogue Mental Health Conference*," ed. Patient and Client Council (August 2011); "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*."; "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015.*," ed. Social Services and Public Safety (Northern Ireland) Department of Health (2012).; "*Evaluation of the 2009-2011 Bamford Action Plan*," ed. Social Services and Public Safety (Northern Ireland) Department of Health (Jan 2012).; "*Is Bamford making a difference? Report from Open Dialogue Mental Health Conference*."; "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*."
[89] "*Consultation on proposals to extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and implications for Mental Health powers.*," ed. Department of Justice (NI) (2012). p7
[90] Ibid.
[91] Ibid.p7-8
[92] "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015.*." p23

This fused Act would include all aspects of the needs of all people in relation to mental health, physical health, welfare or financial needs[93] and would be based on incapacity and would only apply to those assessed as having impaired decision-making capacity.[94] A process similar to the MCA 2005 would be used,[95] with a two stage approach. Formal assessment of capacity would only take place when a serious intervention, which had significant consequences or was intrusive, was proposed.[96] Under the new Bill there will be a diagnostic threshold where it must be demonstrated someone has "an impairment of, or a disturbance in, the functioning of the mind or brain." This will be followed by a functional test, ascertaining if, as a result of the impairment or disturbance, the person has the ability to "use, retain, weigh the information in order to make and communicate their decision."[97] This differs slightly from the test in the original Bamford Review, as the original suggested elaboration was required in order to include regard to 'appreciation' on the patient's behalf, to ensure adequate consideration be given to all aspects affecting decision-making capacity.[98] They were keen to ensure a fusion law would contain within it tests which were suitable for use in the psychiatric sphere. The current proposal does not include the term 'appreciation' despite concern still arising the functional stage may be too cognitive in nature. The Equality Impact Assessment (EQIA) failed to engage with these concerns and simply stated the "importance of these issues will be addressed in the preparation of the legislation and the accompanying Code of Practice".[99]

[93] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p53 para 6.1
[94] Ibid.p53 para 6.3
[95] Ibid. p88 para 7.2
[96] Dr. Lesley-Ann. Black, "The Mental Capacity Bill and Children under 16," ed. Northern Ireland Assembly (Research and Information Service Research Paper, 2012). p9 para 5.2
[97]Ibid. p9 para 5.2; see also, "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment*."p5
[98] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p40 para 5.13- 5.14
[99] "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment*." p5 For further discussion about 'appreciation' see chapter 2

1.6. (ii) Szmukler, Daw and Dawson's 'Model Law'

The 'Model Law' is one of the key examples of how and why a fused piece of legislation can and should be produced.[100] The aim of the paper was to give a practical and coherent expression to the case for fusion and to show the separation of legislation authorising civil commitment of persons with mental illness is both unnecessary and discriminatory and should be replaced by legislation governing the non-consensual treatment of both those with mental ill health and physical ill health.[101] The 'Model Law' is based on the MCA 05 and took influence from the Expert Committee, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the debates surrounding reform of the MHA 83 which led to the enactment of the MHA 2007.[102] Szmukler, Daw and Dawson argue strongly the continuance of separate Acts is no longer acceptable because the current two-track approach is inconsistent with general principles of health care ethics and the basic notion of the right of those with mental disorders, to be free from unnecessary discrimination in the law.[103] The 'Model Law' would govern the non- consensual treatment and detention of all people who lacked capacity to consent due to mental 'impairment'[104], whether this was due to mental or physical disorders.[105] Patients would be classed as unable to make decisions because of an "impairment or disturbance in the functioning of the mind" and as a result of this impairment they would lack capacity.[106]

[100] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."
[101] Ibid.p11
[102] Ibid.p15
[103] Ibid.p12
[104] They use the term 'impairment' in its broader sense and explain it is not limited to the legal definition of the term which was to be found in section 1 (2) Mental Health Act 1983 prior to the Mental Health Act 2007 amendments.
[105] Szmukler, Daw, and Dawson, "A model law fusing incapacity and mental health legislation ". p11
[106] George. Szmukler, Rowena. Daw, and John. Dawson, "Outline of the Model Law," *Journal of Mental Health Law Special Edition*(2010).p102

The 'Model Law' would implement the "usual meaning of 'incapacity'" [107] which they define in Part II, s.3 of the 'Model Law'. It reads;

> "3. Definition of capacity
> (1) For the purposes of the Act a person ("P") is unable to make a decision and lacks capacity if unable:
> (a) to understand the information relevant to the decision
> (b) to retain that information
> (c) to use, weigh or appreciate that information as part of the process of making the decision, or
> (d) To communicate the decision (whether by talking, using sign language or any other means)."[108]

They preferred an incapacity test to determine someone's decision-making ability in regards to both their detention and involuntary treatment. They advocated against the 'hybrid' legal position of Ontario, as they felt it has a major disadvantage of leading to the situation where a person can be lawfully detained on the basis of their mental disorder, yet cannot be treated if they retain capacity and refuse.[109] They assert this would be a flexible test, interpreted in a manner allowing the subtleties of mental disorders to be included in the determination of incapacity.[110] Involuntary treatment would generally only be given to those patients who lack capacity,[111] although exceptions would remain for a small number of forensic patients. For those lacking capacity, any subsequent decision-making would be carried out in accordance with the patient's best interests, defined in s.4 of the 'Model Law'[112] and would shift the focus away from a 'risk of harm' criterion as is currently used.[113] It makes use of the functional capacity-based test by focussing on whether the person can attain the required threshold of decision-making ability; rather than being based upon a patient's status as a psychiatric patient. These functional tests are often felt to be

[107] The authors themselves refer to this as the "usual meaning" in Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."p 13
[108] Szmukler, Daw, and Dawson, "Outline of the Model Law."p102
[109] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p13
[110] Ibid.
[111] Ibid.
[112] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p504; see also, Szmukler, Daw, and Dawson, "Outline of the Model Law."p 102
[113] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p504

fairer and more supportive of patient autonomy.[114] They iterate the test should not be linked to any specific disabling condition and for intervention to occur no less restrictive intervention or resolution should be available.[115]

However, the 'Model Law' makes no reference to any 'impairment' or 'disturbance' of the functioning of the brain, as the MCA 2005 does and begs the question as to whom this 'Model Law' will ultimately apply. By excluding those whose inability would stem from an impairment or disturbance of the brain, it seems to exclude those patients whose inability stems from a 'physical' origin, for example a bang to the head, brain damage or even those with Alzheimer's disease. This seems to infer only those whose inability stems from impairment or disturbance of the 'mind' will ever lack decision-making capacity to the extent they need legal protection. This may appear discriminatory on one hand, as it is often interpreted those with mental disorders, have an impairment or disturbance of the mind, rather than the brain. This could lead to some illnesses being over categorised as 'in the mind' such as depression or mood disorders taking it away from the physical origins of chemical imbalances in the brain. As such this law may be seen as only being applicable to those suffering from certain mental disorders and considering the lack of consensus on what causes some mental disorders, the law needs to be catering for all if it truly wants to be non-discriminatory. On the other hand it may be interpreted as discriminatory towards people who lack capacity due to impairments or disturbances in the brain; because they will not be covered by the Act and so will not have any legal framework to rely upon. Szmukler, Daw and Dawson clearly did not intend this to be the case as it would be absurd to suggest they would advocate for a large number of patients to be left without any legal safeguards. It can however be argued what in fact they meant by this is that the definition of a disturbance of the mind was also to include disturbances of the brain. However, this

[114] Callaghan and Ryan, "Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case." p817
[115] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p13

illustrates the complexities surrounding the distinctions between the 'mind' and 'brain' and mental and physical origins of incapacity and shows this area is in need of clarification and further discussion. One could argue this is simply a matter of semantics, but nonetheless it is an important consideration and the exclusion of even one word may have serious implications for a large class of patients. Considering the aim of the 'Model Law' is to reduce discrimination, it must in itself be seen as adhering to the principle of non-discrimination and as such not include or exclude any class of patients by its terminology. It is acknowledged the authors of the 'Model Law' have stated this is by no means a final draft of a piece of legislation and is merely an example of how a 'fused' Act may look;[116] however it needs to be clear as to whom this Act would apply and how the decision-making ability tests contained within it would operate to be fit for practical application.

1.7. Limitations of Fusion on a Broader Scale

1.7. (i) Forensic Patients

Concerns about how a fused law based upon an incapacity criterion can cope with the small number of persons with mental illness who pose a risk of harm to others, have consistently been used as an argument for those in opposition to a fusion approach.[117] The Government excluded any concept of impaired decision-making tests during debates regarding the reform of the MHA 83. They believed any such system would be ineffective at preventing harm to patients or others and would risk people being able to refuse treatment until they lacked capacity.[118] They argued clinicians would feel obliged to use a

[116] Ibid.p15
[117] Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria."p331 and 341; also, Gledhill, "The role of capacity in mental health laws- recent reviews and legislation."p129-130 and 138; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p19 and 95
[118] "Joint Committee on the Draft Mental Health Bill: Session 2004-2005. Volume I, Report, together with formal minutes and annexes." p 53-54, Schedule of comments: Government Response 9(c) (at annex 4)

wider interpretation of impaired judgement, so as to catch those patients they felt were in need of intervention. It is clear the Government's approach was in response to increased media attention given to high profile cases in the 1990s involving people who were mentally ill.[119] The cases of Christopher Clunis and Michael Stone provoked a "media fuelled public panic"[120] and concerns about risk subsequently influenced policy and legislation. The Government switched their focus from safeguarding persons with mental illness and providing adequate resources, to policies of increasing compulsion powers via the mental health legislation, and the focus on protecting the public from these so-called 'dangerous' patients.[121] It is arguable the overwhelming feeling of the UK Government was that it was inappropriate to introduce legislation that could ultimately allow dangerous patients to refuse treatment.[122] This pre-occupation with public protection could be the reason why the Government disregarded many of the recommendations from the Expert Committee and academics who were instead focussed on the introduction of non-discriminatory legislation which respected patient autonomy.

Under both the 'Model Law' and the original Bamford framework, those with capacity who harmed or attempted to harm others could be controlled through the criminal justice system, regardless of whether they had a mental disorder or not, and those lacking capacity would be dealt with under involuntary treatment legislation whether dangerous or not.[123] However both the 'Model Law' and the new Bill in Northern Ireland would allow exceptions. Under the 'Model Law' they proposed to deal with forensic patients in much the same way as non-forensic patients; unless they were a criminal defendant who had

[119] Paul. Bowen, *Blackstone's Guide to the Mental Health Act 2007* (Oxford: Oxford University Press, 2007). p6
[120] Fawcett and Karban, *Contemporary Mental Health: Theory, Policy and Practice*. p37
[121] Ibid.
[122] Peter Bartlett, "Mental Health Legislation," in *Mental Health:From Policy to Practice*, ed. Charlie. Brooker and Julie. Repper (Edinburgh: Churchill Livingstone; Elsevier). p299
[123] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."p504; see also, "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." para7.24 p70.

been found unfit to plead or not guilty due to insanity.[124] These types of forensic patients could be treated without their consent even if they retained capacity when certain conditions applied.[125] These being when the person had committed a serious offence and where a serious mental impairment or disturbance had contributed significantly to the conduct and effective treatment could be offered which would be expected to reduce the risk of the disorder recurring again.[126] They justified the compromising of pure incapacity principles by claiming that to treat these types of patients in such a way would be the "most human disposal, as the option of prison would be inappropriate for a person with a mental impairment of such severity, and indeed would be impossible without a conviction."[127] However, prison is not currently an option for these people because they have not been convicted of an offence. They also suggest the numbers of such persons who would be in this class of patients would be extremely small. It seems strange however these keen fusion advocates would allow compassion to guide their fusion law and overrule strict adherence to autonomy principles when dealing with a small number of forensic patients; yet when dealing with non-forensic patients who would also benefit from involuntary treatment and retain capacity are not given the same kindness or access to healthcare. It could be argued cynically that the distinction has been made because the forensic patients are felt to be more of a risk to the public and therefore need to be 'controlled' using involuntary treatment. However, this would not be the case for all forensic patients, it would be for only a very small number who cannot be managed in prison or in hospital under conventional principles and therefore could be seen as the only way to ensure these people access the healthcare they need. This highlights the apprehension surrounding the

[124] Szmukler, Daw, and Dawson, "A model law fusing incapacity and mental health legislation ".p14
[125] Ibid.
[126] Ibid.
[127] Ibid.

introduction of capacity-based tests and illustrates fusion would need to deal with the legitimate concern about public and patient safety should a 'fused' Act be introduced.[128]

The Mental Capacity (Health, Welfare and Finance) Bill in Northern Ireland also allows for an exception for a small group of patients within the criminal justice system. They suggest those persons who have a mental disorder requiring treatment, and without this treatment would pose a substantial risk of serious harm to self or others, may be subjected to involuntary treatment or care.[129] Some of the consultations argue such patients are vulnerable individuals and there needs to be some sort of provision to ensure their best interests are provided for.[130] Whilst others argued that within the justice system, a duty of care was owed towards patients and care or treatment may need to be provided, especially when dealing with persons with severe personality disorders.[131]

It seems the reasons behind such a change in approach are due to issues of protecting the public from a perceived risk of serious harm.[132] The lack of detail in regards to this was highlighted in the responses to the EQIA, where commentators questioned the rationale for setting aside the arrangement for capacitous decisions to be overruled for certain forensic persons.[133] They questioned how the Bill could apply to such persons when the Bill was designed to apply to those lacking capacity.[134] We are awaiting further reports from Northern Ireland and the introduction of the Bill into law.

However to offer some insight into the reasons, Dawson and Szmukler writing in 2006 suggested that "perhaps in a small category of forensic cases pure incapacity principles should be compromised, to respect the competing ethical imperative of reducing harm to

[128] Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal." p52
[129] "*Consultation on proposals to extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and implications for Mental Health powers.*."p 30-32
[130] Ibid.p53
[131] Ibid.
[132] "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment*."p8-9 (para 17-20)
[133] "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment. Analysis of Responses*." p7 (para 17)
[134] Ibid.

others."[135] This is in stark contrast to their stance an incapacity framework would shift from a 'risk of harm' criterion.[136] To implement the fusion approach in this way, which ultimately allows forensic patients with mental illnesses who retain capacity, to be treated differently to other patients may create an even more stigmatized forensic population and could do more to stigmatise persons with mental illness.[137] They explain the consequences of applying capacity principles to forensic care may appear problematic and point to the fact protecting autonomy over the treatment of patients with capacity is not the only important ethical principle.[138] They explain there is a need to protect other people from serious harm and so a modification of strict capacity-based tests may be needed especially in the forensic field.[139] These modifications to the strict rules may be in response to the concern for public protection which the Government has been keen to promote. [140]However where do we drawn the line? It is agreed it is not necessary to overplay the connections between mental disorder and harm, but as Gledhill acknowledges it is well known the state has a duty to protect people from themselves and this cannot be ignored.[141] Clinicians need to provide care and treatment to their patients and beneficence still has a role to play in modern mental health services. Nonetheless, these exceptions in a fusionist example call into question the appeal of fusing general incapacity legislation with mental health legislation and could leave any attempt to fuse them as an "inherently quixotic endeavour".[142]

[135] Dawson and Szmukler, "Fusion of mental health and incapacity legislation."p508
[136] Ibid.p504
[137] A. Buchanan, "The treatment of mentally disordered offenders under capacity-based mental health legislation," *Special Edition of the Journal of Mental Health Law* (2010).p45
[138] Szmukler, Daw, and Dawson, "A model law fusing incapacity and mental health legislation ". p14
[139] Ibid.
[140] Appelbaum, "Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law."p30
[141] Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal." p52
[142] Appelbaum, "Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law." p30 and Appelbaum, "Harnessing the power of fusion? A valiant but flawed effort to obviate the need for a distinct mental health law."32

Szmukler, Daw and Dawson respond to the associated risk of violence by saying dangerousness is not a necessary condition of having a mental illness and we must avoid stereotyping persons with mental illness as somehow being a danger to others.[143] They explain discrimination comes from the unequal treatment of people who are equally 'risky'.[144] For example those who are risky and have a mental illness are singled out for intervention, even where no crime has been committed. In contrast those who are habitually aggressive, but do not have a mental illness will only be detained if they commit a crime.[145] This begs the question of both models as to how they can advocate for the use of a risk of harm justification when dealing with the involuntary treatment of offenders with a mental illness under their 'fused' approaches; even when such patients retain capacity. Surely this is stereotyping forensic patients with mental illness as dangerous and it is stigmatising. It could be argued this is because forensic patients have already proven to be a risk, but is this a good enough argument to cover up the conflict? Szmukler, Daw and Dawson explain it is almost inevitable the different perspectives on human conduct from both the criminal justice and healthcare viewpoints will not allow tidy reconciliation.[146] However this fails to give a detailed analysis of the issues and highlights that just because something is not easily remedied it does not mean it should not be done. Surely if they are intent on reducing discrimination, their own proposals need to avoid being interpreted as discriminatory themselves.

So can fusion offer a way of providing care and treatment to those in need, whilst at the same time providing public protection? It is true to say by using incapacity as a criterion for commitment, it may exclude some people who are a danger to themselves or others,

[143] G. Szmukler, R. Daw, and J. Dawson, "Response to the Commentaries," *Special Edition of the Journal of Mental Health Law* (2010).p93
[144] Ibid.p94 and 95
[145] Ibid.p95
[146] Ibid.p96

who cannot be committed because they retain decisional capacity.[147] The current mental health legislation does provide an "important humanitarian safeguard" against the self-harming actions of people with mental health problems whether they have capacity or not.[148] It can be seen as a 'special measure' designed to promote the interests of persons with mental illness, rather than unfairly discriminating against them,[149] providing a legitimate piece of law that helps vulnerable people. Nonetheless, the justifications for compulsory treatment still need to undergo careful scrutiny.[150] The approach of the original Bamford Review may have provided an acceptable 'fused' approach to this dilemma. It clearly stated if a person has capacity, whether they have a mental illness or not, they are not to be treated against their will, even if they pose a risk to others or themselves. They stated that "[S]hould they [patients with capacity] refuse services, however, and their behaviour is such as to place either themselves and/or others at risk, they must take responsibility for the consequences of any decisions they might make."[151] This clearly shows the original Bamford Review did not feel the issue of risk to others was a concern of the mental health legislation; rather it was for the criminal justice system. It is felt this framework is a more consistent approach to the underlying aims and principles of the fusion hypothesis on the whole, as it allows *all* patients with capacity to decide for themselves and avoids the risk of being seen as discriminatory. By not singling out forensic patients with mental illness as a group of patients in need of specialist separate legislation, the original Bamford framework complied with the principle of non-discrimination fusionists hold so highly. However, the current Bill awaiting implementation does not replicate the original Bamford stance. Therefore the legislation in

[147] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law." p28
[148] Callaghan and Ryan, "Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case." p812
[149] Rees, "The Fusion Proposal: A Next Step?." p90
[150] Callaghan and Ryan, "Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case."p812
[151] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p96 para 7.23

Northern Ireland, if it remains unchanged into the Act, will have missed an opportunity to introduce a fully non-discriminatory piece of law that allows *all* patients with capacity the ability to decide for themselves. We will have to wait for the Act to be enacted to examine its impact.

1.8. Conclusion:

The fusion approach to mental health law reform has captured the attention of legal scholarship at this time because it illustrates how and why the current law is still incoherent and inadequate. The above discussions have shown there is still controversy surrounding the use of capacity-based tests in mental health law and questions remain as to the best method of employing involuntary treatment to those who need it. There is little consensus about the form new legislation should take, and even if new legislation is actually required. Fusion advocates suggest we need to combine the two distinct legal frameworks, whereas others have suggested separate legislation can still be used with integrated capacity-based tests.

Developing the fusion approach has resulted in the questioning of how the legislation should be implemented and as such it is necessary to analyse how effective these proposals are going to be and whether they will deliver on the promises they make. As Appelbaum suggests, fusion of the two types of legislation may not make any sense and the effort put into this approach may well be better spent improving the distinct legal regimes.[152] It is appropriate to determine whether Appelbaum is correct and to conduct further analysis into the utility of a 'capacity-based' test in order to determine fusion's value and potential. Only when it has been established that capacity has the tools to deal with *all* patients effectively, will it be possible to answer the claims of whether the fusion proposals are too

[152] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law."p33

simplistic to implement and to subsequently promote autonomy and reduce discrimination. After considering the debates it is felt the fusion hypothesis is naive in its claim that the simple introduction of a fused piece of legislation will enhance patient autonomy and eradicate discrimination. Although a 'fused' system seems intuitively appropriate, it is also too simplistic to assume that merely treating persons with mental illness the same as the physically ill under the same Act will eradicate discrimination and is thus in need of further discussion later in the thesis. Therefore the question of equal treatment and discrimination still needs to be answered and the justifications for the separation have to be drawn out in order to validate the approach of fusion. Within fusion discussions the term 'discrimination' is often used without any real explanation of what the term means. This loaded term needs to be examined to explain whether the discrimination that is alluded to in the current mental health laws is unlawful or unjustified. Or whether the fusion hypothesis is too simplistic in its approach to the concept of discrimination?

Chapter Two: The Relationship between Autonomy, Capacity and Fusion. Will autonomy be enhanced?

2.1. Introduction

Drawing upon the previous chapter, this section will consider why fusionists have chosen capacity as a concept to enhance autonomy and how it may be enhanced in mental health law. This chapter aims to establish the connection between autonomy and capacity in order to assess the full extent of the fusionist claims that implementing capacity-based tests will enhance patient's autonomy. To do this autonomy will be discussed, as will the decisional abilities one must possess in order to be deemed as having the required capacity to exercise the right to make decisions.

Discussions of whether it is ever acceptable to overrule people's capable decisions and thus overrule autonomy for the sake of other interests will be examined. This is because the research up to date surrounding the fusion approaches have tended to suggest this is unacceptable, despite some of the main fusionist proposals providing exceptions.

This chapter will conclude that although capacity-based tests in theory may be capable of enhancing patient autonomy; in practice they could do little to increase this autonomy in any substantive way. Less well established claims about autonomy and capacity will be considered which may in certain circumstances justify the curtailment of patient's autonomy in the short term. Examples remain where even decisions of capable people can be justifiably overridden and highlights the inclusion of capacity-based tests into a fused law may not be the most appropriate way forward. Therefore fusionists and other law makers may need to look to alternatives to produce acceptable legislation.

2.2. What is autonomy?

Autonomy is a philosophical concept easier to use than define and has almost as many conceptions, as there are commentators discussing it.[1] Nonetheless it has for many become one of the most fundamental ethical principles within medicine, with few rejecting its importance.[2] Autonomy can be defined as self-government or self-determination or it can

[1] A. Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge: Cambridge University Press, 2009). p 10; Jonathan. Herring, *Medical Law and Ethics*, 3rd ed. (Oxford: Oxford University Press, 2010).; Ronald. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, And Individual Freedom.* (New York: First Vintage Books, 1994). p222; Onara. O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002).p23; Charles. Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law* (Portland: Hart Publishing, 2009).p7-9; J. Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge, 1985).p195-196; Anne. Flamme and Heidi. Forster, "Legal Limits: When does Autonomy in Health Care Prevail," in *Law and Medicine: Current Legal Issues*, ed. Michael. Freeman and Andrew. D. E. Lewis (Oxford: Oxford University Press, 2000).p141; Marina. Oshana, "How much should we value autonomy?," in *Autonomy*, ed. Ellen Paul, Frankel., Fred.D. Miller Jr, and Jeffrey. Paul (Cambridge: Cambridge University Press, 2003).p101; Richard. Lindley, "Paternalism and Caring," in *Ethical Issues in Caring*, ed. Gavin. Fairbourn and Susan. Fairbourn (Aldershot: Avebury, 1988).p57; Raanan. Gillon, "Autonomy and the principle of respect for autonomy," *British Medical Journal* 290(1985).p1806-1807; Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge."p82-89; Buchanan, "Mental Capacity, legal competence and consent to treatment.."; David. Molyneux, "Should healthcare professionals respect autonomy just becasue it promotes welfare?," *Journal of Medical Ethics* 35(2009).p245; Nigel. Eastman and R.A. Hope, "The Ethics of Enforced Medical Treatment: the balance model," *Journal of Applied Philosophy* 5, no. 1 (1988).p50.; Ellen Paul, Frankel., Fred. D. Miller Jr, and Jeffrey. Paul, eds., *Autonomy* (Cambridge: Cambridge University Press, 2003).; Mark. R. Tonelli and Cheryl.J. Misak, "Compromised Autonomy and the Seriously Ill Patient," *CHEST* 137, no. 4 (2010).; Michael. Dunn and Charles. Foster, "Autonomy and welfare as amici curiae," *Medical Law Review* 18, no. 1 (2010); Natalie. Stoljar, "Theories of Autonomy," in *Principles of health care ethics*, ed. Richard. Ashcroft (Chichester: John Wiley & Sons Ltd, 2007); Richard. Ashcroft, ed. *Principles of health care ethics*, 2nd ed. (Chichester: John Wiley & Sons Ltd, 2007).;Stephen. Darwall, "The Value of Autonomy and Autonomy of the Will," *Ethics* 116, no. 2 (2006).; John. Coggon, "Harmful rights-doing? The perceived problem of liberal paradigms and public health," *Journal of Medical Ethics* 34(2008).; Matti. Hayry, "Forget Autonomy and Give Me Freedom," in *Bioethics and Social Reality*, ed. Matti. Hayry, Tuija Takala, and Peter. Herissone-Kelly (Amsterdam and New York: Editions Rodopi B.V., 2005); Matti. Hayry, Tuija. Takala, and Peter. Herissone-Kelly, eds., *Bioethics and Social Reality* (Amsterdam and New York: Editions Rodopi B.V., 2005).

[2] Herring, *Medical Law and Ethics*. p192- 193; Rebecca. Bailey-Harris, "Patient Autonomy-A Turn in the Tide?," in *Law and Medicine: Current Legal Issues*, ed. Michael. Freeman and Andrew. D. E. Lewis (Oxford: Oxford University Press, 2000).p133; Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge."p80; N. Eastman and R. Dhar, "The role and assessment of mental incapacity: a review," *Current Opinion in Psychiatry* 13, no. 6 (2000).p557; Molyneux, "Should healthcare professionals respect autonomy just becasue it promotes welfare?."p245; Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism."; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."; Roy. Gilbar, "Family Involvement, Indepedence, And Patient Autonomy in Practice," *Medical Law Review* 19, no. Spring (2011).p192; Raanan. Gillon, "Ethics needs prinicples-four can encompass the rest- and respect for autonomy should be 'first among equals'," *Journal of Medical Ethics* 29(2003).p310; Christopher. Meyers, "Cruel Choices: Autonomy and Critical Care Decision-Making," *Bioethics* 18, no. 2 (2004).p107; Angus. Dawson and E. Garrard, "In defence of moral imperialism: four equal and universal prima facie prinicples.," *Journal of Medical Ethics* 32(2006); Sidney. Bloch and Stephen. A. Green, eds., *Psychiatric Ethics*, 4th ed. (Oxford: Oxford University Press, 2009); Tom.L. Beauchamp, "The philosophical basis for psychiatric ethics," in *Psychiatric Ethics*, ed. Sidney. Bloch and Stephen. A. Green (Oxford: Oxford University Press, 2009); Allen. E. Buchanan and Dan.W. Brock, *Deciding for Others: The Ethics of Surrogate Decision-Making* (Cambridge: Cambridge University Press, 1989).

be used as a means of restricting people's actions. However the most general view of autonomy is that it relates to self-government or self-determination.[3] This means people are free to choose how to live their own lives, according to their own values, beliefs and ideals, free from outside interference and encompasses the liberty to define meaning for oneself. [4] Harris suggests people are said to be autonomous to the extent they are able to control their own lives and secure their own destinies by using their own faculties.[5] This notion has become accepted in medical law because of the importance it places on allowing people to make their own decisions regarding health care, thus moving away from the paternalistic approach of the past.

Autonomy requires individuals to be in full possession of "capacity" or the capabilities required to make choices to ensure decisions are valid and worthy of respect.[6] Autonomy only becomes relevant and worthy of respect once it has been proven patients have this required capacity and have exercised it autonomously.[7] In this sense autonomy can be used in an evaluative way; used to determine if someone, or indeed their decisions deserve respect.[8] Fusionists attach importance to this because under the current legal regime, not all people can make decisions according to their own beliefs and values, even if they retain

[3] John. Coggon and Jose. Miola, "Autonomy, liberty and medical decision-making," *Cambridge Law Journal* (2011). p524; see also, Harris, *The Value of Life: An Introduction to Medical Ethics*. p195

[4] Tom.L. Beauchamp and James. F. Childress, *Principles of Biomedical Ethics*, 2nd ed. (Oxford: Oxford University Press, 1983). p59-60; see also Harris, *The Value of Life: An Introduction to Medical Ethics*. p195; Raanan. Gillon, *Philosophical Medical Ethics* (Chichester: John Wiley & Sons, 1986). p60; O'Neill, *Autonomy and Trust in Bioethics*.p23; M. Oshana, "How much should we value autonomy?," in *Autonomy*, ed. E.F. Paul, F.D. Miller. Jr, and J. Paul (Cambridge: Cambridge University Press, 2003). p 101; Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*. p 10; Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, And Individual Freedom.*p224; Lindley, "Paternalism and Caring." p57; Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge." p82; Wim. J. M. Dekkers, "Autonomy and dependence: Chronic physical illness and decision-making capacity," *Medicine, Health Care and Philosophy* 4(2001). p185; Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*. p8.; Isaiah. Berlin, *Four Essays on Liberty* (Oxford: Oxford University Press, 1969).; Bruce. Jennings, "Public Health and Liberty: Beyond the Millian Paradigm," *Public Health Ethics* 2, no. 2 (2009).

[5] Harris, *The Value of Life: An Introduction to Medical Ethics*. p195

[6] R. Lindley, "Paternalism and Caring," in *Ethical Issues in Caring*, ed. G. Fairbairn and S. Fairbairn (Aldershot: Avebury, 1988). p57

[7] Lindley, "Paternalism and Caring." p57; Owen et al., "Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge."p82; Eastman and Dhar, "The role and assessment of mental incapacity: a review." p557; J. Coggon, "Varied and principled understandings of autonomy in english law: Justifiable inconsistency or blinkered moralism?," *Health Care Analysis* 15(2007).

[8] Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*. p8-9

decision-making capacity. This 'self-regulation' view of autonomy sits more easily with fusionist approaches allowing them to pursue the agenda that all patients should be able to make their own decisions and choices, following their own values and beliefs. They argue this will enhance personal autonomy.

Autonomy can also be invoked as a reason for restricting someone's actions, where the autonomy of X will be invoked as a reason to restrict Y's autonomy.[9] This can be linked to the writings of Mill, where he stated;

> "...the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."[10]

The controversy when viewing autonomy in this way is it is often the case many people with mental illness, who have been detained, retain decisional capacity and the ability to exercise autonomy; but because they are perceived to be at risk of harming themselves or others they can be involuntarily treated against their wishes. This conception of autonomy does not sit quite as well with some of the fusionist approaches. Some fusionists take a hard line approach to autonomy and believe only when someone's decision-making is impaired can they ever be treated against their wishes.[11] In contrast, some suggest in certain circumstances autonomy can be invoked as a means of restricting autonomy for the sake of harm prevention.[12] Regardless, this does not in itself provide us with any real understanding of the term 'autonomy.'[13] Fusionists talk very little of the details of their conception of autonomy and in fact it could be argued what they are really discussing is

[9] Ibid. p8; see also, Coggon, "Varied and principled understandings of autonomy in english law: Justifiable inconsistency or blinkered moralism?."
[10] J.S. Mill, *On Liberty* (London: Penguin Books, 1859). p68
[11] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."
[12] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015*."; Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."
[13] Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*.p8

not autonomy, but liberty.[14] A distinction becomes possible if one defines autonomy as relating to having free will and self-determination, whilst defining liberty as being able to exercise one's autonomy without third party interference.[15] Accordingly, it is suggested by Coggon and Miola liberty is open to legitimate restriction in a way that autonomy is not.[16] O'Neill identifies a different approach than relying on a purist notion of autonomy and claims instead of focussing on individual autonomy of any distinctive kind, discussions about autonomy are actually discussing the right to choose or refuse treatments offered to patients.[17] When we look to the frameworks on offer to enhance autonomy, she claims they are generally attempting to enshrine the requirements for informed consent.[18] It can be argued by introducing a universal test; fusionists are really enhancing the opportunity for all people to choose autonomously. Therefore when fusionists talk of enhancing autonomy, what in fact they are doing is proposing frameworks aimed at promoting the rights of patients to choose for themselves. This can be seen as liberty enhancing; which may ultimately enhance autonomy, by allowing people to choose independently. The tests may do more to ensure people are free to make their own decisions without interference, rather than to ensure the real exercise of personal autonomy in any substantive way. Therefore fusion could be accused of merely paying lip service to the enhancement of autonomy. Nonetheless liberty is no less important; in order to respect people as autonomous agents, people must be free to act, not just free to reason.[19]

[14] Coggon and Miola, "Autonomy, liberty and medical decision-making." p530
[15] Ibid.p525
[16] Ibid.p530
[17] O'Neill, *Autonomy and Trust in Bioethics*.p37
[18] Ibid.
[19] Coggon and Miola, "Autonomy, liberty and medical decision-making."p530

2.3. What do fusionists say about autonomy and capacity?

In order for someone to exercise their autonomy, they must first possess certain decisional abilities. Commentators talk of patients having the required 'capacity' to make decisions; which essentially means somebody has the required functional skills to make decisions worthy of respect.[20] For decisions to be regarded as autonomous, one must have the requisite capacity to exercise this choice and decision-making must be unimpaired. Accordingly fusion approaches believe all people with the requisite capacity should be free to make their own decisions and exercise their autonomy, regardless of whether decisions are in regards to mental or physical illness.[21] The traditional argument for why the law allows the involuntary treatment of patients detained under the MHA who retain capacity, is that they are more likely to be incompetent and therefore unable to decide for themselves.[22] As Saks notes, theory and reason suggest incompetency is relevant as to whether intervention is justified against people's wishes, because only competently made choices deserve respect.[23] The increasing acknowledgement that having a mental illness

[20] Commissioner for Human Rights, "Who Gets to Decide? Right to legal capacity for persons with intellectual and psychosocial disabilities," ed. Council of Europe (Strasbourg2012).;Buchanan, "The Treatment of Mentally Disordered Offenders under Capacity-Based Mental Health Legislation." Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria."; Gledhill, "The role of capacity in mental health laws- recent reviews and legislation."; Appelbaum and Grisso, "The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment."p108; Grisso et al., "The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment."; Grisso and Appelbaum, "The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments."p154; Anthony. Holland, "Consent and decision-making capacity," in *Seminars in the psychiatry of learning disabilities.*, ed. William. Fraser and Michael. Kerr (London: Gaskell/Royal College of Psychiatrists, 2003).p311-313; Thomas. Grisso and Paul.S. Appelbaum, "Comparions of Standards for Assessing Patients' Capacities to Make Treatment Decisions," *Am J Psychiatry* 152(1995).p1036; David. Okai et al., "Mental Capacity in psychiatric patients: Systematic review," *British Journal of Psychiatry* 191(2007).

[21] Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism."; Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Matthews, "Mental and Physical Illness-An Unsustainable Separation?."; Rosenman, "Mental Health Law: An Idea Whose Time Has Passed."; Campbell, "Mental Health Law: Institutionalized Discrimination."

[22] Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*.p47Doyal and Sheather, "Mental health legislation should respect decision making capacity."p1468.

[23] Elyn. R. Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill* (Chicago and London: The University of Chicago Press, 2002). p47

does not automatically render patients incapable,[24] makes the calls for the provision of legislation allowing all patients to make their own choices more imperative and worthy of academic interest.

The main examples of fusion laws are Szmukler, Daw and Dawson's 'Model Law,'[25] the original Bamford Review[26] and the current Mental Capacity (Health, Welfare and Finance) Bill.[27] Alongside these are suggestions from commentators who agree the fusion of the laws would be a good idea but have not offered any specific examples of such laws.[28] The Bamford Review highlighted the importance of autonomy in mental health law and suggested autonomy, along with justice, benefit and least harm should be the key principles taken into account in any new legislation.[29] The Mental Capacity Bill (NI) will be based upon the principle of autonomy and arises out of the recommendations for a single framework and the introduction of decision-making ability tests into the legislation. Their view was that in order to promote patient autonomy, respect should be extended to all capacitous decisions. It was felt the principles should be applied in a non-discriminatory way to both mental health and physical health decisions[30] and only when someone's individual autonomy was impaired could their decision-making be interfered with.[31]

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[24] Owen et al., "Mental capacity and psychiatric in-patients, implications for the new mental health law in England and Wales."p153; Moser et al., "Using a Brief Intervention to Improve Decisional Capacity on Schizophrenia Research." p116 & 118; Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*. p193; "*Code of Practice, Mental Health Act 1983*." p188; Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*.; Hale, *Mental Health Law*.p69 and 187; Bowen, *Blackstone's Guide to the Mental Health Act 2007*.p274.

[25] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." And Szmukler, Daw, and Dawson, "Outline of the Model Law."

[26] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."

[27] Herein known as the Mental Capacity Bill (NI). For further discussion see; "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015*.."; "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment*."

[28] Matthews, "Mental and Physical Illness-An Unsustainable Separation?."; Campbell, "Mental Health Law: Institutionalized Discrimination."; C. Lauber et al., "What about psychiatrists' attitude to mentally ill people?," *European Psychiatry* 19, no. 7 (2004). For further discussion refer to chapter one.

[29] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."p37 Chapter 5- para 5.1

[30] Ibid.p38 para 5.3

[31] Ibid.p42 para 5.23

It can be argued fusionist approaches are too cognitively biased because their tests have been based upon cognitive functioning.[32] This was a criticism of the original Bamford Review and was a reason in subsequent consultations for the continuation of separate treatment in certain circumstances regarding persons with mental illnesses.[33] In psychiatry, emotions and moods play a huge role in decision-making.[34] By limiting capacity-based tests to the assessment of rational and conscious aspects of decision-making, they are not representative of how people make decisions.[35] Decisions are often based upon emotions or intuitive factors that are not easily assessed. The influence of emotions and moods are especially important when dealing with patients with mental illnesses because disorders such as depression can cause patients to be governed by severe mood changes or depressed moods and emotions. For example a depressive patient may have functioning capacity and pass a capacity test, but their decision-making may be based upon an altered state of emotions or governed by their illness and so they refuse treatment.[36] It could be said they are not autonomous.

2.4. Decisional Capabilities

Decisional capabilities are required in order to have capacity and therefore be capable of exercising one's own autonomy. The ways in which these abilities are assessed can pose difficulties for the enhancement of autonomy; as well as illustrating the differences in

[32] Torsten.M. Breden and Jochen. Vollman, "The Cognitive Based Appraoch of Capacity Assessment in Psychiatry: A Philosophical Critique of the MacCAT-T," *Health Care Analysis* 12, no. 4 (2004). p276
[33] "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*."
[34] Vellinga et al., "Instruments to assess decision-making capacity: an overview." p 415; G. S. Owen et al., "Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study," *Psychological Medicine* 39, no. 8 (2009).p1396; Breden and Vollman, "The Cognitive Based Appraoch of Capacity Assessment in Psychiatry: A Philosophical Critique of the MacCAT-T."p276-279; Hotopf, "The assessment of mental capacity."p583
[35] Breden and Vollman, "The Cognitive Based Appraoch of Capacity Assessment in Psychiatry: A Philosophical Critique of the MacCAT-T." p276
[36] Eric. Matthews, "Autonomy and the Psychiatric Patient," *Journal of Applied Philosophy* 17, no. 1 (2000). p67

approach to how persons with mental illness may be treated compared to those with physical illnesses.

2.4.(i): Appreciation

The word 'appreciation' is nowhere to be found in the MCA or the MHA; however both the 'Model Law'[37] and the original Bamford Review,[38] have noted its inclusion in their proposed capacity-based tests. The proposals of such fusion approaches reveal a view of capacity that is inconsistent with the current statutory approach and that of the Mental Capacity Bill (NI). The MCA 2005 and the Bill only demand people can 'use or weigh' information when determining capacity and so these fusionist proposals would add an extra element to the current statutory tests. So why have they added appreciation to their tests? According to Appelbaum and Grisso, the appreciation standard requires patients to recognise they are suffering from a disorder and recognise the risks and benefits of treatment apply to them.[39] The original Bamford Review agreed with this definition but limited the use of appreciation to specific circumstances.[40] They suggested a failure to appreciate is only counted when choices are "based on beliefs which are substantially irrational, unrealistic, or a considerable distortion of reality; are consequences of the person's impaired cognition or affect; and are relevant to the person's treatment decision."[41] It was felt the current MCA 05 test which did not include 'appreciate' had a more cognitive or intellectual bias and did not reflect all aspects of mental functioning which could potentially affect decision-making capacity.[42] However, this was the extent of

[37] Szmukler, Daw, and Dawson, "Outline of the Model Law."p102
[38] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."p88 para 7.2
[39] Appelbaum and Grisso, "The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment." p114-115
[40] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p55 para 5.11
[41] Ibid.
[42] Ibid.p55-56.para 5.13-5.14

the discussion surrounding 'appreciation' in the original review and despite giving a brief description of when the term should be used in practice it does little to explore how it will would have worked to the advantage of all patients. With the exclusion of the term in the Bill and with the Equality Impact Assessment stating they will only discuss the importance of the term 'appreciation' in the Code of Practice and the preparation of the legislation; it is difficult say with any certainty why the term was left out of the Bill. It could be argued the Bill in Northern Ireland was attempting to mirror the MCA 05 which also does not include 'appreciation' or it could be surmised that to include such a term would have caused problems in its practical application.

This supposition is reinforced because concerns have been raised in regards to the use of appreciation in several pieces of research. For example, patients with schizophrenia were more likely to not appreciate they were ill, compared to patients with angina and depression; but both those with schizophrenia and major depression, were more likely not to appreciate the value of treatment.[43] Saks found patients may not wish to be labelled as 'mentally ill', which can be stigmatising and concluded the attempt to avoid the negative consequences of a mental illness diagnoses may well be a rational choice.[44] According to Saks and Behnke denial of illness may help a patient draw on resources they would be too discouraged to use if they were to accept their illness.[45] Simply by forcing a patient to accept a diagnosis, even if they are willing to accept treatment for the symptoms they do acknowledge, does nothing to answer the question as to whether they are capable of making decisions. [46] Other problems with the use of the term appreciation are patients may not wish to agree with doctor's diagnoses, as it is common for disagreements to arise about

[43] Grisso and Appelbaum, "The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments." p162-164
[44] Elyn. R. Saks and Stephen.H. Behnke, "Competency to Decide on Treatment and Research: MacArthur and Beyond," *Journal of Contemporary Legal Issues* 10(1999). p120
[45] Ibid.
[46] Ibid.p121

psychiatric diagnoses and categories of illnesses.[47] If a patient has been ill for many years and received several different diagnoses, using an 'appreciation' criterion risks labelling a patient as lacking capacity simply because they have chosen not to believe the doctor this time around.[48] Patients may be regarded as lacking capacity simply by choosing to disagree with medical professionals and harks back to the era of 'doctor knows best.' This risks capacity assessments becoming too high a standard for patients to pass and could therefore become a standard which to Kirk and Bersoff is "most offensive to individual liberty."[49] They demonstrate how autonomy constricting 'appreciation' can be by comparing the refusals of two types of patient.[50] First, a patient with mental illness who is also a Christian Scientist rejects the potential benefits of medication based on recognised religious grounds. The second patient also has a mental illness, but refuses because they truly believe psychotropic medications are unhelpful and the side effects outweigh any benefit. Because the first patient's refusal is based upon recognised religious grounds, it is respected; however, the second patient's refusal is not. They say although each claim is neither medically nor scientifically true, the only difference must be that society tolerates interference into the lives of those with mental illness; but does not tolerate the interference with religious beliefs. They agree it is correct to interfere when decisions are unequivocally delusional, however a disagreement with science and medicine and the effectiveness of medication is not clear evidence of incompetence.[51] Slobogin further demonstrates being classified as incompetent merely on the basis one has disagreed with doctors or lawyers, is "insufficiently respectful of autonomy."[52] This may cause problems in mental health law because side effects of psychiatric medication can be worse than the symptoms they are

[47] Ibid.p117 and p120
[48] Ibid.p117
[49] Trudi. Kirk and Donald. N. Bersoff, "How many procedural safeguards does it take to get a psychiatrist to leave the lightbulb unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study," *Psychology, Public Policy and Law* 2, no. 1 (1996). p63
[50] Ibid.p64
[51] Ibid.
[52] Christopher. Slobogin, ""Appreciation" as a Measure of Competency: Some Thoughts About the MacArthur Group's Approach," *Psychology, Public Policy and Law* 2, no. 1 (1996).p22.

supposed to be relieving. Many patients take large amounts of medication to combat the side effects of psychiatric treatment. Therefore when we look to the decision-making of persons with mental illness, it is wholly reasonable in some cases for patients to want to refuse certain treatments, especially those with severe side effects such as memory loss due to ECT and the zombie-like effect of strong anti-depressants. When we look to what it means to be autonomous, in regards to people being free to decide how to live according to their own beliefs and values, it is nobody's decision but the patients as to whether they want to be subjected to side effects of medication. More often than not, whether a belief is true or not is disputable and as Saks and Behnke suggest, if society requires certain beliefs, patients may be prevented from pursuing the truth according to their own "lights".[53] Restricting what people can and cannot believe in risks curtailing the unconventional and the eccentric.[54]

Nonetheless, the proposed introduction of the term appreciate may be able to ensure the tests will be nuanced enough to catch the most vulnerable patients. Such a term may also lead to the introduction of a two-tiered test through the back door, where patients with mental illness who are refusing treatment, may be held to a higher standard than other patients. So could the inclusion of such terms as appreciation add an extra layer to the test that will bring in a mental ill health capacity assessment under the guise of a universal test? As Kirk and Bersoff suggest the likelihood of erroneous determinations of incompetency will be higher if mental health 'refusers' are held to a higher standard.[55] If fusionists not only want to enhance autonomy, but reduce discrimination as well, they will need to ensure the inclusion of such terms as appreciation and the tests they utilise will not end up creating an unjustified additional mental health hurdle in the capacity assessments.

[53] Saks and Behnke, "Competency to Decide on Treatment and Research: MacArthur and Beyond."p116
[54] Ibid.p117
[55] Kirk and Bersoff, "How many procedural safeguards does it take to get a psychiatrist to leave the lightbulb unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study." p65

2.4.(ii) Communicating

Both the Model Law and the Bamford Proposals agree in order for someone to have capacity they must be able to communicate their decisions. However, recent cases have shown the difference in the court's approach to issues of communication in regards to capacity assessments. In the case of *XB*[56], the courts had to determine whether XB, who had motor neurone disease, had capacity at the time of drafting his advance decision (AD) to refuse life-saving treatment. There was very little discussion, if any at all, about whether XB truly had capacity at the time in question. The courts simply acknowledged his AD complied with the necessary formalities to be valid and the only law referenced was in regards to the validity of them under ss.24-26 MCA 05. The presumption XB had capacity was clearly very strong as there was no real investigation into other aspects of capacity when making the AD. It seems it was enough to decide XB had capacity at the time of making the AD, merely because he could communicate with others; "XW [XB's GP] was able to communicate with XB."[57] This is in contrast to the approach taken in the case of *E* which concerned a 32 year old woman with severe anorexia nervosa, alcohol and opiate dependency and personality disorder.[58] The courts were determining the capacity of E to refuse life-saving feeding and held E lacked the relevant capacity required under the MCA 2005, ordering the force feeding should commence against her wishes. There is very little discussion about how the judge came to the decision E in fact lacked capacity. In contrast to XB's case the judgement focused mainly on how to decide what action would be in E's best interests having found her lacking capacity. Regardless, the case reiterated "[p]eople with capacity are entitled to make decisions for themselves, including about what they will

[56] *The X Primary Care Trust v XB, (By the Official Solicitor as Litigation Friend), YB* [2012] EWHC 1390 (Fam)
[57] *The X Primary Care Trust v XB, (By the Official Solicitor as Litigation Friend), YB* [2012] EWHC 1390 (Fam) para 29; words in brackets added.
[58] *A Local Authority v E* [2012] EWHC 1639 (COP)

and will not eat, even if their decision brings about their death...the Court of Protection, is only entitled to interfere where a person does not have the capacity to decide for herself".[59] In contrast to *XB,* the judge explained the relevant sections of the MCA in regards to capacity assessments; however took only seven paragraphs to conclude E lacked capacity. The court was in no doubt E had an impairment of, or disturbance in the functioning of her mind or brain due to her severe anorexia.[60] However it was stated she clearly understood and retained the information she had been given by the healthcare teams and had clearly communicated her decision and so passed three of the four subsections of the test in s.3 MCA 2005.[61] The hurdle E fell at was in regards to her weighing up the information she had been given.[62] The judge cited there was "strong evidence that E's obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way."[63] On one reading, the assertion E lacked capacity can be compared to the decision in *Re MB*[64], where the fear of needles was said to inhibit the decision-making process of MB, when refusing a life-saving caesarean section. It could be argued the fear of weight gain and the "compulsion to prevent calories entering her system"[65] prevented E from engaging in a productive and unimpaired decision-making process as was the case in *Re MB.* However, it is unfortunate this is merely conjecture, as Mr Justice Jackson did not go into much detail regarding E's capacity status.

It seems the presumption of capacity is given more weight to those with physical illnesses, as opposed to those with mental illnesses. Could this be because of the operation of the current laws, whereby capacity is not a 'gateway' criterion for the operation of the MHA? Therefore when dealing with persons with mental illnesses, the starting point for

[59] *A Local Authority v E* [2012] EWHC 1639 (COP) per Mr Justice Peter Jackson at para 7
[60] S.2 (1) MCA 2005
[61] S.3 (1) (a), (b) and (d) MCA 2005.
[62] S.3 (1) (c) MCA 2005
[63] *A Local Authority v E* [2012] EWHC 1639 (COP) at para 49
[64] *Re MB* [1997] 38 BMLR 175
[65] *A Local Authority v E* [2012] EWHC 1639 (COP) at para 49

consideration focuses more on providing care and treatment rather than on increasing patient autonomy and allowing patients to choose. Does this mean when the courts and medical professionals look to the capacity status of patients they focus on different aspects of the tests for different classes of patients?

E's case could easily have been decided in a manner similar to *B v Croydon Health Authority*[66] as she could well have been detained under the MHA 83 and subjected to involuntary treatment under s.63 which allows for the involuntary administration of treatments for mental disorder, including force feeding, regardless of the capacity status of the patient. In *B v Croydon Health Authority* the capacity status of B, who also faced force-feeding, was not considered by their Lordships as they declined to rule on whether B lacked capacity to refuse the treatment, because it could be forcibly given to her under s.63 MHA 83.[67] The fact E's capacity status was taken into account is a step in the right direction, but the decision is still open to criticism because the capacity assessment received little discussion in the judgement and has been left open to interpretation.

Traditionally when dealing with treatment for physical illnesses without consent, the courts have limited their power to those cases where the patient is deemed to lack decision-making capacity.[68] In *Re C*[69], the courts held the decision of Mr C to refuse the life-saving amputation of his leg due to gangrene must be respected. Despite being diagnosed as a chronic paranoid schizophrenic, the courts held he had the required capacity to consent to or to refuse treatment and his decisions must therefore be respected, no matter what the consequences were or whether he had a mental illness or not. The decision in E is also at

[66] [1995] 1 All ER 683
[67] Keywood, K. '*B* v *Croydon Health Authority* 1994, CA: Force-Feeding the Hunger-Striker under the Mental Health Act 1983'. Available via: http://webjcli.ncl.ac.uk/articles3/keywood3.html [accessed 30th November 2013] However some of their Lordships did mention in passing the question of B's capacity.
[68] Fistein et al., "A comparison of mental health legislation from diverse Commonwealth jurisdictions." p148
[69] *Re C* (adult: refusal of medical treatment) [1994] 1 All ER 819

odds with this and the judgement in the *Ms B*[70] case where a tetraplegic woman expressed a wish to be removed from a ventilator and be left to die. In this case it was held Ms B had the capacity to refuse life-saving treatment and as such she was even awarded nominal damages due to the unlawful treatment she had been receiving against her wishes. Although there are similarities between the two cases as both women were highly intelligent and articulate and had both expressed a wish to die, the final judgements were decided differently. It might be cynical to suggest the only relevant difference was Ms B was not suffering from a mental disorder. E was and this inevitably meant there were more question marks about E's capacity than Ms B's. Unlike in XB the presumption E had capacity was not strong. In one way the case of E reflects how uncomfortable people are with the idea of letting people with a mental illness be allowed to make decisions that can lead to death. The idea decision-making is severely affected by one's illness is discussed much more in cases such as E's where the patient has a mental illness, compared to cases involving patients with physical disorders, such as XB. The courts therefore appear more sympathetic to the autonomy of those with physical illnesses than those with mental illnesses.

This highlights a potential difficulty in regards to the decision-making ability of those with mental illnesses and shows the relationship between autonomy and capacity is not as simplistic as the fusionists suppose. The capacity hurdle may prove to be difficult to overcome due to the tradition of paternalism within healthcare and the courts. This raises concerns about how the capacity of people with mental illness will be viewed and although not academic commentators, E's parents raised a valid observation in regards to how these rights are viewed. They stated:

> "[i]t seems strange to us that the only people who don't seem to have the right to die when there is no further appropriate treatment available are those with an eating disorder. This is based on the assumption that they can never have capacity around

[70] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam)

> any issues connected to food. There is a logic to this, but not from the perspective of the sufferer who is not extended the same rights as any other person."[71]

2.4.(iii) Understanding

Further concerns are raised when looking to 'understanding' as a decisional capability. As Saks points out, if a person does not understand information given to them, they are in no position to make a valid decision as to how to proceed and demonstrates basic understanding is a necessary ability to possess.[72] Both examples of fusion laws include the need for a patient to understand information; however understanding by itself is not sufficient.[73] Under the MCA 2005 guidance, capacity to understand information is required but any further requirement patients need to prove they have actually understood, creates a dangerously high hurdle for patients to overcome.[74] One risk of over-identifying someone as understanding is what may actually be happening is that their memory is being tested.[75] People may be classified as lacking capacity by simply forgetting what they were told, despite understanding every word. On the other hand people may be held to have capacity by simply being able to regurgitate what was told to them without any real understanding.[76]

According to the Code of Practice for the MCA 2005 it is sufficient for a patient to understand the information in 'broad terms' and to understand the nature of their diagnosis and prognosis, the nature of the proposed treatment, the anticipated benefits and potential

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[71] *A Local Authority v E* [2012] EWHC 1639 (COP) para 52
[72] Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. p178 and 180; C.W. Van Staden and C. Kruger, "Incapacity to give informed consent owing to mental disorder," *Journal of Medical Ethics* 29(2003).p42
[73] Saks and Behnke, "Competency to Decide on Treatment and Research: MacArthur and Beyond." p113; Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. p178
[74] Johnston, ed. *Medical Treatment: Decisions and the Law: The Mental Capacity Act in Action*. p9 para 1.14
[75] Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. p180-181
[76] Ibid.p181

risks of treatment, the risks associated with not having treatment and any alternatives, and the risks and benefits of such alternatives.[77] Under Part IV of the MHA 83 the statutory test of capacity is that the patient is 'capable of understanding the nature, purpose and likely effects of treatment'. In the MHA Code of Practice a patient needs to "understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it."[78] Therefore when we look to the fusion examples, which are based upon the MCA 2005, the question needs to be answered as to how much a patient will need to 'understand' in order to be deemed capable. Will fusion examples follow the guidance from the MCA 2005 and Part IV MHA 83 or will they require a deeper 'understanding' in order to have capacity? Such tests do not assess a patient's autonomy in any substantive way and in order for patients to exercise their autonomy they need to be able to pass the capacity tests. If they are too difficult to pass, fewer people will be able to exercise their autonomy to the fullest. Therefore the fusionists need to implement tests that people, including those with mental illnesses, can pass in practice.

2.5. When can autonomy and capacity be trumped?

Despite the flaws of some of the decisional capabilities, fusionists believe the absolutism of autonomy supports the introduction of capacity-based tests. Some defend the use of a pure autonomy approach because by virtue of autonomy's absolutism it has the advantage of certainty.[79] Striving for certainty in a complex area of medical law is commendable, however to say the use of an autonomy approach provides clarity is somewhat misguided. As has been shown, autonomy is not as straight forward a concept as some assume. The

[77] Mental Capacity Code of Practice, Chapter 4; for further explanation see Johnston, ed. *Medical Treatment: Decisions and the Law: The Mental Capacity Act in Action*. p23 para 2.3
[78] "*Code of Practice, Mental Health Act 1983*."para 23.34
[79] R. Bailey-Harris, "Patient Autonomy- A Turn in the Tide?," in *Law and Medicine*, ed. M. Freeman and A.D.E. Lewis (Oxford: Oxford University Press, 2000). p 133

use of autonomy does not provide certainty for a number of reasons. It has different meanings to different people; it can be advanced or restricted in many different ways and it is guilty of subjectivity. Whenever humans are involved in any decision making or determination, an element of subjectivity will be present. Therefore it is a spurious claim to say autonomy is certain simply because it is absolute. Suggestions there is a universal 'ideal' way of life are more likely than not to impose the doctor's ideal upon their patients and "smacks of hegemony."[80] However, autonomy's absolutism raises concerns as to whether society would accept it within psychiatry. Foster suggests by simply saying someone is autonomous does nothing to explain what autonomy is or means, but only suggests whether or not their decisions deserve respect.[81] Lindley curtails the extent to which autonomy should be invoked by stating it does not follow people should always be allowed to do as they please, despite the intrinsic value of autonomy.[82] Thus the emphasis on autonomy risks ignoring other important obligations and interests, including obligations to others, pursuit of common goals and notions of justice in health care decisions. [83]

So are there any situations when choices made by people with capacity can be overruled?[84] Will society accept the absolutist approach when patients are allowed to starve themselves to death or continue their day to day lives despite being a risk to the public because they meet a legal standard of capacity? Of course the purists would say yes; society needs to accept this because autonomy is absolute. If patients have the ability to make decisions about treatment or detention, decisions must be respected regardless of the consequences. This happens with physically ill patients; therefore it is unfair not to allow the same for

[80] Oshana, "How much should we value autonomy?." p 106
[81] Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*.p9
[82] Lindley, "Paternalism and Caring." p58
[83] Herring, *Medical Law and Ethics*. p194; Jonathan. Herring, "Case Commentary: The Legal Duties of Carers," *Medical Law Review* 18, no. Spring (2010).p254-255
[84] E.J.D. Prinsen and J.J.M. van Delden, "Can we justify eliminating coercive measures in psychiatry?," *Journal of Medical Ethics* 35(2009).; Garrett. Cullity, "Beneficence," in *Principles of health care ethics*, ed. Richard. Ashcroft (Chichester: John Wiley & Sons Ltd, 2007).; David. Archard, "Paternalism Defined," *Analysis* 50, no. 1 (1990).

persons with mental illness. Is it just the price we pay for allowing everybody to make their own choices?

From a legal perspective, capacity is a dichotomous concept.[85] In law you either have capacity or you do not. Because of this dichotomous distinction the law suggests we can sometimes overrule people's choices. This usually occurs because someone is found to lack capacity and can then be involuntarily treated in the promotion of other interests. These discussions force us to examine the claims of the fusionists in regards to the use of capacity-based tests in mental health legislation and to question whether there are any justifications to allow the involuntary treatment or admission of those who retain capacity. If it can be shown involuntary treatment of persons with a mental disorder who retain capacity can be justified, the fusion approach may have to rethink the use of capacity-based tests and its reliance upon autonomy. Therefore even if fusion were to be implemented, exceptions would still remain. We already have a capacity-based test in the MCA 05, yet under certain circumstances the law allows the treatment of patients who appear to be capable. It is acknowledged the operation of the MHA 83/07 would cease should a fusionist approach be implemented to its fullest; however the addition of concepts such as 'appreciation' may bring those who are 'barely' or 'just' competent under the umbrella of justified involuntary treatment under the guise of advancing their autonomy. Such patients before fusion may have been free to make their own decisions, whereas under fusion they may be classified as lacking capacity and forced to accept treatment in the name of enhancing autonomy.

This section of the thesis will demonstrate that whilst autonomy and capacity are important, some less well established claims about them will be discussed which may in fact justify curtailing patients autonomy in the short term. It will illustrate that the

[85] Holland, "Consent and decision-making capacity." p311; Genevra. Richardson, "Involuntary Treatment: Searching for Principles," in *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Committment*, ed. Kate. Diesfeld and Ian. Freckleton (Aldershot: Ashgate Publishing Ltd, 2003). p69

relationship between autonomy and capacity is not as simple as some fusionists suggests. In order for some patients to exercise their autonomy, in certain situations curtailment of their present autonomy is necessary. When we look to the mental health care system, moving away from traditional perspectives may not necessarily be the easiest or most acceptable move to make. It will be shown that the fact capable decisions can be overruled in some instances demonstrates that even with the introduction of a fusionist framework, the law and healthcare professionals will find a way to overrule patient choices if it is deemed necessary and justifiable to do so. If exceptions can be shown to the current system, which already uses a capacity-based test in some areas, then the implementation of a universal capacity-based test may do very little to ensure the advancement of autonomy for persons with mental illness. This will be unless, of course the current justifications for involuntary treatment only occur in regards to patients who would subsequently be covered by a fusion law. If fusionists can show the current justifications would not apply if a fused Act was in place then the practice of involuntarily treating capable patients may cease.

2.5.(i) The Interests of Others

There are situations where the autonomy is restricted and even those with capacity can have their wishes ignored. One such instance is in the promotion of harm prevention and in the interests of others. Many have questioned whether everyone who is capable of autonomy or self-determination, should be worthy of an autonomous life.[86] It is clear

[86] Oshana, "How much should we value autonomy?." p108; see also, Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*.; Lindley, "Paternalism and Caring."; Jonathan. Herring, "Losing it? Losing what? The law and dementia," *Child and Family Law Quarterly* 21, no. 1 (2009).; Michael. Cavadino, "A Vindication of the Rights of Psychiatric Patients," *Journal of Law and Society* 24, no. 2 (1997).; Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, And Individual Freedom*.p219 and 226; Willard. Gaylin and Bruce Jennings, *The Perversion of Autonomy: coercion and constraints in a Liberal society* (Washington D.C.: Georgetown University Press, 2003).p201; Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*.p12 and 53-54; Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*.p47-48.

fusionists believe everyone who is capable should have their choices respected.[87] A legal framework allowing this will in turn enhance patient autonomy. However not all fusionists ask or indeed answer, whether everyone deserves to have their autonomy respected. The exercise of autonomy is not the only concept with intrinsic value.[88] The involuntary treatment and detention of patients, even those retaining capacity, may be enforced in order to promote the autonomy or liberty of others.[89] Even the Expert Committee envisaged in certain circumstances it would be appropriate to subject some patients to compulsion despite the fact they retained capacity.[90] They felt it was justified to restrict someone's autonomy in the interests of public safety if the risk was sufficiently great.[91] In order to explain further an example used by Oshana will be given. Nancy the narcoleptic driver has the freedom to drive and it would certainly diminish her autonomy if this freedom was taken away.[92] However her narcolepsy causes driving to become unsafe, posing a risk to herself and others. Despite this risk she ignores her responsibility to others and continues to drive. According to Oshana, because Nancy has ignored this knowingly, she does not deserve autonomy with respect to her driving and measures to restrict her autonomy are necessary. Nancy is regarded as autonomous and as a responsible agent; however it is not necessary or desirable to respect her autonomy because of her reckless behaviour. Valuing autonomy too highly in this regard may tempt people to overlook the desirability of the constraint.[93] This reasoning could be applied to justify the involuntary treatment and detention of patients with mental illness who retain capacity. If a patient with capacity decides to refuse treatment or detention, even though they are aware of the dangers to their own health and to others, then it could be argued they have deliberately ignored their responsibilities and therefore measures to restrict their autonomy may be justifiable. Even

[87] With the notable exception of forensic patients in Dawson, Daw and Szmukler's proposals.
[88] Lindley, "Paternalism and Caring." p58-59
[89] A. Flamme and H. Forster, "Legal Limits: When does autonomy in health care prevail?," in *Law and Medicine*, ed. M. Freeman and A.D.E Lewis (Oxford: Oxford University Press, 2000). p157
[90] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*.", p94 para 7.19
[91] Ibid.p19, para 2.7
[92] Oshana, "How much should we value autonomy?." p109
[93] Ibid. p110

under fusionist proposals, autonomy can be viewed as a way to restrict people's actions. Both examples agree autonomy can be curtailed, but disagree doing so is the job of mental health legislation. Under both the Mental Capacity Bill (NI) and the 'Model Law', if a person was at risk of self harm or suicide, only when they lacked capacity would it be justified for the fusion legislation to step in. If a person posed a risk to others whilst retaining capacity it would be the job of the criminal justice system to deal with this. However both models do include exceptions which would allow the restriction of the autonomy of a small number of forensic patients with capacity in the name of public safety. The original Bamford Review insisted even where patients suffering from mental disorders who retained capacity and posed a risk to others only, and not to themselves, would not be covered by this framework, but would instead be subject to regimes under the Criminal Justice System.[94] As such the original review went further than the 'Model Law' and even the current Mental Capacity Bill (NI) insisting on following a pure autonomy stance. Despite the original reports fervent support for a pure autonomy stance, the Northern Irish assembly has chosen not to introduce such legislation. Instead they have chosen to introduce legislation that on the whole applies to only those who lack capacity; however retaining within it a 'safety catch' allowing a small number of patients who are deemed to be dangerous to be involuntarily treated or cared for.[95]

This discussion shows even under fusionist approaches, capable patients could still have their autonomy restricted, albeit they would be restrained by the criminal justice system. But could this end up creating a situation whereby to get capable psychiatric patients to receive involuntary care they will be labelled as criminals in order to attain the treatment medical professionals feel is necessary? When we look to the comments in the post-legislative scrutiny of the MHA, it was worrying to hear some doctors had been detaining

[94] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."para 7.24
[95] Mental Capacity (Health, Welfare and Finance) Bill Northern Ireland

patients under the MHA in order to provide them with the care they needed but could not access voluntarily.[96] Although only conjecture, if true this shows some doctors are prepared to willingly apply the law incorrectly, in order to treat vulnerable patients and it does not require a huge leap to believe some may also twist any sort of fusion law in order to get treatment for patients who desperately need it.

A situation likely to arise in psychiatric care is that of patients refusing food and thus potentially starving themselves to death. Patients with anorexia have been shown to score highly on all the abilities in the Mac CAT-T,[97] which is a clinical tool used to assess patient's capacities to make decisions.[98] Its use has helped to explain how people make decisions and how clinicians can assess decision-making capacity. It can be argued under a fusion regime patients with anorexia will also retain capacity. Herring argues current legislation is "insufficiently subtle to deal with the issues at stake" and suggests even in circumstances where patients have capacity the law should allow involuntary intervention to prevent harm to self.[99] Therefore the rejection of autonomy could be justifiable, by weighing up the person's autonomy versus the risk of serious harm. It is clear there are issues with the decision-making ability of persons with anorexia as highlighted in cases such as E, which causes concern when dealing with the implementation of such tests.[100] A fusion test needs to be wide enough for patients who possess the relevant decisional abilities to be left to make their own treatment choices, yet at the same time it needs to be capable of 'catching' patients whose decision-making ability is questionable in order to protect them with appropriate legal safeguards. Decision-making ability is not easily

[96] House of Commons, "*Post-legislative scrutiny of the Mental Health Act 2007. First Report of Session 2013-2014: Report, together with formal minutes, oral and written evidence.*."p11-12. Also Q4 and 9
[97] Tan, Hope and Stewart (2003) cited in Edward. D. Sturman, "The capacity to consent to treatment and research: A review of standardized assessment tools," *Clinical Psychology Review* 25(2005). p961
[98] Grisso, Appelbaum, and Hill-Fotouhi, "The MacCAT-T: A Clinical Tool to Assess Patients' Capacities to Make Treatment Decisions."
[99] Herring, "Losing it? Losing what? The law and dementia." p8
[100] Sturman, "The capacity to consent to treatment and research: A review of standardized assessment tools." p961

quantified and so any capacity test employed needs to capture the nuances of mental illness and human behaviour if it is to work effectively. Fusionists therefore need to address this legitimate concern about patient's welfare and ensure tests employed are fit for purpose.

2.5(ii) Patients are 'Not Fully Autonomous'

Autonomy may also be curtailed when it is questionable as to whether the patient was fully autonomous when making decisions. The distinction between being an autonomous person and not being an autonomous person is not as easily drawn as fusionists suggest. Risks arise in psychiatry that doctors are accepting consents from people who are not entirely autonomous and yet refusing to accept consent from the more eccentric or bizarre patients who may well be autonomous. Nonetheless Oshana warns that valuing autonomy too much can also have a negative effect when doctors act in haste; if they expect too much of someone who may not be ready to decide for oneself or indeed be capable of doing so.[101] Fusionists infer impaired decisions can be overruled and base their proposals on the idea unimpaired decisions need to be respected. Therefore it can be argued decisions regarded as not fully autonomous may also be overruled. Some argue people with mental illness are not fully autonomous because by its very nature, mental illness affects mental functioning and therefore interferes with the cognitive abilities needed for unimpaired decision-making.[102] However, not all people without a mental illness can be said to be fully autonomous. Just as it can be said that not all persons with mental illness lack capacity.

[101] Oshana, "How much should we value autonomy?." p103
[102] Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*.p47; Appelbaum and Grisso, "The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment."p111; J.G. Wong et al., "Capacity to make health care decisions: its importance in clinical practice," *Psychological Medicine* 29(1999).p437

Therefore if someone is barely competent and risking serious harm, can and should autonomy be outweighed? Herring suggests decisions need not be respected if it is unclear if it was a 'richly' autonomous decision.[103] When dealing with cases of patients with depressive illnesses or anorexia, some but not all, will retain capacity; however they may be making decisions that will seriously harm or even kill them. By not respecting their decisions, this will allow them to receive treatment which will return them to a state where they can make fully autonomous decisions. The justification for involuntarily treating such patients is if such patients were left to make their own decisions they may die or suffer immeasurably. Those who are making decisions based on delusions or during manic stages of illnesses may not necessarily be making these decisions in line with their previous personal beliefs and life values and may be deemed to be 'just' capable.[104] This illustrates that the relationship between autonomy and capacity can become muddled. Therefore the decision-making process needs further scrutiny because as this shows, just because someone retains capacity it does not automatically mean they have got autonomy or have made a fully autonomous decision. Therefore when we look to the fusion approaches it needs to be uncovered whether the proposed tests will actually enhance autonomy in any real sense.

Case law, at the level of rhetoric at least, backs up the proposition that one's decisions can in fact be "irrational"[105] or "appear morally repugnant" [106] to others or be made "for any reason, rational or irrational or for no reason at all,"[107]and bolsters the idea people are free to decide without interference. But to allow *any* kind of decision, especially ones that on the face of it seem irrational, could lead to some people being left to decide for themselves when they are in fact not autonomous or capable of doing so. To allow free reign could

[103] Herring, "Losing it? Losing what? The law and dementia." p9-10 and 12
[104] Ibid.p7
[105] *Re T* [1992] EWCA Civ 18 at para 30
[106] *St George's Healthcare NHS Trust* v *S* [1998] 3 WLR 936 at 957
[107] *Re MB* [1997] 38 BMLR 175

result in devastating consequences, especially when dealing with patients who are threatening self-harm or even suicide. O'Neill states by simply giving people the freedom to make a decision; it in no way ensures decisions are autonomous.[108] Merely by virtue of people being free to make choices does not mean autonomous people will always act autonomously and where they do not, these actions may well be contrary to their own long term autonomy.[109] If this is the case then this does not back up fusionist claims that autonomy will be enhanced by a fusion regime. What it will do is back up the claim that fusion regimes give people the freedom to make decisions, but not necessarily autonomous ones. Because the situation may arise where people are free to make their own decisions, if too many people are left to make decisions with devastating consequences such as death or self harm, the fusion regimes may need to tighten their capacity assessments in order to restrict the numbers of people who are allowed to make such harmful decisions. By doing this, it will then restrict people's autonomy and therefore be going against the underlying premises of its own approach. This highlights that in order for fusion to work and to allow those with autonomy to make their own decisions, it needs to ensure its (in)capacity criterion are suitable for use and again shows the complexity of the relationship between autonomy and capacity.

Therefore it has been shown that if a patient has not made a fully autonomous decision, their autonomy may be justifiably restricted. Under fusion, the inclusion of such terms as appreciation may go some way to ensuring the decision-making process of patients is more nuanced and more detailed to ensure patient's decisions are in fact as autonomous as they can be. This may eradicate the justification to ever involuntarily treat capable patients because they will have been through a more stringent capacity assessment under a fused system. However the concern for patient welfare will remain as patients who are deemed

[108] O'Neill, *Autonomy and Trust in Bioethics*.p37. See also, Foster, *Choosing Life, Choosing death: The Tyranny of Autonomy in Medical Ethics and Law*.p13-14
[109] Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*.p12

as having capacity under a fusion test may still continue with self harming or even suicidal actions. This may inevitably make capacity assessments so broad they become difficult for patients with mental illnesses to pass.

2.5.(iii) Maximisation of Individual's Long Term Interests

Fusionists argue as long as patients have capacity they should be able to make their own decisions. Brazier claims the respect for persons is a "two-edged weapon" and belies a conflict;[110] do healthcare professionals manifest more respect for patients with mental illnesses by respecting current decisions that are limited or distorted, or by relieving their immediate illness and therefore restoring their well-being?[111] Campbell further clouds the issues stating "we must also accept that for some of us all of the time and for all of us some of the time the maintenance of autonomy will not be the major issue. Instead we need to know that we are responded to, loved, protected by people we can trust."[112] This is especially true in psychiatry as many patients will be aware they may be subject to involuntary detention and treatment. In order to answer Brazier's dilemma, many factors needs to be considered. It may be easier for such patients to come to terms with a temporary loss of autonomy to get them well again, if they know they will be cared for and decisions will be made in line with their interests. This is nonetheless an idealistic view of how decisions are made and merely conjecture on the views of patients. However, this continues to highlight the dichotomy between the patient's present interests and their long term health issues. The fusion proposals fail to engage with this dilemma sufficiently and do not question whether it may be true that patients, whether with a mental illness or physical illness, may benefit from a holistic approach to decision making where autonomy does not rule and beneficence can have an influence. Dworkin claims it may be harsh to

[110] M. Brazier, "Competence, Consent and Proxy Consents," in *Protecting the Vulnerable: Autonomy and Consent in Health Care*, ed. M. Brazier and M. Lobjoit (London: Routledge, 1991). p 42
[111] Ibid.
[112] Alastair. Campbell, "Dependency Revisited: The limits of autonomy in medical ethics," in *Portecting the Vulnerable: Autonomy and Consent in Helth Care*, ed. Margaret. Brazier and Mary. Lobjoit (London and New York: Routledge, 1991).p111

not allow people to make decisions out of concern for their present autonomy, however it needs to be recognised by allowing someone to make a decision against their own interests in order to protect a capability they do not and cannot have, is also of no kindness.[113]

Cavadino offers a justification for compulsory treatment based on the protection and maximisation of the rights to positive freedom.[114] He calls his approach "parentalism";[115] allowing the restriction of individual liberty in the interests of individuals.[116] He justifies this on the basis some patients are incapable of looking after their own interests sufficiently well and explains for persons with mental illnesses, it would be acceptable to intervene for the sake of a more important competing right possessed by that individual patient.[117] Lindley agrees and claims the restriction of patient choices should be justified where decisions made, contradict the values underlying the individual's life.[118] He believes people should not always be allowed to do as they please because sometimes current choices, even if autonomous, may themselves be damaging to the agent's own long term autonomy.[119] Herring also argues such decisions may be regarded as not autonomous or only weakly protected by the principle of autonomy, unless it can be shown the individual made a conscious decision to depart from their strongly held beliefs and values.[120] These arguments could be relevant in regards to patients suffering with illnesses such as bi-polar disorder, mania or suffering from delusions. Not all patients will lack capacity; however those who are making decisions based on delusions or during manic stages of illnesses may not necessarily be making these decisions in line with their previous personal beliefs and life values. If the intervention results in the promotion of the health of the patient, in time

[113] Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, And Individual Freedom.* p226
[114] Cavadino, "A Vindication of the Rights of Psychiatric Patients." P240
[115] Cavadino explains this is a play on the word 'paternalism' at p242.
[116] Cavadino, "A Vindication of the Rights of Psychiatric Patients."p242
[117] Ibid.
[118] Lindley, "Paternalism and Caring."p58; see also Herring, "Losing it? Losing what? The law and dementia."
[119] Lindley, "Paternalism and Caring." p60-61
[120] Herring, "Losing it? Losing what? The law and dementia."p12

this would lead to the maximisation of the patient's positive freedom.[121] Therefore following these arguments, if a patient was to be given involuntary psychiatric medication because they were deemed to be incapable of looking after their own interests; the involuntary treatment and rejection of autonomy would be justified on the grounds it would return them to a state of health where they were able to make their own decisions. This would mean the balancing act between interests would be between the right to make one's own decisions in the present, weighed up against the right to make one's own decisions in the future. The intervention would be justified because the infringement of the patient's autonomy in the short term would ensure the protection of their autonomy rights in the long term.

Despite it being paradoxical to invoke paternalism to protect autonomy, Lindley argues it may be consistent with a caring attitude to respect autonomy in order to protect long term autonomy.[122] Although a patient retaining capacity may be refusing treatment at present, their choices now will damage their long term autonomy, because a refusal of treatment means their illness will take over. However, not all commentators agree. Harris suggests autonomy is the running of one's own life according to one's own lights[123] and says just because the lights change over time, it is not evidence later lights are better or more 'one's own', than their earlier counterparts.[124] They are just different and as such demand no more or less respect than any other autonomous decision. He believes that to be autonomous is to be able to do what one wishes, not to be able to do what one wishes at some point in the future.[125] Nonetheless these arguments do not give healthcare professionals *carte blanche*

[121] Cavadino, "A Vindication of the Rights of Psychiatric Patients."p242
[122] Lindley, "Paternalism and Caring." p61
[123] Harris, *The Value of Life: An Introduction to Medical Ethics*. p199
[124] Ibid.
[125] Ibid.

to pursue paternalism and Cavadino insists that before any intervention commences patient's decisions must be classed as not being fully autonomous.[126]

A further issue identified by Coggon is how the law can state there is an 'absolute' right to refuse treatment, when capacity is a graded concept.[127] If fusion goes ahead, the tests contained within will need to reflect the legal notion there is an 'absolute' right to refuse treatment. If fusionists want to adhere to the presumption all those with capacity have an absolute right to refuse treatment, there can be no exceptions to the rules and there needs to be only one overarching capacity-based test in operation to avoid the risk of the courts and judges basing their judgements upon paternalistic thinking or their own "moral compasses".[128] So what might be used instead? An alternative is to view people with mental illness as being generally impaired in respect to their decision-making abilities.[129] Persons with significant mental illness may present with delusions, impaired cognitive abilities or depressed moods and emotions may play a large role in their decision-making processes. Although it is very unlikely anybody has full autonomy, whether they have a mental illness or not, very few people are as significantly impaired as people with severe mental illness when it comes to decision-making.[130] Therefore what is needed is a more nuanced decision-making assessment tool which will inevitably need to be suitable for use for all patients.

[126] Cavadino, "A Vindication of the Rights of Psychiatric Patients."p242
[127] Coggon, "Varied and principled understandings of autonomy in english law: Justifiable inconsistency or blinkered moralism?."p246
[128] Ibid. p247
[129] Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. p47
[130] Ibid.p48

2.6. Conclusion

So how might these arguments justify the continued use of legislation allowing involuntary treatment of patients with capacity? It is simply not enough for someone to have a right to autonomy; there needs to be a more substantive notion of ensuring people are able to exercise these rights. Therefore what is needed is the ability to exercise the right in a fully autonomous way. It may not be enough to simply classify someone as having capacity, therefore they can exercise autonomy. People need to prove they are exercising 'richly' autonomous decisions. Simply allowing unfettered decision-making is unacceptable because some people, despite having marginal capacity, still need help to make decisions especially if a risk of harm is present. Sadly some people need outside interference to live a good life. Unfortunately fusion advocates fail to engage fully with the idea that autonomy may not always need to be respected and by simply saying autonomy will be advanced by introducing a capacity test is somewhat misguided.

Overall the implementation of capacity-based tests into mental health law will undoubtedly enhance the autonomy for a large number of patients. On the face of it, fusion may seem like a good idea. It aims to ensure all patients are given equal respect under the law; however the practical application of implementing such a scheme may well be unattainable. The choice of standards is important to any framework as this determines which patients are classified as impaired in relation to their decision-making ability and this will affect which patients are subjected to involuntary treatment and which patients can make their own choices.[131] The fusionists need to carefully consider which standards to implement. If they choose one concept over another it may adversely affect one group over another and this will fly in the face of their commitment to both enhance autonomy and reduce discrimination. It is clear there is a need to use a combination of decision-making

[131] Grisso and Appelbaum, "Comparions of Standards for Assessing Patients' Capacities to Make Treatment Decisions." p1036

assessment standards because no single standard is sufficient at identifying all patients whose decision-making is impaired.[132] However, if new concepts are added to these assessments this also risks increasing the threshold for patients to pass and could risk increasing the numbers of people who cannot pass the test and therefore cannot make their own decisions.[133] In the end whether someone has capacity or not will depend upon the test being implemented[134] and raises the question as to whether it is feasible or even necessary to use a 'one-size-fits-all' capacity-based test. Is trying to shoehorn everyone into a category of decision-making ability only going to be an impossible endeavour where ultimately some people will have their autonomy enhanced, whilst others will see it diminish? From a number of studies no two groups of patients have the same responses or decision-making abilities so it is invariably going to be very difficult to come up with a single solution to this problem.[135] Nonetheless, it can be argued that aiming for the enhancement of autonomy is an inherently good thing.

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[132] Ibid.

[133] Kapp and Mossman, "Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"." p77; see for further discussion, T. R. J. Nicholson, W. Cutter, and M. Hotopf, "Assessing mental capacity: the Mental Capacity Act," *British Medical Journal* 336, no. 7639 (2008).p322

[134] Sturman, "The capacity to consent to treatment and research: A review of standardized assessment tools." p971; Grisso and Appelbaum, "Comparions of Standards for Assessing Patients' Capacities to Make Treatment Decisions."p 1034; Kapp and Mossman, "Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"."p82; Ladislav. Volicer and Lind. Ganzini, "'Health Professional' Views on Standards for Decision-Making Capacity Regarding Refusal of Medical Treatment in Mild Alzheimer's Disease," *J Am Geriatr Soc* 51(2003). p1270;

[135] Kapp and Mossman, "Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"."p77 and 83; Sturman, "The capacity to consent to treatment and research: A review of standardized assessment tools."p961; Molly.S. Jacobs, Nancy.L. Ryba, and Patricia.A. Zapf, "Competence-Related Abilities and Psychiatric Symptoms: An Analysis of the Underlying Structure and Correlates of the MacCAT-CA and the BPRS," *Law and Human Behavior* 32(2008).p65; Grisso and Appelbaum, "Comparions of Standards for Assessing Patients' Capacities to Make Treatment Decisions."p1036; Hotopf, "The assessment of mental capacity."p583; Jennifer. Moye and Daniel.C Marson, "Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research," *Journal of Gerontology* 62B, no. 1 (2007).p4; Volicer and Ganzini, "'Health Professional' Views on Standards for Decision-Making Capacity Regarding Refusal of Medical Treatment in Mild Alzheimer's Disease."p1270-1271; Jeanette. Hewitt, "Schizophrenia, mental capacity, and rational suicide," *Theor Med Bioeth* 31(2010).p64; Ian. Freckleton, "Involuntary Detention Decision-Making, Criteria and Hearing Procedures: An Opportunity for Therapeutic Jurisprudence in Action," in *Involuntary Detention and Therapeutic Jurisprudence: International Perpectives on Civil Committment*, ed. Kate. Diesfeld and Ian. Freckleton (Aldershot: Ashgate Publishing Ltd, 2003).p327; Kate. Diesfeld, "Insights on "Insight": The Impact of Extra-Legislative Factors on Decision to Discharge Detained Patients," in *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Committment*, ed. Kate. Diesfeld and Ian. Freckleton (Aldershot: Ashgate Publishing Ltd, 2003).p360.

The number of instances where it is justifiable to overrule even capacitous decisions demonstrates autonomy enhancement is not as simple as giving people the freedom to choose. Maybe we should do as Herring says and simply come out and say why we really want to restrict some people's autonomy,[136] rather than paying lip service to a principle which can be overruled in certain circumstances with some clever legal manoeuvring.

Therefore, if a fusionist regime is to work, modifications are essential to ensure the tests are fair for all and do not unnecessarily bring patients with mental illnesses under the scope of the legislation.

[136] Herring, "Losing it? Losing what? The law and dementia." p9

Chapter 3: The Fusion Hypothesis and Discrimination

3.1 Introduction

The overall aim of this chapter is to determine whether a fusion approach will in practice ensure people are treated in a non-discriminatory manner. Throughout the literature discussions of discrimination have been based predominantly on whether there is a continued need for separate mental health legislation. Debates examine the arguments for and against separate and differential treatment between persons with mental illness and persons without. As such there has been little discussion about what is really meant by the term discrimination and whether the current legal regimes are in fact unlawful or unjust. The specific examples of fusion models have failed to give any detailed account of their perceptions of discrimination and so one of the main purposes of this chapter is to examine what the fusionists really mean when they talk of discrimination. It will be suggested that what in fact fusionists are talking of is not discrimination; rather they are attempting to promote formal equality. In order to reach this conclusion the chapter will discuss if we already have any systems of formal equality and equal treatment in the current legislation and answer whether such systems are unacceptable in contemporary mental healthcare. The debates surrounding the need for separate treatment for mental and physical illnesses is investigated in relation to the fusion approaches and their quest for equality and it is questioned whether there is any longer a justifiable reason for keeping the separation. It will be concluded that even if we accept a more substantive view of equality is needed to pursue equality and non-discrimination; some people will inevitably require help to live a good life and to promote their well being, which may involve being treated differently or in a discriminatory manner.

3.2. What are fusionists arguing for?

The fusion approach is based upon the premise that the introduction of combined mental health legislation and mental capacity legislation will help to eradicate discrimination.[1] But what do the fusionists mean when they talk of discrimination? The fusionists do not go into detail about what they actually mean by the term discrimination. According to Dawson and Szmukler the current mental health legislation is "unjustified *legal* discrimination"[2] and it is the singling out of mental disorder as the trigger for the operation of separate, specialist legal treatments which forms unjustified discrimination.[3] However, Dawson, Daw and Szmukler suggest there is a pressing need for equality under the law, especially in regards to medical decision-making and it is this suggestion which forms the basis of their fusion approach. [4] It seems therefore, that what they are arguing for is 'equality' in the operation of the legislation, rather than 'non-discrimination'. They aim to stop using mental disorder as a trigger for the operation of the mental health legislation, and instead argue for the implementation of a law based upon a person's lack of decision-making capacity. They argue their approach to mental health care would reduce the discrimination in the law against psychiatric patients and would thus apply consistent ethical principles across medical law.[5] The Bamford Review and subsequent consultations argued the use of such holistic, patient-centred approaches could avoid the stigmatisation of the mental

[1] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation."; Szmukler, Daw, and Dawson, "Response to the Commentaries."; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism.";Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism.";"*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*."; Campbell, "Mental Health Law: Institutionalized Discrimination."; Campbell and Heginbotham, *Mental Illness: Prejudice, Discrimination and the Law*.; Matthews, "Mental and Physical Illness-An Unsustainable Separation?."; Rosenman, "Mental Health Law: An Idea Whose Time Has Passed."

[2] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p504. My emphasis

[3] Ibid. p505. See also; Tina. Minkowitz, "The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychatric Interventions," *Syracuse Journal of International Law and Commerce* 34(2006-2007). p426

[4] Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p14

[5] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p509; also, Atkinson and Patrick, "Balancing autonomy and risk: the Scottish approach." p78; also, Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p707

health legislation[6] and the notion of applying the law fairly and equally should be a prominent underlying principle to base mental health law upon.[7]

The premise behind fusion approaches is that a law covering all patients who are lacking capacity, whether this was caused by a mental or a physical illness would be less stigmatising and would promote the principle that an adult with capacity has the right to consent to, or refuse any treatment that is offered to them.[8] This type of law should be applied equally to the treatment of persons with mental disorders and persons with physical disorders and/or both. Corrigan argues restricting the rights of someone merely based upon the fact they have a mental illness is dubious,[9] because mental illness does not automatically render patients as lacking capacity.[10] According to fusionists this provides a good explanation as to why the current mental health legislation is discriminatory and why the use of capacity and a lack of it may in turn be less discriminatory. By affording equality to persons with mental illness under the legislation, it is hoped this will challenge the negative stereotypes of mental ill health and will reduce discrimination towards those who suffer from it.

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[6] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p9 para 2.8; see also, "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Draft for consultation.*."; "*Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Reivew of Mental Health and Learning Disability. Action Plan 2009-2011*."; "*Bamford Taskforce Annual Report 2011*."; "*Annual Report of the Bamford Monitoring Group*."; "*Evaluation of the 2009-2011 Bamford Action Plan*."; "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015*.."

[7] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p5 para 1.8; for further discussion in Northern Ireland see note 6 above.

[8] A. Zigmond and A.J. Holland, "Unethical Mental Health Law; History Repeats Itself," *Journal of Mental Health Law* (2000). p54 & 56

[9] P. W. Corrigan, F. E. Markowitz, and A. C. Watson, "Structural levels of mental illness stigma and discrimination," *Schizophrenia Bulletin* 30, no. 3 (2004). p486.

[10] Hale, *Mental Health Law*.p69 and 187; Bowen, *Blackstone's Guide to the Mental Health Act 2007*.p274; Owen et al., "Mental capacity and psychiatric in-patients, implications for the new mental health law in England and Wales."p153; Moser et al., "Using a Brief Intervention to Improve Decisional Capacity on Schizophrenia Research."p116; Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*.p193; "Code of Practice: Mental Health Act 1983."p188; Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*.

3.3. What is equality?

Equality can mean different things, to different people. However it can be argued its purpose is to challenge the equation of difference with inferiority.[11] Some talk of equality in terms of 'formal' equality or treating 'likes alike.'[12] This is where like cases of people are afforded 'equal' or the same treatment.[13] For example in employment, people who work the same job under the same conditions will be paid the same wages regardless of their gender, race or any other factor. This equal treatment demands impartiality and as mentioned forbids certain criteria such as race or sex from being the justifications for differentiation.[14] The concept of formal equality, Bamforth *et al* argue, fits with the view of equality that is associated with the rule of law and justice.[15] By implementing such a concept of equality, it is felt the consistent treatment will in the end lead to fairness.[16] This reasoning underlies the fusion approach to legal reform in mental health and offers a reason as to why it can be argued they are advocating formal equality more than the principle of non-discrimination.

[11] Rosemary. Kayess and Phillip. French, "Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities," *Human Rights Law Review* 8, no. 1 (2008). p8
[12] Sandra. Fredman, *Discrimination Law*, 2nd ed. ed. (Oxford: Oxford University Press, 2011). p8; see also, Nicholas. Bamforth, Maleiha. Malik, and Colm. O'Cinneide, *Discrimination Law: Theory and Context*, 1st ed. (London: Sweet and Maxwell, 2008). p178; Peter. Westen, "The Empty Idea of Equality," *Harvard Law Review* 95, no. 3 (1982).p543
[13] Karon. Monaghan, "Constitutionalising equality: new horizons," *European Human Rights Law Review* 1(2008). p31-32
[14] Hugh. Collins, "Discrimination, Equality and Social Inclusion," *The Modern Law Review* 66, no. 1 (2003). p16.
[15] Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p179. For further discussion about equality and the law see, Graeme. Lockwood, Claire. Henderson, and Graham. Thornicroft, "The Equality Act 2010 and mental health," *British Journal of Psychiatry* 200(2012).
[16] Fredman, *Discrimination Law*.p8

3.3.(i) Should mental health legislation be aiming for formal equality?

Questions are often raised as to the use of formal equality with discussions focussing on "treating likes alike."[17] Therefore, when it comes to law making, the fusionist argument follows the line of argument there should be no arbitrary distinctions between individuals, and everyone should be equal before the law.[18] When fusionists talk of equal treatment for all patients, their suggestions of using a universal capacity-based test is actually a way of promoting formal equality. This would ensure patients with a mental illness, who retained decision-making capacity, would be treated in the same way under a Fusion law, as those patients who retain capacity, but who do not have a mental illness. This would signal a change in the way the law works because at present, these two groups of patients can be legitimately treated differently under certain circumstances. It is this difference which they identify as discrimination and is the basis for the fusionist calls for equality under the law in relation to medical decision-making.[19] Dawson and Szmukler are keen to see formal equality in the mental health legislation as they argue they can "see no good reason for special legal rules to apply"[20] to those patients who are incapacitated who are prescribed

[17] Ibid.; see also, Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p178;
[18] Fredman, *Discrimination Law*.p8; see also, Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p179; Lyndon.B. Johnson, "*Commencement Address at Howard University*," *The US Constitution: A Reader. Hillsdale College* (1965). For further discussion on anti-discrimination law see, Sir Bob. Hepple, "The Aims of Equality Law," *Current Legal Problems* 61, no. 1 (2008).; "*Promoting the rights of people with mental disabilities*," ed. World Health Organisation (Geneva2007).; William. Bingley, "Achieving Human Rights for People who Lack Capacity," *Journal of Mental Health Law* (2000).p88; Michael. Connolly, "Case Comment: The House of Lords narrows the meaning of disability related discrimination," *Employment Law Bulletin* 86(2008).; Richard. Stone, *Textbook on Civil Liberties and Human Rights*, 9th ed. (Oxford: Oxford University Press, 2012).; Anne. Rogers and David. Pilgrim, *A sociology of mental health and illness* (Maidenhead: McGraw Hill, Open University Press, 2010); Anne. Rogers and David. Pilgrim, *Mental Health and Inequality* (Basingstoke and New York: Palgrave Macmillan, 2003); Anne. Rogers, David. Pilgrim, and Ron. Lacey, *Experiencing Psychiatry: User's Views of Services* (Basingstoke and London: Macmillan in association with MIND Publications, 1993).; Robert.M. Page, *Stigma* (London: Routledge & Kegan Paul, 1984).; Liz. Sayce, *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (Basingstoke and London: Macmillan Press Ltd, 2000).
[19] Boyle, "The Law and Incapacity Determinations: A Conflict of Governance?." p442; see also, Szmukler, Daw, and Dawson, "A Model Law Fusing Incapacity and Mental Health Legislation." p11; Campbell, "Mental Health Law: Institutionalized Discrimination."; Matthews, "Mental and Physical Illness-An Unsustainable Separation?."; Rosenman, "Mental Health Law: An Idea Whose Time Has Passed."; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Bruce.G. Link and Jo.C. Phelan, "Stigma and its public health implications," *The Lancet* 367(2006).; Vanessa. Pinfold, "Time to change- let's end mental health discrimination: the challenges ahead," *British Journal of Psychiatry* 193(2008).p507
[20] Dawson and Szmukler, "Fusion of mental health and incapacity legislation." p507

psychotropic medicines, when there is no such rule for patients prescribed medicine for physical conditions within general medicine.[21] The underlying premise here is there should be equivalence of treatment for both persons with mental illness and those with physical illness.[22]

A further argument for the introduction of formal equality in mental health legislation was raised by the original Bamford Review in Northern Ireland. Here they considered the consequences of having two separate laws; one for those with mental illness and one for those with physical illnesses. They concluded not only was this "anomalous, confusing and unjust"[23], it was also discriminatory.[24] To show how confusing this was they offered the question as to under which Act would someone with severe depression caused by thyroid problems be treated.[25] If there was formal equality such a patient would be treated the same, regardless of how their depression was caused. The Bamford Review suggested any new legislation should favour a principles-based approach and this has been followed in the Mental Capacity (Health, Welfare and Finance) Bill (Mental Capacity Bill (NI)).[26] The

[21] Ibid.;see also; Campbell, "Mental Health Law: Institutionalized Discrimination." p554; see also, Zigmond and Holland, "Unethical Mental Health Law; History Repeats Itself." p 54; see also, Rosenman, "Mental Health Law: An Idea Whose Time Has Passed." p561 and p565; see also, Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism." p662-663; see also, Bartlett, '"The necessity must be convincingly shown to exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983." p540

[22] Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal." p50; see also, Zigmond and Holland, "Unethical Mental Health Law; History Repeats Itself." p56

[23] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p49 para 4.64; see also, Genevra Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions" *Modern Law Review*, [65] (2002) 702- 723 p711

[24] Ibid.p48 para 4.62-4.63. For further discussion about the discrimination of mental health patients see, David. L. Penn and Til. Wykes, "Stigma, discrimination and mental illness," *Journal of Mental Health Law* 12, no. 3 (2003).; Corrigan, Markowitz, and Watson, "Structural levels of mental illness stigma and discrimination."; Barbara. Hocking, "Reducing mental illness stigma and discrimination- everyone's business," *MJA* 178(2003); Patrick.W. Corrigan and David. Penn, "Disease and discrimination: Two paradigms that describe severe mental illness," *Journal of Mental Health* 6, no. 4 (1997); Patrick. Corrigan et al., "An Attribution Model of Public Discrimination Towards Persons with Mental Illness," *Journal of Health and Social Behavior* 44, no. 2 (2003).; O. F. Wahl, "Mental health consumers' experience of stigma," *Schizophrenia Bulletin* 25, no. 3 (1999); Patrick. Corrigan, "How Stigma Interferes with Mental Health Care," *American Psychologist* 59, no. 7 (2004).; Arthur.H. Crisp et al., "Stigmatisation of people with mental illnesses," *British Journal of Psychiatry* 177, no. 4-7 (2000).

[25] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p48 para 4.62

[26] Ibid.p66 para 5.49

original Bamford Review suggested people who were unimpaired in their decision-making cannot be excused from the consequences and responsibilities of their own decisions[27] and "wherever possible" people with mental illness or learning disability should retain the same rights and entitlements as those without.[28] This shows there is still support for the introduction of a single Bill as a means of providing the most effective way of reducing the stigma of separate mental health legislation.[29]

Some argue the continuation of separate mental health legislation legitimises the prejudices apparent in the current system and legitimises the use of compulsory admission and treatment of people with mental illness, even for those who do not lack decision-making capacity.[30] This perpetuates the assumption persons with mental illnesses are incapable of making their own decisions and are in some way in need of care, whether they wish it or not.[31] With these assumptions comes the notion mental illness is somehow different to physical illness and can somehow affect someone's ability to care for themselves. Matthews suggests this negative view is further entrenched by mental illness being seen as something that pervades every part of the person who has it and thus affects their ability to make decisions;[32] whilst Campbell views this as promoting the institutionalisation of a lawful system of coercion and control.[33]

At first glance, the drive for formal equality looks like an attractive option. The idea all patients, regardless of their illness, would be subjected to the same legal regimes appears to

[27] Ibid.
[28] Ibid.p50 para 5.1
[29] "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment. Analysis of Responses*." para 10. See also; "*Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Action Plan 2012-2015.*."; "*Mental Capacity (Health, Welfare and Finance) Bill: Equality Impact Assessment*."
[30] Campbell, "Mental Health Law: Institutionalized Discrimination." p556
[31] Ibid. See also, Boyle, "The Law and Incapacity Determinations: A Conflict of Governance?." p441
[32] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p49. See also, Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p708
[33] Campbell, "Mental Health Law: Institutionalized Discrimination." p556

solve the problem of discriminatory treatment because all patients would be treated the same. The fact someone had a mental illness would not be the trigger for involuntary admission or treatment procedures, as this would instead be determined by the assessment of whether they lacked the requisite capacity to decide for themselves. Therefore the use of universal capacity-based tests would indeed allow all patients to be treated under the same law; but would this ensure they were all treated fairly? Several concerns become apparent when the notion of formal equality is further unpacked.

First, what is the threshold question of when two people, or classes of persons, are relevantly alike, to be treated alike?[34] In other words: who are we treating like whom? The fusionists support the idea all patients with the requisite decision-making capacity are treated the same. Thus all patients who have the capacity to make decisions will have these decisions respected, regardless of the outcome. But a concern arises as to how reliable this decision-making ability test will be. Will all patients really be subjected to the same test? There may be a danger the capacity tests could be applied in a discriminatory way and could treat people differently, defeating the purpose of fusion in the first place. Despite this it could be argued from a fusionist point of view it would be enough for patients to have their decisions respected in relation to mental or physical illness, merely based on the fact they had passed some sort of capacity-based test. If all fusionists want is formal equality, this would be acceptable.

However there are tensions between the concept of equal treatment and a more substantive approach to equality.[35] One approach is to equalise starting points by treating people differently in a bid to equal the disadvantages people face. [36] Monaghan explains in some

[34] Fredman, *Discrimination Law*. p8. see also, Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p178-180
[35] Collins, "Discrimination, Equality and Social Inclusion." p18. See also, Monaghan, "Constitutionalising equality: new horizons." p31-32; also, Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p180
[36] Monaghan, "Constitutionalising equality: new horizons." p32

situations, merely treating people alike will not achieve equality.[37] Fredman suggests unequal treatment may be necessary to ensure 'genuine equality'[38] and illustrates in some circumstances it is quite legitimate to treat people in different ways. For example, it is acceptable to distinguish tax rates based on high income and low income;[39] this way people are treated fairly by being asked to contribute a percentage of money they can afford, despite the fact they are treated differently. However, she makes clear that to distinguish treatment on the grounds of someone's race, ethnic origin, sex or colour is unacceptable.[40]

She also demonstrates a more nuanced substantive approach to equality highlights it is important to consider the extent to which people can actually exercise choices.[41] Despite people having some sort of 'formal equality' or a right to act in a certain way, this does not necessarily mean they can do, due to extraneous constraints such as economic, social or physical constraints.[42] Therefore some people may find themselves being given an equal right, but finding they cannot access these rights because of certain constraints. In the case of mental health law, these constraints may be mental disorders. As Appelbaum states just because people are treated the same, does not guarantee people are treated fairly and justly.[43] Sayce suggests mental health service users should be treated fairly, but not necessarily identically in all cases.[44] Fredman agrees explaining equal treatment can in practice perpetuate inequalities and formal equality could simply require that as long as people are treated the same; there is no real difference in principle whether they are treated equally badly or equally well.[45] For example in the mental health setting, if two patients

[37] Ibid. See also, Kayess and French, "Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities."p8; also, Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p180; also, Fredman, *Discrimination Law*. p2
[38] Fredman, *Discrimination Law*.p13
[39] Ibid.p8-9
[40] Ibid.p9
[41] Ibid.p27
[42] Ibid.
[43] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law." p33
[44] Liz. Sayce, "Stigma, discrimination and social exclusion: What's in a word?," *Journal of Mental Health* 7, no. 4 (1998). p341
[45]Fredman, *Discrimination Law*. p2 and 9

with different mental illnesses (one suffering from mild depression, one suffering with severe anorexia) are treated exactly the same, by being force fed, this could lead to the patient with mild depression being treated involuntarily and against their wishes in a very liberty restricting way. However, because the patient with mild depression is being treated on an equal basis as the patient with severe anorexia, according to a strict adherence to formal equality, this would be acceptable. This is despite the fact that force feeding had nothing to do with the treatment of mild depression. By giving each patient individualised treatment, we could ensure that although being treated differently, they would receive the most suitable treatment for them and both would be treated fairly.

In *Thlimmenos v Greece* the ECtHR stated the right under Art 14 ECHR not to be discriminated against is violated when states treat "differently persons in analogous situations without providing an objective and reasonable justification."[46] They went on to say this may not be the only facet of the prohibition on discrimination. The right not to be discriminated against is also violated when states "without an objective and reasonable justification *fail to treat differently persons who situations are significantly different."*[47] Therefore by not allowing healthcare professionals to intervene could in itself be deemed as discrimination under the ECHR. The discrimination would be towards those persons whose disabilities, whether mental or physical, affected them so significantly that to treat them the same as others with different disabilities would be discrimination. This would be because they would be failing to treat differently persons whose situations are significantly different.

Quinn asks if we 'treat like alike', will this allow the 'differences' of disability to be characterised as so profound that the non-enjoyment of legal capacity becomes justified

[46] (2001) 31 EHRR 15, para 44.
[47] (2001) 31 EHRR 15, para 44 (my emphasis)

under the notion of pursuing equality?[48] Burns argues by simply ignoring the differences of mental illness and treating all people alike, will not make the differences disappear.[49] Within a mental health setting, treating someone suffering with delusions who may have impaired decision-making ability, in the same way as someone who does not suffer delusions, does not make the delusions go away.

3.4 What are the justifications for not upholding formal equality?

A further question is when there is talk of 'equality' why do we look to treat persons with mental illness the same as those without? Maybe the reason we automatically assume persons with mental illness want to be treated like persons without mental illness, is simply because persons without mental illness have more rights that are less easily interfered with than those of persons with mental illness. This begs the question then: when we are looking to provide equal treatment, who are we looking to be equal to? Is there an argument to suggest the physically ill should be treated like persons with mental illness? If it is acceptable to treat a person with mental illness involuntarily, even when they retain capacity for some paternalistic, welfare argument, then surely it is acceptable to treat someone with a physical illness, who also retains capacity, if it is also in their interests to receive such treatment?[50] The first retort to this suggestion is people who retain decision-making capacity deserve to have their decisions respected in order to allow them to exercise their personal autonomy. But why does the current MHA not allow those with certain mental disorders this right to autonomy? What is it about mental disorders that justifies differential treatment? And should we continue to allow a separation in treatment for some people and in what situations could rights be legitimately interfered with? These

[48] Gerard. Quinn, "*Personhood & Legal Capacity: Perspectives on the Paradigm Shift of Article 12 CRPD. Concept Pa*per.," in *HOPD Conference* (Harvard Law School2010).p19
[49] Burns, "Mental illness is different and ignoring its differences profits nobody." p36-37.
[50] Campbell, "Mental Health Law: Institutionalized Discrimination." p558

questions force us to examine thoroughly the claims of the fusionists in regards to the discriminatory nature of the mental health legislation, and answer the question as to whether the continued discriminatory treatment of persons detainable and treatable under the MHA is justifiable. If it can be shown differential treatment of persons with a mental disorder can be justified, the fusion approach may have to rethink its notion of discrimination and its ideas regarding reform.

3.4(i) Differential treatment

There are undoubtedly pragmatic reasons for distinguishing between conditions that are best treated by a psychiatrist, as opposed to a cardiologist.[51] As Campbell explains, the term 'mental illness' is classificatory within the medical context and its function is to prompt treatment, not to legitimise coercive and involuntary interventions.[52] However does this justify the continued separate legal treatment? The Grand Chamber in *Stec v UK*[53] held that:

> "[a] difference in treatment is however, discriminatory if it has no objective and reasonable justification; in other words if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. The Contracting State enjoys a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment."[54]

This illustrates even the courts are willing to allow some difference in treatment and look not at whether the treatment is discriminatory or different treatment; but whether the discriminatory or differential treatment is justified or not and whether it pursues a legitimate aim.

[51] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p50
[52] Campbell, "Mental Health Law: Institutionalized Discrimination." p555
[53] (2006) 43 EHRR 47
[54] (2006) 43 EHRR 47 at para 51

The fusion approach on the whole, argues all autonomous decisions, no matter how bizarre or harmful must be respected if the decision maker has capacity. They suggest this is the only way to ensure the law is not discriminating against those persons with mental disorders, because everyone will be judged under the same legislation. Although this is has undoubted appeal, fairness does not require everyone to be treated the same and not every distinction is discriminatory or unjustifiable. As mentioned earlier fairness only requires those similarly situated, be treated the same.[55] It can be argued those with mental illness are not similarly situated as those without. Therefore when we look to the mental health legislation, it could be argued the distinction between persons with mental ill health is quite legitimate. Some people with mental illnesses are perceived to need help and protection, from themselves and others, and may be incapable of making their own decisions regarding healthcare. Robinson states the features characteristic of serious mental illnesses is generally not found in other types of illnesses.[56] Therefore on benevolent grounds the distinction can be justifiable in certain circumstances. So how far can the law go to interfere with patients' rights? The fact the law allows the differential treatment of certain groups of persons, and in some cases even less favourable treatment, is not in itself unlawful. 'Like' treatment may in practice produce further difference and discrimination, thus unequal treatment may be necessary in order to achieve genuine equality.[57] As Sayce has recommended patients should be treated fairly, but not necessarily equally to each other.[58]

The fusionist's however argue that the need for specific mental health legislation would become less obvious, if the notion there was a significant difference between mental illness

[55] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law." p32
[56] R. Robinson, "the mental capacity tribunal under the model law: what are we arguing about?," *Special Edition of the Journal of Mental Health Law* (2010).p55
[57] Fredman, *Discrimination Law*. p13
[58] Sayce, "Stigma, discrimination and social exclusion: What's in a word?." p341

and physical illness was abandoned.[59] Hence they base their approach upon the premise there is no real significant difference justifying the separation of treatment.[60] However, others such as Robinson have based their concerns on the idea persons with mental disorders have a significantly higher risk of suicide or self-neglect[61] and thus the risk of harm justifies different treatment. There is also an association between the presence of certain symptoms of mental illnesses and a risk of violence to others within a small minority of patients.[62] Although the complexity of mental illness compared to physical illness may not by itself preclude separate legislation, it does demonstrate psychiatry is complex and encompasses a range of interests from those of the patients, doctors, families and the wider public.[63]

So is the separate legislation at present no longer justified because the line between mental illness and physical illness is becoming too blurred to distinguish? Or can the law ignore the principle of formal equality and continue to differentiate between classes of persons and legitimise different treatment in certain circumstances? This section of the chapter will discuss when the law can and does justify separate treatment between classes of persons and will question whether this should be the case for the mental health legislation.

3.4 (ii) The 'Harm' Argument:

The underlying premise of any 'harm' argument is that the risk of harm to oneself or others is deemed so high other interests must heed to it. In some circumstances this includes the right to autonomy. Therefore, it needs to be established in what circumstances, if any, the risk of harm trumps other interests.

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[59] Matthews, "Mental and Physical Illness-An Unsustainable Separation?." p55
[60] Barber, Brown, and Martin, *Mental Health Law in England and Wales: A Guide for Mental Health Professionals*. p1. See also; Dawson and Szmukler, "Fusion of mental health and incapacity legislation."; Szmukler, Daw, and Dawson, "A model law fusing incapacity and mental health legislation ".
[61] Robinson, "the mental capacity tribunal under the model law: what are we arguing about?."p55
[62] Ibid.
[63] Ibid.p55-56

The distinction between persons with mental illness and persons with physical illness in pursuit of public protection has been accepted by the Expert Committee headed by Prof. Genevra Richardson.[64] The Committee agreed in certain circumstances the right to self-determination would be out-weighed by society's interest in public safety,[65] as would be the risk of self-harm, although the Committee felt this argument was less easy to draw than the public protection argument.[66]It is deduced this was due to the strong support for the exercising of personal autonomy. The Expert Committee further discussed the possibility of accepting the argument that in certain circumstances a capable refusal could be overridden on the grounds of public protection.[67] The reasons forwarded were a mixture of pragmatism and principle and were based upon the risk of harm posed and the availability of appropriate health intervention for those who were presenting with a mental disorder which was likely to benefit from such an intervention.[68] Gledhill argues the use of mental disorder as a feature of which to base legislation on is not discriminatory once we come to accept that we need to protect people.[69] This is especially true if we agree with Zigmond and Holland's assertion that the MHA can be seen to save lives.[70] This approach however, poses some dilemmas.

First, it singles out mental disorder as a distinguishing factor and is discriminatory, despite being justified on public protection grounds. This singling out may continue to perpetuate negative stereotyping and prejudicial attitudes. The presumption persons with mental

[64] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*." See also, Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p719
[65] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*." Chapter 2. See also, Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p719
[66] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p20 para 2.08-2.10. See also, Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p719
[67] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p19 para 2.7
[68] Ibid.
[69] Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal." p52
[70] Zigmond and Holland, "Unethical Mental Health Law; History Repeats Itself." p54

disorders are dangerous and it is the mental disorder, and this alone, that is the reason for someone to be deemed a risk rather than any other factors, is stigmatising and likely to cause further discrimination. Therefore this suggestion may fall foul of the principle of non-discrimination and could be unacceptable to use. Secondly, the issue of self harm continues to raise concerns.[71] If we were to implement a strict, autonomy adhering, non-discriminatory law, it could end up having to respect the capable refusals of people who could ultimately kill themselves, which to some would be unpalatable. However this is the situation with patients with physical disorders such as in the *Miss B*[72] case, where a woman was allowed to refuse treatment which led to her death. Therefore autonomy purists would allow this because persons with mental illnesses, who retain capacity, would be able to refuse treatment on an equal basis with capable persons without mental illness.

Overall the Richardson Committee regarded the principle of non-discrimination as central to the provision of care and treatment for those with mental disorders, yet they did not fully endorse the full implementation of formal equality.[73] They recommended, "that *wherever possible* the principles governing mental health care should be the same as those which govern physical health".[74] This approach provides a more substantive form of equality as it would ensure persons with mental disorder were given fair treatment appropriate to their needs. This echoes the recent report on the MHA in regards to the need for "parity of esteem" which states the needs of mental health users should be on an equal footing with those of the needs of physically ill patients.[75] The Expert Committee however raised the question as to whether it would be appropriate to force patients with capacity who posed a risk of harm, to accept health interventions; or whether confinement within a therapeutic

[71] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p20 para 2.8. See also, Rachel. Bingham, "The gap between voluntary admission and detention in mental health units," *Journal of Medical Ethics* 38(2012).
[72] *Ms B v An Hospital Trust* [2002] EWHC 429 (Fam)
[73] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p21 para 2.14
[74] Ibid.p21 para 2.15 (my emphasis)
[75] House of Commons, "*Post-legislative scrutiny of the Mental Health Act 2007. First Report of Session 2013-2014: Report, together with formal minutes, oral and written evidence*.."p13

environment with the offer of treatment would be sufficient to guard against the perceived threat of harm?[76] Further demonstrating despite public protection providing a justification for differential treatment, people are still not wholly comfortable with subjecting patients with capacity to treatment without their consent because of the severe infringement on personal liberty.[77]

However, when we look to the current law there are several areas where the right to autonomy is trumped by the risk of harm. The law, for example does not allow people who are under the influence of drink or drugs, to drive a vehicle because of the risk of harm to themselves and others. On the other hand, the law does allow sober people to drive because the risk of harm is reduced. This shows although treatment may well be different for different categories of people, it does not render the treatment unjustifiable or unlawful *per se*.

A further example of the law allowing difference in treatment is in the case of managing people who have or are suspected of having contagious diseases. The Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008 (The Public Health Act) refers to infection and /or contamination as anything "which presents or could present *significant harm to human health*."[78] This Act allows for the differential treatment of people who pose significant harm to human health and justifies it by stating it is necessary in order to remove or reduce risk.[79] The Act allows such persons to be subjected to a number of involuntary acts such as being detained, disinfected and having to submit to medical examinations, amongst others.[80] Therefore the existence of this

[76] Richardson, "*Report of the Expert Committee: Review of the Mental Health Act 1983*."p94 para 7.19
[77] Ibid.p94 para 7.20
[78] s.45A (3) Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008. Emphasis added.
[79] S. 45G (1) (d) Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008
[80] S. 45G (2) (a)-(k) Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008

legislation could provide an argument for a similar piece of law being enacted to govern medical decision-making in general based upon a risk of harm. If a patient was deemed to be posing a significant risk of harm to human health by refusing treatment, they could be forcibly admitted and treated. However, the fact the Public Health Act does not allow the involuntary treatment of any such patients, despite a significant risk of harm, seems to suggest this would be unacceptable.

In Ontario patients are not to be treated without informed consent or if the patient is deemed to be incapable, there is consent from the patients substitute decision-maker.[81] This applies equally to those who have physical or mental illnesses and could go some way to reducing discrimination by treating all patients under the same framework. It covers patients in and out of hospital and if in hospital, whether the patient was there voluntarily or involuntarily and patients are given the right to choose whether or not to be treated. Under section 20 of Canada's Mental Health Act patients may be detained either because they are suffering from a mental disorder that will likely result in serious bodily harm to a patient or another; or the patient is likely to result in serious physical impairment[82]; or where there is evidence of the likelihood of serious bodily harm, substantial physical or mental deterioration or physical impairment.[83] The distinguishing factor between how two classes of persons would be treated would be the risk of harm, and the discrimination would be justified in terms of patient or public protection which has been shown to be a legitimate distinction in other circumstances. However, it could be argued this does not go far enough to eliminate discrimination, because people can still be involuntarily detained on the grounds of mental disorder. Nonetheless, the introduction of this type of legislation could be a step in the right direction as it could eliminate discrimination by giving people the chance to exercise their autonomy rights. At the same time it would be providing

[81] s. (10) (1) Health Care Consent Act 1996, S.O. 1996, c.2, sch. A,
[82] MHA (Canada), s. 20(5)(a)(ii) and (iii)
[83] MHA (Canada), s.20 (1.1)

necessary treatment for those who need it and consent to it; whilst reassuring the public that those at risk, either to themselves or others, can be detained if necessary. This could provide a legitimate alternative to the fusion approach and offers an example of separate mental health legislation which includes a capacity-based test fulfilling the requirements of non-discrimination, whilst at the same time taking account of the complexities of mental illness and allowing involuntary detention when necessary. On the other hand such a law as Ontario's could make mental health professionals nothing more than gaolers and would not guarantee the health of the patient would improve.[84] Bartlett rebuts these arguments and suggests this does not appear to be happening in Ontario stating what seems to be happening is psychiatrists and patients are working together to create treatment plans which are beneficial for both parties.[85] Regardless these discussions raise questions as to whether there is a need for fusion or whether the introduction of capacity-based tests into the existing separate legislation is all that is needed.

As Richardson rightly states the desire to differentiate between decisions is very strong, especially when a patient is refusing treatment and even more so when the patient may die, should their refusal of treatment be respected.[86] She explains the formal justifications for the singling out of mental disorder for separate treatment in the current mental health legislation is a combination of paternalism and social protection.[87] This is because the MHA 83 can legitimately detain and forcibly treat someone who has a mental disorder and who is posing a risk to themselves or others thus demonstrating the justification for detention and treatment is in order to protect either the patient or the public. The fact the MHA 83 only applies to a minority of people with mental disorder (those who satisfy the statutory criteria) could form the basis of an argument for the continued separation of

[84] Bartlett, "The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria." p333
[85] Ibid.p333-334
[86] Richardson, "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions." p704
[87] Ibid.p708

treatment for those with and without mental disorders. This is because unfortunately a small number of people may require involuntary treatment to protect themselves from harm or to protect their long term interests. Therefore a law continuing to endorse involuntary mechanisms, even for the minority of patients who retain capacity may well be justified to protect people from harm. As has been demonstrated in earlier chapters, even some fusionists advocate for the involuntary treatment of a small minority of forensic patients who retain capacity. The argument becomes that if it is justifiable for a small number of forensic patients to be subjected to involuntary procedures in order to protect them or others from harm; then why not allow a small minority of patients with a mental disorder who retain capacity who need help and treatment to be subjected to involuntary procedures?

Persons with mental illness can evoke concerns about violence, dangerousness and criminal behaviour and so their situation can be viewed as very different to that of persons without mental illness.[88] These concerns emanate from examples of 'difficult cases' where persons with mental disorders are threatening self harm or suicide, or where they are threatening to harm others. Herring's ideas may go some way to suggesting an alternative approach for the fusionists and may offer a more appropriate view of decision making processes in mental health law. He views the current legal principles as "crude and unsophisticated"[89] and asserts that using a sharp distinction such as capacity in such cases

[88] Appelbaum, "Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law." p33; see also, Alan. A. Stone, "The social and medical consequences of recent legal reforms of mental health legislation in the USA: the criminalization of mental disorder," in *Psychiatry, Human Rights and the Law*, ed. Martin. Roth and Robert. Blugrass (Cambridge: Cambridge University Press, 1985).p9.; Geoffrey. Pearson, "Madness and Moral Panics," in *Law without Enforcement: Integrating Mental Health and Justice*, ed. Nigel. Eastman and Jill. Peay (Oxford and Portland, Oregon.: Hart Publishing, 1999).; Helen. Lester and Jon. Glasby, *Mental Health Policy and Practice*, 2nd ed. (Basingstoke: Palgrave Macmillan, 2010).p35; Anne. Rogers and David. Pilgrim, *Mental Health Policy in Britain*, 2nd ed. (Basingstoke: Palgrave Macmillan, 2001).p176; J.K. Mason and Graham. Laurie, *Mason and McCall Smith's "Law and Medical Ethics"*, 8th ed. (Oxford: Oxford University Press, 2011).p423; R. Jacob et al., "Self-harm, capacity, and refusal of treatment: implications for emergency medical practice. A propspectiv observational study," *Emerg Med J* 22(2005).; Terry. Carney, "Mental Health Law in Postmodern Society: Time for New Paradigms?," *Psychiatry, Psychology and Law* 10, no. 1 (2003).

[89] Herring, "Losing it? Losing what? The law and dementia." p3 and 8

"fails to capture the range and complexity of the issues [*in mental health]."*[90] The standard legal approach to decision making, and that of the fusionist approach, would be to respect the wishes of all those persons found to have capacity. This is regardless of whether the subsequent decision will cause harm or be contrary to the persons past beliefs and wishes.[91] Controversially, Herring supports the notion that not all decisions made by competent individuals deserve full respect and offers arguments explaining why. He asserts that in regard to patients who are 'just competent', a decision does not need to be respected where a patient has made a decision where it will cause them serious harm; where it will interfere with the individual's ability to exercise future autonomy or where it is unclear if the decision was a 'richly' autonomous one. [92] This offers a compelling approach when dealing with cases of patients with mental illnesses. Here some patients, but not all, will retain capacity, but may well be making decisions that will seriously harm or even kill them. Therefore the choices made, need further scrutiny and if necessary may not be respected in order to prevent harm. In these situations the risk of harm to the patient justifies differential treatment and the rejection of formal equality. In these situations, following a more substantive approach to equality would appear more acceptable and compassionate.

Regardless of these discussions, fusionists still question why laws regarding admission and treatment should be any different for persons with mental disorders, who retain capacity, to that of laws relating to people with physical illnesses with capacity? It is true someone with a mental illness may benefit from involuntary treatment and admission and this may well protect them from themselves or protect others from them if they pose a risk. But the same is also true of the person who has Tuberculosis or other physical illnesses such as diabetes which could also benefit from involuntary treatment. These benevolent arguments

[90] Ibid.p7. Note and emphasis added.
[91] Ibid.p8
[92] Ibid.p7 and 12

on their own may not provide strong enough reasons to continue to justify the differential treatment of persons with mental illness who retain capacity. As Buchanan argues, the premise MHAs are there as a moral necessity to provide medical treatment is inadequate on its own and fails when we recognise that we do not detain non-mentally disordered persons who pose a risk without consent.[93] Regardless, Buchanan does not advocate for a fused system, but one introducing a decision-making ability element to the question of compulsory admission and treatment.

So how might this argument fit with a fusionist approach? The use of legislation allowing the involuntary confinement of even those with capacity would be less discriminatory than legislation allowing the involuntary treatment of such people. This would be because both mental health and public health legislation would be operating on an equal footing and providing the same treatment to both types of patients. However this does not fit with the underlying fusionist idea that no compulsory treatment or admission should be enforced upon anyone retaining capacity. This approach would be less discriminatory and would promote the idea of formal equality but fails to provide a legal mechanism for people who genuinely need compulsory intervention to ensure their long term interests are protected. A final argument is that even some fusionist models of law would allow the detention and treatment of some capable patients on the basis of a risk to the public. This clearly demonstrates even those who advocate for a fusion agenda still believe in certain circumstances public protection can and should outweigh other interests including personal autonomy.

In contrast, the original Bamford Review did not hold to this approach and their suggestions for a fused law would not have allowed any involuntary treatment of any

[93] Alec. Buchanan, "Psychiatric detention and treatment: a suggested criterion," *Journal of Mental Health Law* (2002). p37

person who retained decision-making capacity, even if they were a forensic patient.[94] They based this upon the premise that where decision-making capacity was not impaired, regardless of whether the patient had a mental disorder or was deciding upon treatment for either mental or physical illness, the final decision was down to the patient.[95] They felt people who suffered from mental ill health or have learning disabilities must not be discriminated against in regards to public protection.[96]

Despite public protection being an important aspect, it is felt it is not a good enough reason to deny all persons with mental disorders the right to exercise their autonomy and not to be discriminated against. The fact a patient detained under the MHA can consent to or refuse any treatment related to a physical disorder, but cannot refuse psychiatric treatment is absurd and goes to show the only distinguishing factor is related to mental disorder. This situation is "anomalous, confusing and unjust"[97] and there is no good reason why such compulsory intervention should only be confined to those with a mental disorder when there may be persons with physical illnesses that are also a risk to the public.[98] As Rosenman points out, the needs addressed by the MHA do not apply exclusively to all persons with mental illness nor exclusively to them only.[99] And as Gledhill argues what may be needed instead of fusion is a framework maintaining the proportionality of the intervention used, between physically ill persons who pose a risk and those with mental

[94] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p95-96 para 7.21-7.24; for further discussions see, David.J. Moser et al., "Coercion and Informed Consent in Research Involving Prisoners," *Comprehensive Psychiatry* 45, no. 1 (2004).; Ian. Freckleton, "Involuntary Detention of Persons Found Not Guilty of Murder by Reason of Mental Impairment or Found Unfit to Stand Trial: A New Jurisprudence from Victoria," in *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Committment*, ed. Kate. Diesfeld and Ian. Freckleton (Aldershot: Ashgate Publishing Ltd, 2003).
[95] "*The Bamford Review of Mental Health and Learning Disability (Northern Ireland): A Comprehensive Legislative Framework*." p95-96, para 7.21-7.24. See also, A Zigmond and AJ Holland, "Unethical Mental Health Law; History Repeats Itself", *Journal of Mental Health Law,* Feb 2000, 50-57 p56
[96] Ibid. p67 para 5.53
[97] Ibid. p49 para 4.64
[98] Campbell, "Mental Health Law: Institutionalized Discrimination." p556. See also, Szmukler and Holloway, "Mental Health Legislation Is Now Harmful Anachronism." p664
[99] Rosenman, "Mental Health Law: An Idea Whose Time Has Passed." p561

illnesses who pose a risk.[100] His argument supports the continuation of involuntary procedures, yet does not overplay the exaggerated connection between mental disorder and harm, whilst providing procedures to protect people from themselves or others.[101]

3.4(iii) Not all decisions deserve respect

It may not necessarily be a bad thing if people's decisions are questioned, especially when and if these decisions are going to risk serious harm to selves or others, or are going to restrict the rights and options of the person in the future.[102] This is further supported by ECHR jurisprudence in light of the decision in *DL*[103], which not only supports intervention but mandates it. Lord Justice McFarlane in *DL* held that the inherent jurisdiction of the High Court survived the introduction of the MCA 2005 and is targeted solely at adults whose ability to make decisions is compromised by factors other than those covered by the MCA 2005.[104] He states that in certain circumstances such persons require and deserve the protection of the law so they can regain autonomy.[105] The Supreme Court in *Rabone*[106] also held that NHS hospitals owe an obligation under Art 2 ECHR to patients even when they are not detained under the MHA 83. In this case the hospital failed to stop a young woman, who was an informal psychiatric patient, from leaving the premises and committing suicide. These decisions illustrate the courts are unhappy with the idea of leaving vulnerable adults to their fate and shows not all decisions are worthy of the full respect of the law. This approach flies in the face of the fusion hypothesis, as it presumes patients with mental illness or adults who are vulnerable, need to be monitored and given

[100] Gledhill, "The Model Law Fusing Incapacity and Mental Health Legislation- a Comment on the Forensic Aspects of the Proposal." p51
[101] Ibid.p52
[102] Herring, "Losing it? Losing what? The law and dementia."p10
[103] *DL v A Local Authority and Others* [2012] EWCA Civ 253
[104] At para 4 [2012] EWCA Civ 253
[105] At para 63 [2012] EWCA Civ 253
[106] *Rabone and another v Pennine Care NHS Foundation Trust* [2012] UKSC 2

the care and treatment they require even if they have not been detained under the MHA 83 and even when they retain capacity.

Herring rejects aspects of the current law which regards the principle of autonomy as always protecting the decision-making rights of those persons with capacity, including those with only marginal capacity.[107] His approach would allow weight to be attached to the views of people lacking capacity, including those only just competent; whilst at the same time allowing the overriding of the wishes of persons with marginal capacity in certain circumstances. The rejection of formal equality in this situation would be justified in order to provide healthcare to those who cannot access it by themselves. Again if patients with only marginal capacity were to be treated the same as those with full capacity, the law could be denying them full access to healthcare. This is because patients with marginal capacity are not always fully capable of making decisions allowing them to access treatment they required, so if left to make decisions on their own this may have a detrimental effect upon their future interests. We would not be 'treating likes alike' because the two classes of patients are not 'alike' due to one group being able to access healthcare voluntarily whilst the other class of patient, the 'marginal' group, would not be able to access healthcare by themselves. Therefore in order to ensure a fairer, more substantive form of equality and to provide fair medical treatment, different treatment would be acceptable in these circumstances.

Cavadino's approach is based upon the same underlying premise that not all decisions are worthy of respect and upon his ideas about positive freedom.[108] This "parentalism" allows the restriction of individual liberty in the interests of individuals and is justified on the

[107] Herring, "Losing it? Losing what? The law and dementia."p3
[108] Cavadino, "A Vindication of the Rights of Psychiatric Patients."p240

basis some patients cannot look after their own interests sufficiently well.[109] By doing this, people's autonomy can be preserved for future use. This approach is not envisaging a separate situation from incapacity; rather he is envisaging intervention would be acceptable in certain circumstances for persons with mental illness for the sake of a more important competing right possessed by that individual patient, especially if the intervention would in time lead to the maximisation of the patient's future positive freedom.[110] He argues if psychiatric patients are to have human rights, then morally and fundamentally, they must have equal rights to maximise their positive freedom.[111] To ensure this he suggests we must have a 'liberal mental health law' which only allows compulsory psychiatric intervention on the basis of limited criteria based upon rigorous due process. He demonstrates formal equality can justifiably be ignored in order to protect people and to ensure fair treatment; however, the nature or the risk to others must be balanced against the likelihood of it happening and the reduction in the positive freedoms of the patient.[112] Therefore if a patient was to be given involuntary treatment because they were deemed incapable of looking after their own interests; the rejection of formal equality would be justified on the grounds that by giving them medication this would return them to a state of health where they were able to make their own decisions. This would balance the patient's present interests against their rights to make decisions in the future. Therefore this approach could justify the restriction of someone's rights in the short term, to allow the promotion and protection of liberty and positive freedom in the long term. By treating them differently, this would enable both groups to access healthcare and treatment. However the risks identified in regards to patients being incorrectly detained under the MHA because of the lack of beds does raise some worrying concerns.

[109] Ibid.p242
[110] Ibid.
[111] Ibid.p241
[112] Ibid.

This argument could be useful when looking to the use of discriminatory legislation when dealing with psychiatric patients. It could be argued the discrimination and inequality, (in the guise of the rejection of formal equality) flowing from the legislation in the short term may well be justified in order to promote equality (substantive equality) and non-discrimination in the long run. The equality and non-discrimination would come from the interventions which would restore the person with an illness to a position where they were once again capable of protecting their own interests sufficiently well or where they were no longer a risk to themselves or others. Nonetheless this does not give healthcare professionals the green light to intervene at will. [113] Before any intervention could commence the patient's decisions would still need to be assessed as not being made voluntarily.

By ignoring formal equality and not respecting patient decisions and treating them differently, could potentially save their lives and in the long run return them to a state where they can make decisions which deserve full respect. However this could be accused of being discriminatory as this distinguishes between classes of people and supports the involuntary treatment of patients with mental disorders who retain capacity. However, commentators such as Herring do not restrict the distinction between those with and those without mental disorders; in fact he distinguishes between those who have made decisions with a 'rich' sense of autonomy and those who have not.[114] He acknowledges autonomy is important, but believes if someone is barely competent and is risking serious harm, autonomy can, and should be outweighed.[115]

[113] Ibid.p242
[114] Herring, "Losing it? Losing what? The law and dementia."p12
[115] Ibid.p9-10

3.5. Conclusion

How might these arguments justify the use of legislation that does discriminate between classes of patients? Just because legislation allows for differential treatment between certain classes of patients, it does not automatically mean such treatment is unlawful or unjustified. It is possible to argue the approaches discussed are not suggesting the restriction of decisions should ever be based upon arbitrary distinctions such as race, colour, sex or even mental status.[116] The distinctions proffered would be based solely upon the decision making of individuals, and the determination that individual's decisions are not fully autonomous, and thus not worthy of the full respect of the law. It just so happens that many of the people who would be subjected to this type of regime would be those with mental disorders. However, if such suggestions basing the law on decision-making processes were to be used, many persons with mental illnesses would find themselves being able to consent to and refuse treatments and admissions because it would be decided that in fact their decisions were fully autonomous and deserving of respect. Therefore such suggestions offer viable alternatives to the flawed dichotomous distinction of capacity used in a fusion approach and could offer a decision making process that did not single out those with mental disorder as being subject to involuntary and differential treatment regimes. Although this would be controversial, (by not yielding to the absolute nature of autonomy), it would at the same time ensure those capable of making autonomous decisions could; and those who could not make decisions were protected by the law. It is suggested that in order for fusion to be suitable to help both autonomous persons and those who sometimes need involuntary treatment, they make modifications to their proposals. A key modification would be that instead of only providing an exception for forensic patients they widen it for other vulnerable patients. Despite suggestions for modification, the argument remains that mental disorder should not be the trigger for compulsory admission or treatment and

[116] To distinguish on the status of one's health, for example those with mental disorder and those without, is arbitrary in this regard, just as it would be to distinguish between those with asthma and those without.

instead it should be a question of a lack of decision-making ability, along with a justifiable risk of harm. Because no cogent argument can be fully supported for the differential legal treatment of persons with mental illness compared to those with physical illness, it is argued there is a pressing need for equality of legal treatment.[117] However, this needs to be qualified. What is being suggested is a piece of legislation that could in certain circumstances provide differential treatment. However the reasons for this differential treatment would not be the fact someone had a mental disorder, rather that the person would be making a decision that was not fully autonomous. This supports the need for the development of legislation providing equal legal protection and regimes for all patients, regardless of the type of illness patients have; whilst at the same time providing care and support for those who really need it.

Fusion has got a prima facie case for its implementation but it needs to ensure the capacity-based test employed does not work in a discriminatory manner. Although it may not be wholly appropriate to implement a system treating all patients alike, due to inherent difficulties and inequalities produced by doing so, we still need separate treatment; especially in the case of mental health care in order to ensure all people have access to the help and care they deserve. It may be a sad truth of life that some people need extra help and assistance in order to live a good life.

[117] Rosenman, "Mental Health Law: An Idea Whose Time Has Passed." p565

Conclusion: Moving Forward with Fusion

The fusion approaches to mental health law reform have clearly captured the attention of legal scholarship highlighting the flaws remaining in the current law. Although a fusion approach seems intuitively appropriate it is still felt it is naive in its claim that the introduction of a fused piece of legislation will enhance patient autonomy and eradicate discrimination on the whole. The implementation of capacity-based tests into mental health law will undoubtedly enhance the autonomy for a large number of patients. By basing the law on decision-making ability and introducing fusion, many persons with mental illnesses would find themselves being able to consent to and refuse treatment which they could not do under the current system. This would be because having passed a 'capacity-based' test, their decisions were fully autonomous and deserving of full respect. However the instances where it is justifiable to overrule even capacitous decisions demonstrates autonomy enhancement is not just simply giving patients the freedom to make decisions by themselves. Fusion has therefore got a prima facie case for its implementation but needs to ensure the capacity-based test used do not work in a discriminatory manner. Even with the introduction of a fusionist regime, patient's choices can be overruled if it is deemed necessary and justifiable to do so in certain circumstances. It has been shown in chapter three fusionists are in fact arguing for formal "equality" rather than any real advancement of non-discrimination and in some situations to discriminate between groups is justified. Regardless, treating all persons with the respect they deserve is no less worth striving for, whether it is labelled 'non-discrimination' or 'equality'.

Moving forward further research needs to be undertaken in relation to the use of a risk of harm criterion in regards to the fusion hypothesis. It is beyond the scope of this research to examine the inclusion of such a criterion but it is felt risk of harm is an important aspect of healthcare, regardless of the origins of a patient's illness. It is suggested research needs to

be considered to question the possible introduction of a risk of harm criterion in relation to all illnesses; not just mental health legislation in order to provide equality of treatment and how this might work in a fusion framework.

Other limitations to this study have been the focus upon the decision-making of adults. The law governing the decision-making of children is complex and is based upon different underlying principles and again is beyond the scope of this research, but it would be interesting to see where fusion would fit in.

Regardless of fusion's merits, a major concern moving forward is the introduction of the UN Convention on the Rights of Persons with Disabilities (CRPD). This convention may halt fusion in its tracks and may even render the whole hypothesis as incompatible with international principles and therefore requires further discussion.

A Cautionary Tale from the CRPD?

The ratification of the CRPD is possibly one of the strongest arguments for mental health law reform due to the changes it brings to international norms. Although not a model of the fusion of mental health and mental capacity legislation; it is likely to have profound effects on the way in which modern mental health legislation is viewed. It aims to promote full recognition of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind. Therefore any new legislation will need to take heed of the articles contained within it.

The CRPD aims to "*promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect*

for their inherent dignity." [1] The convention was developed to provide international standards of human rights for persons with disabilities.[2] Its fundamental objectives are to prohibit discrimination based upon disability and to recognise fully persons with disabilities are subjects of rights; not objects of welfare or charity.[3] This rights based convention highlights an increased emphasis on human rights in modern law.[4] It is based upon the social model of disability and steers itself away from the traditional view of disability as a medical issue and presents potential for the reclassification of mental ill health as a disability.[5] The inclusion of this definition of a social model of disability would signal a massive paradigm shift[6] and would emphasise anti-stigma, positive rights and equality agendas without disintegrating the important aspects of legality, due process and

[1] Article 1, CRPD

[2] Frances. Owen and Dorothy. Griffiths, eds., *Challenges to the Human Rights of People with Intellectual Disabilities* (London and Philadelphia: Jessica Knightly Publishers, 2009). p65. See also, Michelle. Funk *et al*, "*Mental Health and Development: Targeting people with mental health conditions as a vulnerable group*," (World Health Organisation, Mental Health and Poverty Project, 2010). p4; Bernadette. McSherry, "The Right of Access to Mental Health Care: Voluntary Treatment and the Role of the Law," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010).p390; "*Promoting the rights of people with mental disabilities*."

[3]Annegret. Kampf, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010). p138-139. See also, Funk *et al*, "*Mental Health and Development: Targeting people with mental health conditions as a vulnerable group*." p49 para 4.2.7; also, Annegret. Kampf, "The Disabilities Convention and its Consequences for Mental Health Laws in Australia," *Law in Context* 26, no. 2 (2008). p22; also, Penelope. Weller, "The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives," *Journal of Mental Health Law* Spring, no. 74-83 (2011).p76.

[4] J. Zuckerberg, "International human rights for mentally ill persons: The Ontario experience," *International Journal of Law and Psychiatry* 30, no. 6 (2007). p527. See also; L. Davidson, "Human rights vs. public protection - English mental health law in crisis?," *International Journal of Law and Psychiatry* 25, no. 5 (2002). p515

[5] Office of the High Commissioner for Human Rights United Nations Human Rights, "*Monitoring the Convention on the Rights of Persons with Disabilities, Guidance for Human Rights Monitors. Professional training series no.17*," (New York and Geneva: United Nations, 2010). p7. See also, McSherry Bernadette. and Kay. Wilson, "Detention and Treatment down under: Human Rights and Mental Health Laws in Australia and New Zealand," *Medical Law Review* 19(2011).p549; Sarah. Fraser-Butlin, "The UN Convention on the Rights of Persons with Disabilities: does the Equality Act 2011 measure up to the UK international commitments?," *Industrial Law Journal* 40, no. 4 (2011).p431-432; Grainne. de Burca, "The European Union in the negotiation of the UN Disability Convention," *European Law Review* 35, no. 2 (2010).p186.

[6] Philip. Fennell, *Mental Health: Law and Practice*, 2nd ed. (Bristol: Jordan Publishing, 2011). p55. See also; Peter. Bartlett, "Thinking About the Rest of the World: Mental Health and Rights Outside the 'First World'," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010). p400; also, Phil. Fennell and Urfan. Khaliq, "Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law," *European Human Rights Law Review* (2011).p663-664

proportionality.[7] The convention is based heavily upon the principle of non-discrimination and is underpinned by the notion rights are to be guaranteed to everyone without distinction, exclusion or restrictions based on disability.[8] It rests upon the assumption segregation and marginalisation on the grounds of disability is "*per se* unlawful".[9] Under Article 12 CRPD persons with disabilities are to be given the "right to recognition everywhere as persons before the law"[10] and those people with disabilities will "enjoy legal capacity on an equal basis with others in all aspects of life."[11] This recognition enshrines the notion it is unacceptable for persons with disabilities to be ignored or given less rights to equality before the law in any area of life. This represents a paradigm shift in the way persons with disabilities are viewed in regards to their capacity.

The CRPD does not define disability, but does describe in Article 1 that:

> *"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"*

This social model of disability aims to promote the idea that it is society which needs to adapt to allow persons with disabilities to participate.[12] This moves away from the perception disability only occurs due to a characteristic of the individual themselves; to the reality that disadvantages occur when persons with disabilities meet inaccessible, socially

[7] Philip. Fennell, "Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010). p21
[8] CRPD Article 5
[9] Fennell and Khaliq, "Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law."p665
[10] CRPD, Article 12 (1); see also, "Draft General comment on Article 12 of the Convention- Equal Recognition before the Law*: Advanced Unedited Version," ed. Committee on the Rights of Persons with Disabilities (2013). *adopted by the Committee at its tenth session- 2-13th Sept 2013. para 1
[11] CRPD, Article 12 (2). See also, Kampf, "The Disabilities Convention and its Consequences for Mental Health Laws in Australia." p10
[12] Ibid.p22. See also, Penelope. Weller, "The Convention On The Rights of Persons With Disabilites And The Quiet Revolution in International Law," *The Journal of Law and Social Justice* 4(2009). p83; Thomas. Hammarberg, "Disability rights: from charity to equality," *European Human Rights Law Review* 6(2011).

engineered environments.[13] The advantage to using such a definition is the focus shifts from medical conditions which may cause disability or impairment, to focussing upon the nature and origin of the obstacles faced.[14] However the effects of this definition on fusion are it may mean their focus upon impaired decision-making being based upon impairment or disturbance of the mind or brain may be following the outdated medical view of disability, rather than the contemporary social view. Advocates of the CRPD may claim fusion approaches fail to deal adequately with the social aspects of disadvantage people with disabilities face when it comes to decision-making and as such is not acceptable. When we look to the current situation of the mental health legislation, patients who are detained under the MHA face the obstacle of being subject to involuntary treatment and admission frameworks, even when retaining capacity. Here the disadvantage comes from not being able to exercise one's autonomy, which is based upon the premise it is the mental disorder the person is suffering from that disables or impairs them. However, following the CRPD's principles, the obstacles persons with mental disorder in this situation face is not their mental disorder, but the socially constructed obstacle of the MHA. It can be argued the fusion approach aims to deal with such societal obstacles, by introducing a legal regime under which *all* patients will be assessed equally and fairly. On one hand introducing a capacity-based test would go some way to avoiding the medical perspective of decision-making by testing someone's ability to make their own choices; however the capacity-based assessment itself may be too medically focussed.

A major concern for a fusion approach moving forward is the requirement from the CRPD that justifications for deprivations of liberty be 'de-linked' from a person's disability.

[13] Commissioner for Human Rights, "*Who gets to Decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*," ed. Council of Europe (Strasbourg 20 Feb 2012). p11-12. See also, Michael. Stein, Ashley., "Disability Human Rights," *California Law Review* 95, no. 1 (2007). p86; also, Luke. Clements, "Disability, dignity and the cri de coeur," *European Human Rights Law Review* 6(2011). p680-681

[14] Bamforth, Malik, and O'Cinneide, *Discrimination Law: Theory and Context*. p1011; Amita. Dhanda, "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?," *Syracuse Journal of International Law and Commerce* 34(2006-2007).p457.

Article 14 of the CRPD aims to prohibit any legislation allowing the detention of persons based on any grounds linked to disability including mental disorder.[15] Article 14(1) (b) states the "existence of a disability shall in no case justify a deprivation of liberty" and is possibly the most concerning aspect in regards to the introduction of a fusion system. This inevitably means fusion approaches will need to ensure justifications for deprivations are not linked to patient's disabilities. However, when can a decision to deprive someone of their liberty be de-linked from their condition, especially in relation to healthcare issues? Surely most patients will be treated or detained in order to treat or care whatever it is that is ailing them. The lack of a clear definition of a disability under the CRPD could be interpreted in a manner allowing large numbers of ailments to be defined as 'disabilities.' But could the CRPD be deliberately making the law so 'de-linked' from disability, it essentially means all decision-making will inevitably come down to a question of whether the person has made a decision with free and informed consent, rather than to ever consider a person's disability or illness.

Furthermore, Article 17 could be interpreted as abolishing separate mental health legislation and involuntary treatment leaving even fusionist approaches unacceptable. It reads: "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others." On first reading this seems to make clear it is unacceptable to not allow persons with disabilities to make the same treatment decisions as others. This Article supports the fusionist's claims of equal treatment of people in regards to both physical and mental disorders and the introduction of a legal regime governing both. Whilst in itself it does not prohibit the use of separate mental health regimes, it has been suggested by Kampf that its negotiated silence does not explicitly permit or prohibit involuntary treatment.[16] When read in light of Articles 5 and 14 and

[15] Article 14 (1) (b). See also, Fennell, *Mental Health: Law and Practice*. p45; also, UN Doc, A/HRC/10/48, Jan 2006, 2009 at para 49

[16] Kampf, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?." p130

following the notion of non-discrimination on the grounds of disability, it could be argued the CRPD does prohibit such regimes. Therefore despite fusionist approaches providing persons with disabilities the right to physical and mental integrity on an equal basis by providing an universal capacity-based test; the fact fusion would make distinctions on the basis of a person's capacity status may fall foul of Articles 5 and 14 of the CRPD. So on the face of it whilst Article 17 may not directly prohibit involuntary treatment regimes, when read together with the other Articles of the CRPD; it may well render certain reform ideas unacceptable. Nevertheless, due to the lack of clarity surrounding the interpretation of Article 17, continuous scrutiny of current involuntary treatment procedures needs to occur[17] and 'taken for granted' practices that may infringe Article 17 require further evaluation.[18] As Bartlett suggests the CRPD does not answer any questions but "opens the door to new ways of thinking about mental health law with which we must engage."[19]

In regards to the definition of disability, Article 2 defines 'discrimination on the basis of disability' as:

> "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation."[20]

One interpretation of this is that psychiatric detention contravenes the CRPD and as a consequence may prohibit separate mental health legislation.[21] Under this interpretation

[17] Kampf, "The Disabilities Convention and its Consequences for Mental Health Laws in Australia." p32
[18] Weller, "The Convention On The Rights of Persons With Disabilites And The Quiet Revolution in International Law." p88
[19] Peter. Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law," *Psychiatry* 8, no. 12 (2009). p496
[20] CRPD, Article 2
[21] Tina. Minkowitz, "Abolishing Mental Health Laws to Comply With the Convention on the Rights of Persons with Disabilities," in *Rethinking Rights-Based Mental Health Laws*, ed. Bernadette. McSherry and Penelope. Weller (Oxford and Portland, Oregon: Hart Publishing, 2010). p167. See also, Minkowitz, "The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychatric Interventions." p406

even a fusion approach could be deemed as prohibited. Despite fusion approaches enforcing universal capacity-based tests on an equal basis for all and ending separate mental health legalisation; the reasons for some deprivations of liberty would be the exclusion and distinction of those who failed the capacity test, which could be linked to a person's disability. Therefore impairing someone's enjoyment or exercise of their human rights and freedoms based upon their disability. The caution to fusionists would be to explain and show how the distinctions of people using the capacity test would not be linked to disability and so would not be prohibited by the CRPD.

In this regard the use of capacity as a means of distinguishing persons who can be subject to involuntary measures and those who cannot raises potential problems of incompatibility between the CRPD and the fusion hypothesis. Both the 'Model Law'[22] and the Mental Capacity Bill in Northern Ireland would determine people's capacity status by assessing if they were unable to make decisions because of an impairment or disturbance in the functioning of the mind, with the Bill in Northern Ireland adding impairment or disturbance of the brain. This demonstrates the suggestions of a fusion approach basing detention criteria upon a capacity test may well be prohibited because when read in light of the description of disability in Article 1, it can be argued that distinguishing people on the grounds of impairment or disturbance in the functioning of the mind or brain could be linked to somebody's long-term physical, mental, intellectual or sensory impairments and thus could fall foul of the prohibition of discrimination on the grounds of disability. Bartlett suggests "it is sophistry to separate incapacity from the disability that causes the incapacity,"[23] therefore any deprivation based upon incapacity is thus based on disability and is doing precisely what the CRPD says we should not do.[24] The implementation of a

[22] Szmukler, Daw, and Dawson, "Outline of the Model Law."p102. It is acknowledged there are other criteria a patient would need to be assessed upon in the 'Model Law' to be declared fully lacking capacity under its provisions.
[23] Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law." p498
[24] Ibid.

fusion approach may well fall foul of the CRPD despite its attempt to reduce discrimination by basing detention and treatment on incapacity rather than on a diagnosis of mental disorder and risk and may still find itself described as discriminatory because the incapacity will almost always be linked to disability.

It could be argued fusion approaches are not discriminating on the grounds of disability and in fact decisions to distinguish between those with capacity and those without is not based directly upon someone's disability. Rather it is as Fennell questions, simply "recognition of the fact that the concept of informed consent generally requires decision-making capacity, and decision-making incapacity generally results from impairments of mental functioning?"[25] It is not the recognition of the disability itself determining the assessment of capacity under fusion, as is the case under the MHA, but the assessment of the level of ability one has to make decisions, which just so happens to be linked to the person's disability, but not always. For example, under the MHA if someone fits the criteria for admission, they will be admitted without consent and this will always be linked to someone's disability which in this case is a diagnosis of mental disorder. However, under a fusion system that very same person, with the very same mental disorder, will not automatically be involuntarily admitted; but will be assessed under the capacity test to see if they have the requisite decision-making ability to decide for themselves. Only when they are deemed to lack this capacity can they be involuntary admitted. Therefore in this case the justification to admit is not based upon the person's disability; but rather based upon their inability to make decisions, which may or may not be linked to their disability.

It seems unlikely the CRPD and those pursuing the rights of persons with disabilities will favour this interpretation; because even as well meaning as a capacity-based test may appear, it can still be seen to link disability with the reasons for deprivations of liberty and this is not endorsed by the CRPD. The Chairman of the House of Lords Select Committee

[25] Fennell, *Mental Health: Law and Practice*. p57

on the Mental Health Act 2005 questioned the compatibility issues between the MCA 05 and Article 12 CRPD in regards to the use of capacity as a threshold in medical decision-making.[26] John Hall from the Ministry of Justice explained the legal advice received had expressly stated the two were compatible.[27] However the senior judiciary have raised concerns and consequently the Government are conducting a report which is due to be released at the end of 2013.[28]

The distinction between capacity and incapacity may prove to be more palatable as a 'gateway' threshold as it is the lack of decision-making capacity justifying involuntary treatment. However the CRPD had demanded such a threshold is to be abolished.[29] Under Article 12 such dichotomous distinctions of capacity and all frameworks which "in purpose or effect violate Article 12" must be abolished in order to ensure full legal capacity for persons with disabilities on an equal basis with others.[30] The Draft General comment on Article 12 CRPD suggests that although legal capacity and mental capacity are distinct concepts, Article 12 does not allow deficits in mental capacity to be a justification for the denial of legal capacity of persons with disabilities[31] stating this is discriminatory and demands support is necessary in order for people to exercising their legal capacity.[32]

Therefore the fusionist proposals may not be acceptable under the convention and illustrates this article could cause major problems with the fusion approaches. Under Article 12 CRPD it is not the recognition of a disability that determines the assessment of capacity; rather it is the assessment of the level of ability one has to make decisions. Bartlett suggests one interpretation of the CRPD may require us to look beyond the

[26] Lords, "*Unrevised transcript of evidence taken before The Select Committee on the Mental Capacity Act 2005: Inquiry on the Mental Capacity Act 2005. Evidence Session No.1/Heard in Public/Q's 1-24*." Lord Hardie (Chairman) p8 Q5
[27] Ibid. John Hall p8
[28] Ibid.
[29] "Draft General comment on Article 12 of the Convention- Equal Recognition before the Law*: Advanced Unedited Version."para 21
[30] Ibid.para 9
[31] Ibid. para 12
[32] Ibid.para 13

competent/incompetent distinction to a framework giving supported decision-making standing.[33] He claims it would be a "significant shift in the legal landscape"[34] for lawmakers to abandon this view of capacity, and hints capacity tests may fall foul of the convention. If this is true any decision-making tests which are based upon the capacity/incapacity threshold, including those of the fusionists, may be in danger of being prohibited.

At first glance a fusion approach seems to support the CRPD, because both approaches set out to recognise persons with disabilities as equal before the law and both allow such persons to enjoy their legal capacity on an equal footing. The fusion approaches recognise the way in which the law operates can prevent people with mental illness from fully exercising their rights, especially those who have been compulsorily detained. The CRPD emphasises supported decision-making instead of involuntary care and treatment within Article 12 (3) and this makes clear states are obliged to ensure mechanisms are in place to help persons with disabilities exercise their own legal capacity.[35] Because of this emphasis when we look to fusion approaches, it will need to be determined how far they go to ensure all patients are given the help and support they need to make their own decisions. The introduction of a universal capacity-based test by fusionists will apply to all patients and so will allow persons with disabilities an equal opportunity to be assessed under the same legal framework as others. However, the extent to this is questionable as the fusion approaches, although they advocate for such decision-making assessments, do not fully embrace the notion of supported decision-making and still advocate for the use of a functional test of mental ability where there remains a distinction between those who pass the test and those who do not. Consequently, under a fusion approach, if one should pass the test, they will be able to exercise their legal capacity fully. However, if one fails, they

[33] Bartlett, "'The necessity must be convincingly shown to exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983."p541
[34] Ibid.
[35] Fennell and Khaliq, "Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law."p668

will be unable to make a decision by themselves and decisions will be made in their best interests by a substitute decision-maker. The emphasis on supported decision-making under the CRPD suggests capacity should be viewed as a continuum; something that is never really lost.[36] Article 12(3) CRPD aims to provide persons with support so they can make their own decisions, rather than endorsing the practice of the complete removal of someone's ability to exercise their capacity themselves.[37] And with the Draft General comment on Article 12 stating that both status and functional tests of mental capacity are to be abolished, the future does not look good for the fusionist approaches.[38] This approach is more empowering and effective for use by individuals as the focus is upon the capacity of the decision-making process, rather than on the capacities of the individual.[39] Nonetheless, the introduction of a fusion regime may go some way to achieving the principle of 'equal recognition before the law' that the CRPD demands. However, it is in need of some modifications in relation to the support systems it offers to allow people to make their own decisions in order for it to be fully compatible. The CRPD may be a more empowering tool as it may offer a more effective way of reducing discrimination than fusionist approaches. The CRPD does not advocate the taking away of anyone's capacity to make decisions and focuses instead on equal participation on an equal basis, whereas the fusionist approach still supports a substitute decision-making process.

Overall, the underlying premises of a fusion approach are to be commended. It will advance autonomy of patients in the majority of cases if dealt with correctly and it will go some way to reducing the discrimination faced by persons with mental illnesses. It has

[36] Bartlett, "'The necessity must be convincingly shown to exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983." p541. See also, Kampf, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?." p141

[37] Commissioner for Human Rights Rights, "*Who gets to Decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*."p14. See also, Kampf, "Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?." p140; also, Minkowitz, "Abolishing Mental Health Laws to Comply With the Convention on the Rights of Persons with Disabilities." p152

[38] "Draft General comment on Article 12 of the Convention- Equal Recognition before the Law*: Advanced Unedited Version."para 21

[39] Commissioner for Human Rights Rights, "*Who gets to Decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*.", p18-19

sparked serious debate about mental health reform and with the imminent introduction of the Mental Capacity Bill (NI), new and important information will be reaching the academic world. It will be interesting to see what effects the CRPD may have in the long run and further illustrates although the broad fusion hypothesis may intuitively be a good idea, it is imperative to assess the tests employed in any of the fusion models in order to ensure they are compliant with international conventions. Only time will tell if and how a fusion approach will work and lawmakers in England and Wales would do well to hold fire until the Bill becomes law in Northern Ireland to see how it works in practice and to wait to determine the full extent of the CRPD's reach on domestic legislation.

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