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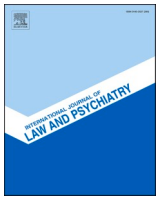

Unified mental health and capacity law: Creating parity and non-discrimination?☆

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ABSTRACT

It has been argued that a fusion of mental health and capacity law creates parity and respects non-discrimination. This approach has been adopted in the Mental Capacity Act (Northern Ireland) 2016, although this legislation is not yet fully in force. Separately the World Health Organisation and the Committee on the Rights of Persons with Disabilities have advocated ending the separate status of mental health law. Across the rest of the UK, the possibility of fusion legislation has recently been considered, although not ultimately recommended in 2018 by the Independent Review of the Mental Health Act for England and Wales and in 2022 by the Scottish Mental Health Law Review. Challenges include potential conflicts with Article 5 of the European Convention on Human Rights, and the Committee on the Rights of Persons with Disabilities' critique of 'mental capacity' and whether a capacity threshold is required for unified mental health and capacity law. This article will consider the approach of the Scottish Mental Health Law Review, why it did not recommend immediate fusion and its proposals for greater alignment of mental health and capacity regimes.

1. Introduction

The refusal of a person with decision-making capacity to treatment or other interventions relating to their physical health must be respected under the law,[1] but this is not necessarily the case in relation to mental health interventions. Capacity legislation generally reflects this, but mental health legislation tends to authorise and regulate non-consensual psychiatric interventions on the basis of a diagnosis of mental disorder together with risk, sometimes combined with some test of impaired decision-making ability.

Supporters of fused, or unified, mental health and capacity legislation claim that it enables parity of esteem, non-discrimination between physical and mental health interventions, better human rights protection and clarity and consistency in approaches to support for persons with mental disabilities (including mental illness, learning disability, neurodivergence, dementia, acquired brain injury and other related conditions). However, with the exception of Northern Ireland,[2] no other country has fully included matters traditionally covered by both mental health and mental capacity laws within the same Act. Interestingly, recent law reviews in Scotland and England and Wales, other UK jurisdictions, have also considered such legislation but not recommended immediate enactment of it.

This article will therefore explore the theoretical case for unified mental health and capacity legislation and challenges associated with creating and implementing unified mental health and capacity legislation. It will locate the case for and against unified legislation in context, namely Scotland with reference to other UK jurisdictions, e.g. Northern Ireland and England and Wales.

2. The development of separate mental health and capacity law

By capacity law, we mean legislation intended to provide a mechanism by which legal decisions can be made and agreements entered into in respect of adults who are judged to lack decision making ability in

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[1] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (every adult with capacity has the right to refuse medical treatment); *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819 (a person with a diagnosis of mental illness may still have capacity to refuse medical treatment); *Re MB* [1997] EWCA Civ 3093 (reaffirming re T and Re C).

[2] A jurisdiction within the UK.

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relation to at least some medical, welfare or financial decisions. By mental health law, we mean legislation which authorises a person's detention and/or non-consensual medical treatment for, and on the basis of, a mental health condition.

Nowadays, throughout most of the UK, Ireland and many other jurisdictions, these two legal frameworks are clearly distinct. Modern capacity law is a relatively recent development in the British Isles, beginning with the Adults with Incapacity (Scotland) Act 2000 (AWIA), followed by the Mental Capacity Act 2005 (MCA) in England and Wales, the Mental Capacity Act (Northern Ireland) 2016, and the Assisted Decision-Making (Capacity) Act 2015 in Ireland. Prior to this, it was a confusing mix of common law and statutory provision, much of it out of date. Modern mental health law in the UK can be dated to the Mental Health Act 1959 (England and Wales) and the Mental Health (Scotland) Act 1960.[3] Northern Ireland's Mental Health (Northern Ireland) Order 1986 will eventually be repealed once the Mental Capacity Act (Northern Ireland) fully comes into force. In Ireland, the Mental Treatment Act 1945 was replaced by the Mental Health Act 2001, the latter currently being in the process of reform.

2.1. Differences between mental health and mental capacity legislation

There are substantial differences in the way capacity and mental health law operate, summarised in the table below:

Capacity law	Mental health law
Mostly used for learning disability, dementia	Mostly used for mental illness
Range of personal, financial, medical issues	Psychiatric treatment, mainly in hospital
Incapacity is essential	Incapacity is relevant but not essential
Proxy decision making – what person would want if they could decide	Coercive intervention against person's stated wishes
Strong respect for advance choices	Weak respect for advance choices
Wide range of permissible timescales, potentially applying across lifespan	Strict time limits, mostly shorter term interventions
Adults only (16 and over)	All ages
Focus on best interests/benefit to person	Focus on risk of harm to self or others
Affects a substantially larger number of people than those affected by mental health law.[a]	

[a] In 2023–24, NHS England reported there were an estimated 332,455 applications for Deprivation of Liberty Safeguards under the Mental Capacity Act, and in one quarter 315,572 lasting powers of attorney were registered. There were 52,458 new detentions under the Mental Health Act: NHS England, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023–24, available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2023-24: Ministry of Justice Family Court Statistics Quarterly: October to December 2023, available at: https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2023/family-court-statistics-quarterly-october-to-december-2023#mental-capacity-act—court-of-protection: NHS England, Mental Health Act Statistics, Annual Figures, 2023–24, available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures

Of course, these are matters of degree, not absolute difference. Autistic people and people with learning disabilities or dementia can be detained under mental health law, and people with a mental illness, particularly an enduring one, may have decisions made under capacity law. Importantly, the assumption that capacity law is not about coercion but simply allowing decisions to be taken on behalf of an adult is not always the case. The difference is arguably that in some situations is that it allows coercion, but with fewer safeguards than mental health law.[4]

3. The case for unified mental health and capacity legislation

There are practical and principled arguments in favour of unification or at least greater alignment. It is argued that unified legislation offers greater consistency, clarity and coherency in service and professional approaches for persons with mental disabilities who may be eligible to be supported and subject to measures under both mental health and capacity legislation (Scottish Executive, 2001).

It has also been argued that a single system that uses the same eligibility criteria for all persons with psychiatric and non-psychiatric medical conditions promotes fairness, equality and non-discrimination (Dawson & Szmukler, 2006; Gledhill, 2010; Harper et al., 2016; Szmukler et al., 2010). This reflects the *T*[5] and *C*[6] rulings which were a consideration of the Bamford Review whose recommendations led to the enactment of the Mental Capacity Act (Northern Ireland) 2016 (Bamford Review, 2006, 2007) and an agreement that the presence of a mental health problem or learning disability should not automatically lead to an assumption of mental incapacity limiting or reducing a person's ability to exercise their rights.

This fairness and equality of treatment is underpinned by human rights treaties. Article 14 of the European Convention on Human Rights (ECHR), for example, requires equality and non-discrimination in the enjoyment of ECHR rights for persons with disabilities. Although, as will be discussed later, the different UN Convention on the Rights of Persons with Disabilities (CRPD) approach to equality presents challenges for the use of mental health and capacity legislation to authorise non-consensual measures, the notion of equality and non-discrimination in rights enjoyment for people with physical and mental disabilities is the cornerstone of the treaty[7] (Committee on the Rights of Persons with Disabilities, 2018). It strongly underpins the CRPD's approach to, for example, the right to health (Article 25), to exercise legal capacity (Article 12) (Committee on the Rights of Persons with Disabilities, 2014a), to liberty (Article 14) (Committee on the Rights of Persons with Disabilities, 2014b) and to independent living (Committee on the Rights of Persons with Disabilities, 2017).

However, a number of challenges must be addressed when determining the appropriateness of unified legislation, partially because of conflicting human rights treaty requirements, but also because of the different historical and conceptual starting points of the two legal regimes.

4. Considerations and challenges for unified mental health and capacity legislation

4.1. Eligibility criteria

The matter of who would fall within the remit of unified mental health and capacity legislation is fundamental. To date, proponents of such legislation have proposed a capacity based threshold (Dawson & Szmukler, 2006; Harper et al., 2016; Szmukler et al., 2010). If linked to a diagnosis of 'mental disorder' this certainly satisfies the requirements of Articles 5 (the right to liberty) and 8 (respect for private and family life) of the European Convention on Human Rights (ECHR), the jurisprudence of which accepts that mental incapacity or impaired decision-

[3] Now replaced by the Mental Health Act 1983 and Mental Health (Care and Treatment) (Scotland) Act 2003.

[4] See, for example, L Series (a) (2019) 'On Detaining 300,000 People: the Liberty Protection Safeguards' 25 *International Journal of Mental health and Capacity Law* 79–196; (1a) (2022) *Deprivation of Liberty in the Shadows of the Institution*, Bristol University Press.

[5] Re T (Adult: Refusal of Treatment) [1993] Fam 95.

[6] Re C (Adult: Refusal of Treatment) [1994] 1 All ER 819.

[7] Article 5 CRPD.

making related to a mental disability diagnosis do, subject to certain safeguards, justify rights limitations. It may not, however, satisfy the requirements of the CRPD as interpreted by the Committee on the Rights of Persons with Disabilities, although some commentators argue that it may align with the CRPD itself (Gather & Scholten, 2024; Szmukler, 2019).

The Committee on the Rights of Persons with Disabilities (CRPD Committee) has interpreted the aforementioned CRPD equality message in terms of ensuring that a disabled person's ability to enjoy rights must be on the same basis as everyone else, with or without disabilities with support being made available to achieve this where necessary (Committee on the Rights of Persons with Disabilities, 2014a).The CRPD Committee's view is that legislation, such as mental health and capacity legislation, which singles out persons with disabilities for differential treatment is discrimination. It is particularly concerned about legislation that employs mental capacity assessments to determine and authorise proxy decision-making resulting in a lack of equality in the exercise of legal capacity through the use of coercive and non-consensual interventions. In order to correct this imbalance it thus calls for the abolition of such laws and for their replacement with support for the exercise of legal capacity (supported decision-making) which transcends mental capacity and related decision-making challenges allowing for the will and preferences of persons with mental disabilities to be respected to the same extent as other.

Mental capacity assessments can indeed be a blunt instrument when it comes to determining whether or not to restrict or support a person, owing to their subjectivity and potential to make misconceived or biased assumptions about a person's decision-making ability and capabilities (Committee on the Rights of Persons with Disabilities, 2014a; Scottish Mental Health Law Review, 2022)). Even functional assessments may fail to recognise that capacity is not linear thus resulting in unnecessary restrictions on an individual or a failure to provide support where this is in fact necessary (Committee on the Rights of Persons with Disabilities, 2014a; Scottish Executive, 2001; Scottish Mental Health Law Review, 2022). These considerations, in addition to the contradictory ECHR and CRPD positions, must be addressed along with those relating to the purpose and scope of unified legislation. If (in)capacity is acceptable as a unifying criterion justifying intervention in both legal regimes, the task of fusion is essentially to graft mental health law onto the existing capacity law framework. Without it, a different unifying principle is necessary. From a practical perspective, the area where the two regimes significantly overlap is around medical treatment of a mental disorder.

4.2. The purpose and scope of unified legislation

The purpose and scope of unified legislation is ultimately in the gift of legislators. However, where human rights alignment is a consideration this can present challenges for states who are parties to both the CRPD and other earlier international human rights treaties, such as the ECHR. This relates to for whom and to what extent the legislation is intended.

For CRPD state parties not only must its approach to equality and non-discrimination be taken into account but also all of a person's civil, political, economic, social and cultural rights. This goes beyond traditional human rights approaches to equality and non-discrimination, particularly the notion that the role of mental health and capacity legislation is primarily to authorise and regulate non-consensual interventions. That approach focuses only on civil rights observance with little or no consideration of the person's economic, social and cultural rights – their wider needs and ability to live life on their own terms on an equal basis with others.

In locating persons with mental disabilities within the full range of the human rights which must be enjoyed to the same extent as other people, the CRPD is in contrast to previous human rights treaties' interpretations of equality and non-discrimination relating to persons with disabilities. When considering safeguards for the rights of persons with mental disabilities these earlier treaties tended to regard the appropriate comparator as others with the same disability rather than other human beings in general (Nilsson, 2014; UN Committee on Economic, Social and Cultural Rights, 2009; UN Human Rights Committee, 2003, 2004). Such an approach allows for the rights of persons with mental disabilities to be denied or restricted in situations where it would not be the case for others which is what has concerned the CRPD Committee. European Court of Human Rights jurisprudence concerning Articles 5 (the right to liberty) and 8 (respect for private and family life) ECHR emphasises the need to detain and/or use restrictive interventions proportionately and for safeguards to protect such rights. However, it ultimately permits diagnosis and incapacity or impaired decision-making to justify detention and other limitations of autonomy. This presents implementation challenges for states which are parties to both the CRPD and the ECHR, or other human treaties adopting a similar approach to the ECHR such as the International Covenant on Civil and Political Rights, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (European Committee for the Prevention of Torture, 2015; UN Committee against Torture, 2013; UN Human Rights Committee, 2004; UN Sub-Committee on Prevention of Torture, 2016). Moreover, unless a state decides to give legislative effect to multiple human rights treaties to ensure compliance with a person's civil, political, economic, social and cultural rights, rights safeguards in such treaties mainly or entirely relate to civil rights.

The World Health Organisation (WHO) adopts a similar approach to the CRPD Committee in its 2023 *Mental Health, Human Rights and Legislation* guidance, noting the imbalance and limitations created by standalone mental health laws.[8]

4.3. Medical treatment of a 'mental disorder'

The Scottish AWIA seeks to carve out Mental Health Act interventions: the authority for medical treatment in section 47 of the AWIA cannot authorise 'placing an adult in hospital for the treatment of mental disorder against his will' However, this carve out is by no means always easy to apply. Borderline issues include the use of psychotropic medication for dementia patients which might be authorised under either mental health or mental capacity legislation, but with fewer safeguards under the latter; and treatment for physical conditions associated with a mental illness, such as artificial feeding for a person with anorexia. The Bamford review cites other examples, such as a person with severe depression which affects decision-making capacity because of low levels of thyroid hormone (Bamford Review, 2007).[9]

Even if one can decide which piece of legislation to use, the regimes operate differently in ways which can be hard to justify. Arguably, mental health law tends to give insufficient regard to autonomy. Many mental health law regimes, including England and Wales, make no reference to decision making capacity in the criteria for compulsory measures. Even though a test of 'significantly impaired decision-making ability' because of the patient's 'mental disorder' is one of the criteria for compulsory measures in Scotland, it is still possible to forcibly administer individual treatment when a patient has capacity in relation to that treatment.[10] Incapacity law, on the other hand, is lacking in strong safeguards once incapacity is established. For example, there is no equivalent in Scotland to the requirement in mental health law[11] for an independent medical assessment for medication given without consent for over two months.

Philosophically, the case for mental health law remaining distinct

[8] Pp 13–14.
[9] Paras 4.23–4.26.
[10] Ss 36(4) (1a), 44(4)(b0 and 64(5)(d).
[11] Mental Health (Care and Treatment) (Scotland) Act 2003 Part 16.

from capacity law may rest on three propositions – all of which are contestable:

- That deprivation of liberty and treatment for mental disorder in hospital is materially different from deprivation of liberty and treatment for mental disorder in other settings
- That treatment for mental health conditions is materially different from treatment for physical conditions
- That the 'public safety' element of mental health law distinguishes it from capacity law.

The first proposition is less compelling now that people with complex medical needs are frequently cared for in community settings, and mental health law in the UK and many other jurisdictions can authorise compulsory medical treatment in the community.

The second proposition suggests a kind of mind/body dualism in law which medicine has arguably moved away from (Matthews, 1999; Richardson, 2007).

One might argue that treatment 'for mental disorder' is ethically different because it seeks to restore a patient's autonomy in a way that treatment for a physical condition does not. But there are numerous grey areas, where treatment for a physical condition may be authorised under capacity law but be aimed at restoring autonomy, for example delirium caused by infection, or confusion associated with diabetic hypoglycaemia.

Thirdly, it is true that risk plays a larger role in mental health than capacity law. But the capacity law tests of 'best interests' (MCA) or 'benefit' (AWIA) mean that risk to self is a relevant consideration in capacity law. Courts have also held that the risk of causing harm to others is relevant to consideration of best interests, on the grounds that it is in the interests of the adult not to commit an offence or make themselves liable to detention.[12] Advocates of fusion acknowledge that 'some modification of pure capacity principles may be required in the forensic field'. (Szmukler et al., 2010). It can also be argued that the justification for preventive detention in mental health law on the grounds of risk to others is difficult to justify when the degree of risk is difficult to establish, and arguably less than for other groups who may cause harm (Richardson, 2007).

4.4. Legalism versus informality

A further tension arises regarding the balance between a legalistic approach favouring formal authorisation of care arrangements and a non-discriminatory approach which favours informality.

Capacity law has increasingly taken a legalistic route. The *Cheshire West* judgment,[13] ruled that an Article 5 deprivation of liberty occurs whenever a person who lacks capacity is 'under continuous supervision and control and is not free to leave,' whether or not they are objecting to the regime and whether or not this is the most non-restrictive arrangement that can be devised. This therefore requires a legal process of authorisation. The practical and resource implications of the large increase in the use of MCA Deprivation of Liberty Safeguards led in turn to the Mental Capacity (Amendment) Act 2019, which sought to replace these with Liberty Protection Safeguards, but its implementation has been repeatedly delayed. In Scotland the Scottish Law Commission recommended reforms to address the lack of an adequate regime to comply with *Cheshire West* in 2014 but legislation has still not been introduced.

By contrast, mental health law across the UK has been based on a principle of informality since the implementation of the recommendations of the Percy Commission in the Mental Health Act 1959 and Mental Health (Scotland) Act 1960 (Royal Commission, 1957). The Commission argued that, to reduce the stigma of 'certification', legal measures to detain someone were only to be required where it was necessary to overcome resistance by patients and families. Others who could not consent but were compliant should be treated without legal formality.[14]

The Wessely review in England and Wales sought to establish a dividing line between the two regimes, so that mental health law would be used where a patient is objecting to their treatment, while the Mental Capacity Act would be used in cases where the adult lacked capacity but 'it is clear that they are not objecting' (Independent Review of the Mental Health Act 2018). However there are difficulties in establishing a workable distinction between refusal and inability to consent, and this approach has not been followed through in the Mental Health Bill introduced to Parliament.

5. UK jurisdictional approaches to unified legislation

5.1. Northern Ireland

In Northern Ireland, the Bamford Review of Mental Health and Learning Disability was established in 2002 to consider the law and policy affecting people with mental health needs and learning disability. Its final report in 2007 recommended an approach which was intended to be holistic, respect the individual, avoid stigma, was recovery-orientated and empowered the individual to lead a fulfilling life (Bamford Review, 2007). It considered that this could be best achieved through a human rights and capacity-based approach which fused both mental health and mental capacity law, and which would replace the existing Mental Health (Northern Ireland) Order 1986 and common law on mental capacity. Seeking to reflect both ECHR and CRPD requirements, it would combine respect for wishes of those with the decision-making capacity whether this related to a physical or mental health issue, and would allow for non-discrimination and equality in an individual's enjoyment of rights which would also extend to deprivation of liberty situations (Bamford Review, 2007).

These recommendations resulted in the enactment of the Mental Capacity Act (Northern Ireland) 2016. However, whilst the Act applies to adults it excludes children under the age of 16, owing to complexities around decision-making competence of children. This this has raised concerns around the ongoing discriminatory nature of the 1986 Mental Health Order which will continue to apply to children (Harper et al., 2016). Additionally, whilst the Bamford Review was clearly influenced by CRPD requirements in its recommendations, the Act itself does link decision-making capacity with diagnosis of mental disorder and disability[15] as it was considered that this was necessary to comply with Article 5 ECHR deprivation of liberty requirements.

Unfortunately, the Act has not been fully implemented, with only its provisions relating to research, deprivation of liberty, and money and valuables currently in force. It is therefore not possible yet to ascertain how effective such legislation is in achieving equality of rights enjoyment for persons with mental disabilities.

5.2. England and Wales

In 2018 the Independent Review of the Mental Health Act 1983 in England and Wales considered the viability of unified legislation. The review's final report stated that five 'confidence tests' would need to be met before the fusion process could commence, namely whether there is overwhelming support for such a venture from persons with lived experience, that there be an assessment of the impact of the Mental Capacity Act (Northern Ireland) 2016 on levels of detention, its operation in the criminal justice context, suicide rates and the impact on those

[12] *Birmingham CC v SR; Lancashire CC v JTA*, [2019] EWCOP 28, *Y County Council and ZZ* [[2012] EWCOP B34]

[13] *P v Cheshire West and Chester Council and another* [2014] UKSC 19.

[14] See Royal Commission 1957 Chapter 2, para 135.

[15] s 3 Mental Capacity Act (Northern Ireland) 2016.

with learning disability/autism (particularly in relation to length of stay in hospital) (Department of Health and Social Care, 2018). However, it also acknowledged that by the time these five tests can be delivered things may, in any event, have moved on thus rendering a fused approach less promising (Department of Health and Social Care, 2018).

The Parliamentary Joint Committee on the Mental Health Bill (UK Parliament, 2023) heard arguments in support of fusion. It concluded that the reforms needed for mental health law were too urgent to support such a radical measure, but suggested an approach not dissimilar to that recommended by the Scottish Review, saying that:

> 'We recommend that there should be an ongoing process of mental health legislation reform, leading in the direction of more "fused" and rights-based legislation and learning from developments elsewhere in the UK and overseas.'
>
> (Para 25)

The UK Government has now introduced a Mental Health Bill (UK Government, 2025), but it does not appear that it will be seeking the enactment of unified legislation. Indeed, because the Bill seeks to limit the scope of mental health law in respect of autistic people and people with a learning disability, it may make fusion less likely. The Bill seeks greater ECHR alignment within the confines of traditional mental health legislation and substitute decision-making but does not actively seek to achieve CRPD compliance.

5.3. Scotland

The issue of unified mental health and capacity legislation has been under consideration in Scotland at least since the Millan Review of the Mental Health (Scotland) Act 1984 the recommendations of which led to the enactment of the existing Mental Health (Care and Treatment) (Scotland) Act 2003. The Millan Review recommended that consistency between mental health and incapacity legislation should be achieved and that 'In due course, mental health and incapacity legislation should be consolidated into a single Act' (Scottish Executive, 2001).[16]

The issue of fusion was again considered in the 2017 Mental Welfare Commission and the Centre for Mental Health and Capacity Law at Edinburgh Napier University report *Scotland's Mental Health and Capacity Law: the Case for Reform* (McKay & Stavert, 2017). Noting a certain ambivalence across stakeholders in Scotland towards such legislation, which may have arisen owing to Scotland's mental health and capacity legislation being rather more developed than the 'blank canvas' which existed at the time of the Banford review in Northern Ireland and that wholesale stakeholder support is imperative for such an initiative to be successful, the report concluded that at that time the case for unified legislation was less clear (McKay & Stavert, 2017).

The 2019–2022 Scottish Mental Health Law Review's Terms of Reference included making recommendations to bring about greater CRPD and ECHR compatibility and consideration of 'the need for convergence of mental health, incapacity and adult support and protection legislation'. The Review was keen to ascertain whether unified legislation would offer a better way of resolving existing shortfalls in current legislation together with a framework most likely to be compatible with international human rights, and whether unified legislation should include all areas currently covered by mental health, incapacity and adult support and protection legislation.

As was the case at the time of *the Case for Reform* report, stakeholder evidence collated by the Review indicated there was no clear consensus for or against unified legislation (Scottish Mental Health Law Review, 2022). Third sector organisations and individual respondents were more in favour of the concept than others, often citing the need to simplify the law, and some respondents indicated that fusion should be a definite future goal with steps being meanwhile being taken towards this goal.

The Review remit included adult support and protection legislation alongside mental health and adult incapacity legislation. Interestingly, those who favoured unified legislation tended to agree with the fusion of mental health and capacity legislation but not including adult support and protection legislation. This was mainly because adult support and protection law was seen as being wider in scope than mental health and capacity law, applying to a wider group than individuals with a mental disability and mental capacity issues. However, there was general agreement that there should be greater alignment of all three pieces of legislation and an appetite for the jurisdiction of the Mental Health Tribunal for Scotland to be expanded from mental health legislation cases to encompass adult incapacity and adult support and protection legislation cases, this being more conducive to a person-centred approach which the Review was seeking to reinforce in its recommendations (Scottish Mental Health Law Review, 2022).[17]

Noting that widespread stakeholder support would be essential for the enactment of unified legislation and the success of its implementation, and the major policy, legislative, financial and implementation exercise involved, the Review therefore recommended that unified mental health and capacity legislation should not be the starting point of reform, but be the ultimate long term goal. In the meantime, alignment of existing mental health, capacity and adult support and protection law should be actively pursued.

Given its concerns about a capacity test, it was important for the Review to establish a common basis for such alignment. It sought to do this through a recommended framework of Human Rights Enablement, Supported Decision Making[18] and Autonomous Decision Making. This framework was recommended as providing an approach to ensure CRPD and ECHR compliance in that, irrespective of a person's decision-making ability, their will and preferences are heard and respected on an equal basis with others and that the rights which support their specific needs are respected and given effect. Moreover, it also ensures that the threshold for considering non-consensual measures cannot be justified by a mental disability diagnosis, although the presence of mental or intellectual disability may inform the type of measure or measures adopted and may, where no other means of safeguarding a person's rights overall can be found and subject to proportionality, allow for deprivations of liberty.

The Review acknowledged that the operational details of Human Rights Enablement and Autonomous Decision Making would need to be clarified. However, the objective of Human Rights Enablement is an approach that will allow for the whole range of an individual's applicable rights at any given time when they come into contact with service providers to be identified, balanced and enabled. This will ensure their needs and choices are respected and non-discriminatorily met. The recommended Autonomous Decision Making approach was designed to replace capacity assessments under existing mental health and incapacity legislation. It recognised the current shortcomings of these tests which may too easily result in either a person's rights being disproportionately restricted in order to meet certain needs or, conversely, needs not being met. The Review appreciated that capacity or decision-making ability assessments linked to a diagnosis of mental disability could result in discriminatory outcomes. It also appreciated that a person's ability to make and communicate their autonomous wishes can be affected by factors ('controlling influences') in addition to those associated with their diagnosis. The Review therefore considered that if the Autonomous Decision Making approach therefore encompasses these additional factors and operates within a Human Rights Enablement framework a person would be more likely to receive the support their require (not necessarily via mental health services but through more appropriate

[16] Recommendation 2.1.

[17] See Chapter 3, Section 3.1.

[18] To ensure that a person's view is heard and respected to the same extent as others in the same situation.

support and services) in the least restrictive manner under the circumstances (Scottish Mental Health Law Review, 2022).[19]

The Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework, together with a repurposed approach to mental health and capacity legislation away from authorising and regulating non-consensual interventions to meeting a person with mental disability's needs so they can live life on their own terms on an equal basis with others, was proposed with a view to reconciling the different CRPD and ECHR approaches. It was proposed that this framework and repurposing would apply whether mental health, capacity and adult support and protection legislation is ultimately only aligned or unified. Similarly, other considerations, such as who would be included within the definition of those to be supported by the legislation[20] and its interaction with criminal law, apply whether or not unified legislation is achieved.

6. A tentative roadmap to fusion

If a strategy of alignment over time is adopted, it will be necessary to identify the core elements of alignment and the sequence of reforms that can bring it about. The sequence will be determined by consideration of the critical path – what changes are needed before others can be adopted – but also by practical and political considerations – where are the areas where there is sufficient clarity and consensus to make rapid progress. The Review sought to divide its recommendations into short, medium and longer term. Although informed by the Scottish context, the following sequence may be relevant for reform initiatives in other jurisdictions.

1. Shared principles and definitions

The current Scottish capacity and mental health acts both include principles which are intended to guide decision-makers, including health care professionals and judicial bodies. These are not identical but overlap to a significant degree, including recognising the importance of considering the wishes and views of the patient, and ensuring that any intervention is the least restrictive compatible with the aims of the intervention. Creating a single set of principles is a relatively straightforward task. An encouraging sign in Scotland is that current proposals for early reform of the Adults with Incapacity Act include reform of its principles to give greater weight to the will and preference of the adult (Scottish Government, 2024c).

It is also necessary to specify to whom the law applies. Currently both Acts apply to persons with a 'mental disorder' as defined at s328 of the 2003 Act (albeit that the Adults with Incapacity Act may also apply to a small number of people with a physical disability which renders them incapable of communicating their wishes). The Review found that this terminology was regarded as stigmatising and recommended that their new regime apply to people with a mental or intellectual disability, whether short or long term.

This does not go as far as the suggestion by the WHO (World Health Organisation, 2023) that distinct mental health law be subsumed within general health law applicable to the whole population. The Review concluded that, in the same way as the CRPD was felt necessary to ensure that universal human rights were secured for people with disabilities, some distinct provision was needed to secure these rights in domestic law for people with mental and intellectual disabilities. At the same time, it recognised that a non-discriminatory approach required a shift away from diagnosis as the determinant of outcomes towards a focus on the human rights of the individual person.

2. Policy and practice reforms to reduce coercion and secure support for decision making

The Review was clear that legal change on its own would not be enough, and that there needed to be a major shift in policy and culture away from coercive practices and towards greater support to allow people to make their own decisions about their lives. These are urgent priorities in their own right but would also, if implemented, throw into sharper relief what are the circumstances where a decision which may conflict with someone's apparent preferences may be justified.

3. A shared judicial forum

The Mental Health Tribunal for Scotland oversees mental health law, while judicial decisions under capacity law are the responsibility of the sheriff court. This can mean that people are subject to two different legal processes, and to confusion over resolving cases which could be covered by either Act. The Review suggested that a shared forum – preferably a tribunal – could alleviate these difficulties, particularly if it was empowered to make orders covering both Acts, however a case initially came before it. This could also facilitate a more consistent approach to the two regimes.

Unfortunately, it appears that the Scottish Government has ruled this out as an early priority, citing administrative and cost issues (Scottish Government, 2024b).

4. Common safeguards for restrictive interventions

Currently, across the UK, a person who is detained in a psychiatric ward under mental health law has more safeguards against coercive treatment for mental disorder than someone with dementia in a care home being given psychotropic medication. The main challenge around unifying the safeguards is a practical one –the numbers of people in care homes is so much greater than the number of detained patients that the mental health law system of second opinions by a senior psychiatrist may not be practical for capacity law.

5. Common framework for non-consensual decision making

As set out above, a fundamental basis of the Review is that capacity tests should be replaced by a new model of Autonomous Decision Making which considers both internal and external threats to autonomy, together with a focus on Human Rights Enablement – that decisions are taken which maximise respect for the full range of a person's human rights.

This focus on human rights as a guide where it is not possible to discern the person's 'will' has been mooted in other jurisdictions (Galderisi et al., 2024), but the practicalities of weighing the full range of human rights in the range of circumstances to which mental health and capacity law may apply is hugely complex. The Review recognised that it had only sketched out the broad concepts and that much work would need to be done on the detail before this could be given effect in legislation.

6. Solutions for the hard cases

Among the more difficult nuts to crack on the route to fusion are the position of children (who are potentially subject to mental health law but not capacity law) and the interaction with the criminal law for those who offend or are felt to pose a serious risk of causing harm to others.

The Review considered whether mental health interventions for children could be incorporated into general child protection legislation, but found significant concern that this might create a new legal cliff-edge at the transition to adulthood. It also proposed ways to align

[19] Please see Sections 8.1 and 8.2, Chapter 8, for a full discussion of the Review's reasoning and recommendations on Human Rights Enablement and Autonomous Decision Making.

[20] Such as persons with learning disability, autism and neurodivergence, and children.

forensic mental health disposals more closely to civil disposals. However, it must be noted that capacity law does not typically identify risk to others as a criterion for intervention, which provides an added complication.

Once we are at or near the end of this sequence, the two regimes in Scotland may be sufficiently aligned that fusion becomes a practical matter of legislative drafting, with the difficult conceptual issues resolved. A possible objection is that by then, the legal, policy and human rights context may well have changed. This is a reasonable point, but this journey allows a jurisdiction to work through the conceptual and practical issues in an iterative and pragmatic way. Even if fusion turns out not to be the end result, the journey towards it has the potential to achieve substantive improvements in rights realisation.

7. Conclusion

As already stated, securing consistency between mental health and mental capacity law has clear benefits. Whether this is best achieved through better alignment or unified legislation, however, remains to be seen. We cannot yet look to how effective the Mental Capacity Act (Northern Ireland) 2016 is as most of its provisions have not come into force, and, in any event, such effectiveness would have to be evaluated over a number of years of implementation. The Wesseley Review also highlighted various conditions which would have to be satisfied before England and Wales should seriously consider unified legislation.

It is certainly arguable that perhaps better alignment is all that is required particularly if this occurs across all relevant legislation, not simply distinct mental health and capacity legislation. There is certainly support from the CRPD Committee and WHO for this in their recommendation that greater equality and non-discrimination can be achieved through the removal of mental health and capacity law and human rights informed provisions which are relevant to persons with disabilities are reflected in legislation that concerns the whole population.

That being said, it could be argued that even in the case of existing mental health and capacity legislation which is largely human and equality rights focused, all that is required is greater alignment, leaving unified legislation for those jurisdictions, such as Northern Ireland, which have not already adopted human rights and equality based legislation.

In Scotland, in the Scottish Government's response to the Scottish Mental Health Law Review recommendation noted that an area where further work is required includes 'Consideration of the benefit of fusion versus alignment of legislation' (Scottish Government, 2023). Despite the uncertain future of many of the Review's recommendations Scottish Government, 2024a; Scottish Government, 2024b) these recommendations do propose a way to navigate through two significant barriers to the benefits of fusion. Firstly, its recommendations for a Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework remove doubts about the Northern Ireland model owing to the CRPD Committee's scepticism about capacity. Secondly, by recommending an ongoing process of alignment the huge complexity of giving effect to fusion immediately is significantly reduced.

CRediT authorship contribution statement

Jill Stavert: Writing – review & editing, Writing – original draft. **Colin McKay:** Writing – original draft.

Declaration of competing interest

None.

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