

**This is a pre-review version of a paper now forthcoming in the Modern Law Review.**

## **The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law**

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### Introduction

The United Nations Convention on the Rights of Persons with Disability (CRPD)<sup>1</sup> was passed by the General Assembly in 2006, and came into effect in May 2008. As of December 2011, it had been signed by 153 countries and ratified by 108, in both cases including the United Kingdom.<sup>2</sup> It is the first major human rights treaty of the twenty-first century. Its impetus was that, whatever the intent of previous human rights treaties, people with disabilities have not shared equally in the rights created by those treaties;<sup>3</sup> and the core of the CRPD is thus the re-articulation of rights found in other treaties in ways that will make those rights meaningful to people with disabilities.<sup>4</sup> For all people with disabilities – people with mental disabilities<sup>5</sup> certainly included - this has the potential for significant benefits. Developed rights to non-discrimination in key areas, including employment, housing, education, health, standards of living and social, political and cultural participation, along with the right to be free from exploitation, violence and abuse, have the potential, if effectively implemented, to transform lives of persons with disabilities.

For people with mental disabilities, the CRPD represents an additional and highly significant change. Previously, international regulation had assumed that control of this group was in some circumstances justified; the issue was determining the bounds of permitted compulsion.<sup>6</sup> The CRPD

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<sup>1</sup> UN General Assembly, A/61/611. For full text, see <http://www.un.org/disabilities/default.asp?id=150>, accessed 15 January 2012.

<sup>2</sup> See website of UN Enable, <http://www.un.org/disabilities/default.asp?id=150>, accessed 22 December 2011. As of that date, its optional protocol, which allows for individual complaints concerning alleged violations of the conventions, had been signed by 90 countries and ratified by 63, again including the United Kingdom.

<sup>3</sup> See D. MacKay, 'The United Nations Convention on the Rights of Persons with Disabilities' (2006-7) 34 *Syracuse J Int'l Law & Com* 323-331.

<sup>4</sup> There is dispute in the academic literature the degree to which the CRPD goes beyond this core function and creates new rights. Thus Kayness and French note that the right to integrity contained in Article 17 has not been articulated in this way in the past, and Maigret notes that the right to be free from violence and abuse is not contained in other treaties. On this issue generally, see G. Quinn, 'Brining the UN Convention on rights for persons with disabilities to live in Ireland', (2009) 37 *British Journal of Learning Disabilities* 245 at 247, P. Weller, 'Supported Decision-Making and the Achievement of Non-Discrimination: The Promise and Paradox of the Disabilities Convention' in B. McSherry (ed), *International Trends in Mental Health Law* (Sydney: Federation Press, 2008) 85 at 89, R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *HRLRev* 1 at 29, F. Mégret, 'The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?' (2008) 30 *Human Rights Quarterly* 494 at 507.

<sup>5</sup> Mental disabilities is herein taken to include people with mental health problems (now sometimes called psychosocial disabilities) and learning disabilities.

<sup>6</sup> See, eg., United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, General Assembly Resolution 46/119 (1991); European Convention for the Protection of Human Rights and Fundamental Freedoms, Art. 5(1)(e) and related jurisprudence; Council of Europe `c:\documents and settings\uazjcw\local settings\temporary internet files\content.outlook\d5aquv9m\crpd and mental health law.docx`

takes no such starting point. Indeed, as will be discussed below, the CRPD appears to proceed on the basis that disability cannot be used as a factor in determining whether compulsion may be imposed. For people with mental disabilities, this would be an extraordinary change. It is not merely that some previous international instruments must be taken as superseded.<sup>7</sup> It is also that the effects on domestic law would be profound. The UN High Commissioner for Human Rights has stated that the CRPD requires the abolition of laws that allow for detention, for the removal of legal capacity, or for criminal defences, when those laws rely in whole or in part on mental disability.<sup>8</sup> Insofar as this is correct, it is difficult to see that UK mental health legislation is remotely compliant. The terms of the CRPD also raise profound questions about the compliance of UK legislation governing mental capacity.

This paper considers the effect of the CRPD on mental health and mental capacity law. The government appears to take the view that this UK legislation is in fact in compliance with the CRPD.<sup>9</sup> It will become clear from what follows that such a view requires at the very least a much more nuanced view than the government provides. While the issues raised apply equally to all parts of the UK, for practical reasons of length the paper focuses on legislation in England and Wales.

The issues in this paper are not purely academic. The CRPD is a formal convention, not mere guidance, and therefore has the force of international law. Further, it establishes a supervisory body, the Committee on the Rights of Persons with Disability, to which all state parties are required to report every four years on progress towards implementation of the CRPD. The Committee comments publicly on these reports.<sup>10</sup> At this time, the Committee has reported on Tunisia and Spain, providing a very initial indication of how it will interpret the Convention.<sup>11</sup> For countries such as the UK that have signed the optional protocol to the CRPD, individuals or groups of individuals may complain to the Committee regarding alleged breaches of the CRPD, and the Committee adjudicates the matter in a quasi-judicial fashion. It therefore cannot be assumed that failure to comply with the CRPD will pass unnoticed.

### An Overview of the CRPD: Interpreting New Paradigms

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Recommendation of the Council of Ministers R(1999)4 on the Principles concerning the Legal Protection of Incapable Adults; Council of Europe Recommendation of the Committee of Ministers Rec(2004)10 concerning the Human Rights and Dignity of Persons with Mental Disorder.

<sup>7</sup> This argument is made most frequently regarding previous UN instruments, most notably the Mental Illness principles of 1991: see, eg., J. Lord, D. Suozzi, A. Taylor, 'Lessons from the Experience of the U.N. Convention on the Rights of Persons with Disabilities: Addressing the Democratic Deficit in Global Health Governance' (2010) *Journal of Law, Medicine & Ethics* 564 at 576; A. Dhanda, 'Constructing a New Human Rights Lexicon: Convention on the Rights of Persons with Disabilities' (2008) 5 *International Journal on Human Rights* 43 at 45 (available on open access at <http://www.surjournal.org>; UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [48].

<sup>8</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [45], [47], [48]. These views will be considered at length below.

<sup>9</sup> United Kingdom, Office for Disability Issues, UK Initial Report on the UN Convention on the Rights of Persons with Disabilities (London: ODI, 2011).

<sup>10</sup> See CRPD Art 35.

<sup>11</sup> For Tunisia, see UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia, CRPD/C/TUN/CO/1 (13 May 2011); for Spain see UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain, CRPD/C/ESP/CO/1 (19 October 2011).

## Scope of the CRPD

A perusal of the short titles in the CRPD suggests that this is a broadly conventional human rights treaty. Many of the substantive rights protected, including rights to life (Art. 10), equal recognition before the law (Art 12), access to justice (Art 13), liberty and security of the person (Art 14), privacy (Art 22), respect for home and the family (Art 23), education (Art 24), health (Art 25), work and employment (art 27), adequate standard of living (art 28), participation in political, public, and social life (Arts 29 and 30), along with freedom from torture or cruel, inhuman or degrading treatment (Art 15), and freedom of movement (art 18), are the daily stuff of human rights law. Only a few of the provisions – the rights to accessibility to the physical environment (Art 9), to personal mobility (Art 20) and to rehabilitation (Art 26) being the most obvious – at first glance appear directly related to disability. This conventional human rights orientation is reinforced both by the preamble, which catalogues the various human rights treaties from which the CRPD is said to grow, and the general principles contained in Article 3, which include autonomy, non-discrimination, and similar human rights values.

At the same time, the CRPD is clearly not a mere repetition of what has come before. Key to the workings of the CRPD are issues of discrimination and reasonable accommodation<sup>12</sup> to ensure that rights may be enjoyed on an equal basis with others. The differences that flow from disability are thus to be met not with the limitation of the right in question, but with the provision of suitable supports so that the right may be enjoyed. This is reflected in a general requirement to provide reasonable accommodation in Article 5(3), but also in the drafting of many of the substantive provisions. The right to freedom of expression (Art 21), for example, is not phrased as a prohibition of state interference with expression, but as a positive duty on governments to provide information in formats that are appropriate to people with disabilities, to encourage the use of such media in the private sector, and to promote the use of sign language.

Occasionally, however, the language of the CRPD is notably sparse. The right to integrity (Art 17) for example is twenty-three words long, and offers no elaboration on what the right entails. The article was fiercely contested in the negotiations leading to the Convention, and at some stages in the drafting process was considerably longer, expressly restricting compulsory treatment. This was not acceptable to the disabled people's organisations present, however, since by restricting compulsion in most circumstances, the provision implicitly allowed it in some circumstances. No detailed wording could be agreed, and the current brief wording ended up in the final text.<sup>13</sup> As a result, much is left to interpretation, and the ground rules for that interpretation are not necessarily obvious. Does the failure to reach agreement on a new text mean simply that the status quo is left in place? In the context of the right to integrity, this could mean that there are only the most basic limitations to involuntary treatment in international law, flowing mainly from prohibitions on torture or inhuman or degrading treatment. These provisions have in turn been interpreted with astonishing deference to the medical profession,<sup>14</sup> and would effectively give state parties carte

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<sup>12</sup> This is substantially similar to the concept of reasonable 'adjustments' in the Equality Act 2010 and, previously, the Disability Discrimination Act 1996, but extends to all areas covered by the CRPD.

<sup>13</sup> On the drafting process regarding Article 17, see A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 608-610; P. Weller, 'The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives', [2011] (Spring) *Journal of Mental Health Law* 74.

<sup>14</sup> See, in the context of European jurisprudence, *Herczegfalvy v Austria*, application no. 10533/83, judgment 31 August 1992, (1992) 15 EHRR 437 (ECHR). See also P. Bartlett, "'The Necessity must be Convincingly Shown to Exist": Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983' (2011) c:\documents and settings\uazjcw\local settings\temporary internet files\content.outlook\d5aquv9m\crpd and mental health law.docx

blanche to continue widespread compulsory treatment – an outcome that would certainly not have garnered general support in the CRPD negotiations.<sup>15</sup> Alternatively, does one use the working documents from the negotiations as an aid to interpretation? This would introduce substance to the article that may reflect at least some of the views of participants in the negotiations, and would avoid leaving a gaping hole in the Convention, but would enforce an interpretation where the negotiators could not reach a consensus. Neither approach seems unproblematic.

The drafting history of Article 17 highlights a different departure of the CRPD: the active involvement of disabled people's organisations throughout the negotiation process. Apart of course from participating in formal votes, these organisations were integrated into the negotiation process, presenting their own draft articles and commenting directly on the proposals by state participants. This ethos of involvement is continued in the procedural requirements of the CRPD, which require that disabled person's organisations be involved in the implementation of the Convention.<sup>16</sup>

By comparison, traditional professional stakeholders – most notably for this article the medical profession – were absent from the negotiations. This no doubt affected the tenor of the negotiations. It also creates difficulties in implementation of the CRPD, as these stakeholders will be confronted with what they are bound to perceive as a *fait accompli* that will when implemented fundamentally alter their conditions of practice.

The CRPD challenges our understandings and categorisations of rights in new ways. De Burca notes that by implication the CRPD challenges simplistic distinctions between public and private action.<sup>17</sup> While evidence can be seen in other conventions of this divide being tested, it is certainly true that the CRPD expects governments to promote and protect the rights of persons with disability in society at large, including requiring private actors to provide reasonable accommodation to ensure that rights may be fully enjoyed by people with disability, and making social integration an overarching objective of the Convention.

The CRPD also integrates civil and political with economic, social and cultural rights in new ways.<sup>18</sup> It is not just that both sets of rights are contained in the same instrument; it is that the very division between these categories is challenged. Article 21 on freedom of expression, noted above, serves as a particularly clear example. Freedom of expression is normally considered a political right; but in the CRPD it is articulated in terms of the sorts of services and support that are required

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19 Medical LR 514; P. Bartlett, 'Re-Thinking *Herczegfalvy*: The ECHR and the Control of Psychiatric Treatment', in E. Brem (ed), *Mainstreaming Diversity: Rewriting Judgments of the European Court of Human Rights* (Cambridge: CUP, forthcoming 2012).

<sup>15</sup> Lord et al argue that sparseness of language will allow considerable interpretive scope not merely regarding Article 17, but also the rights regarding mental capacity in Article 12, perhaps in both cases undermining the progress that had been made controlling the use of compulsion in instruments such as the MI Principles: see J. Lord, D. Suozzi, A. Taylor, 'Lessons from the Experience of the U.N. Convention on the Rights of Persons with Disabilities: Addressing the Democratic Deficit in Global Health Governance' (2010) *Journal of Law, Medicine & Ethics* 564 at 576.

<sup>16</sup> See Art 33(3).

<sup>17</sup> G. de Burca, 'The European Union in the negotiation of the UN Disability Convention' (2010) 35 *European Law Review* 174 at 175.

<sup>18</sup> See, in general, G. Quinn, 'Brining the UN Convention on rights for persons with disabilities to live in Ireland', (2009) 37 *British Journal of Learning Disabilities* 245 at 247; A. Lawson, 'The United Nations Convention on the Rights of Perons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 575; P. Weller, 'The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives', [2011] (Spring) *Journal of Mental Health Law* 74-83.

for people with disabilities to take advantage of the right – the provision of information in specific formats, for example – that would generally be considered more akin to social and cultural rights. This is significant not merely because it challenges a long-established categorical structure, but on a much more practical level, because civil and political rights are to be immediately realised, where economic, social and cultural rights are subject to progressive realisation. Consistent with this, the CRPD itself includes a specific provision allowing for the progressive realisation of economic, social and cultural rights,<sup>19</sup> but no such provision for social and political rights. The difficulty will be to determine the application of this provision in a context where the division between civil-political and socio-economic-cultural rights is so nebulous. Continuing with the Article 21 example, are we to say that freedom of expression is subject to progressive realisation (an outcome that for cogent reasons will be anathema to human rights theorists and advocates); or are we to require poor countries to make information intended for the general public to be made available in Braille and other accessible formats, taking no account of their financial resources to do so? Neither choice seems particularly appealing.

### *The Social Model of Disability*

Article 1 of the CRPD contains a partial definition of disability:

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 drafting reflects some of the tensions discussed above. The inclusion of a definition was in doubt up to the penultimate session of the ad hoc committee drafting the Convention, and is the result of compromise.<sup>20</sup> The chair of the committee proposed that there be no definition, because of the risk that groups would be inadvertently excluded, but the disabled people's organisations present wanted a definition to ensure that states could not adopt unduly narrow readings of the Convention. The result is not entirely satisfactory, in that it appears to include only those with long-term impairments, but the definition is not exhaustive, allowing for further interpretation. Significantly for current purposes, the drafting does make it clear that mental disabilities are included. The issues of duration in the definition may affect some mental conditions, but disabilities relating to schizophrenia and many types of depression, for example, along with learning disabilities are sufficiently long-lasting that the inclusion of people with these disabilities in the CRPD should be uncontroversial.

The reference to barriers to participation emphasises the social model of disability adopted by the CRPD. This may conveniently be juxtaposed to medical and social welfare models.<sup>21</sup> Under the medical model, the disability is viewed as a medical condition that requires fixing. As such, it is

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<sup>19</sup> See Art 4(2).

<sup>20</sup> On the drafting history, see A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 593-595.

<sup>21</sup> On the move to the social model of disability, see D. MacKay, 'The United Nations Convention on the Rights of Persons with Disabilities' (2006-7) 34 *Syracuse J Int'l Law & Com* 323 at 328; A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 571; UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [35]; A. Dhanda, 'Constructing a New Human Rights Lexicon: Convention on the Rights of Persons with Disabilities' (2008) 5 *International Journal on Human Rights* 43 at 45; R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *HRLRev* 1 at 5.

viewed as contained in the body of the person with disability. The person with disability is in turn perceived as a passive recipient of medical care,<sup>22</sup> leading to the marginalisation and objectification of that person. The social welfare model may focus less on people with disabilities as medical objects, but still focuses on their limitations. Under this model, it may be accepted that disability may be a long-term condition not amenable to medical treatment, but it is still firmly located in the individual, and the social response is to provide care. In the most extreme cases, this will involve institutional care, divorcing the individual entirely from the remainder of society, with decisions taken entirely by guardians and similar figures. Even in less extreme forms, the result is the exclusion of people with disabilities in social programmes, rather than their social integration into broader society.

The social model, by comparison, characterises disability in terms of the relationship between the individual and society, and in particular the barriers society creates which exclude the person with disabilities. As such, it is not for the individual to be 'cured' of his or her disability, much less to accept the social exclusion of the social welfare model. It is instead for society to adapt to the needs of people with disabilities so that those people may maximise their participation in society as a whole. As a concrete example, mobility-related disabilities should not be conceived as lying within the individual who may use a wheelchair, but in architectural design that does not ensure that buildings are accessible to people in wheelchairs.

It is in this vision that the CRPD is taken to have much of its transformative potential: this is a convention that strives to include people in society, and it positively brims with optimism in this regard. A considerable amount of this optimism is entirely justified. Even in countries such as the United Kingdom where discussion of the social model has been current for many years, there is still much that can be done, and must be done if people with disabilities are to enjoy rights in the same way as the rest of society. No matter how the implementation of the CRPD in the UK and other countries plays out, this fundamental point should not be lost: things can and must be made considerably better.

That said, it is fair to ask whether the social model is, on its own, an adequate model of disability. Kayness and French locate its origins as a critical theory. In that formulation, it was never intended to deny the subjective elements of disability – there was always a space for 'impairment', to use a word now viewed as stigmatising – but rather to draw attention to the societal responses that are amendable to change. It was never thought to provide a complete model. In the CRPD, they suggest that it has become a 'disability rights manifesto', tending towards 'a radical social constructionist view of disability'.<sup>23</sup> This appears to reflect the readings of the Convention that are current. While impairment is mentioned in the definition in Article 1, this is in the context of interactions with barriers that hinder social participation. The focus of the literature both from within the UN and the academic community has focussed on the social barriers, and this is reflected in the remainder of the convention: the substantive articles are about how society can make rights real for people with disabilities.

Whatever the merits of that approach – and there are many – there are also problems that result. The differences experienced by people with disabilities are real. While the disabled person's

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<sup>22</sup> See, eg., M Oliver, 'A sociology of disability or a disablist sociology?' in L Barton (ed), *Disability and Society* (Harlow: Longman, 1996).

<sup>23</sup> R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 HRLRev 1 at 7.

organisations negotiating the CRPD would have preferred the less stigmatising term 'conditions' to the term 'impairments' that appeared in the final text, this is an argument more about language than substance. And there will be times when those conditions make a difference that cannot be equalised by merely supportive social responses. The difficulty is enhanced by the fact that state and private obligations are not unlimited: the reasonable accommodation that is required in response to apparent discrimination must 'not impose a disproportionate or undue burden' (Art 2). The CRPD does not address the question of what response is appropriate when supportive social interventions do not in practice make rights real for the person with disabilities. States are put in a particularly difficult position when they are under a further duty under the Convention to protect the person with disabilities, as in Article 16, which requires states to protect individuals from exploitation, violence and abuse.<sup>24</sup> Depending on how this article is interpreted, it might be taken to provide a role for proactive state action of a sort that the person with disability may sometimes view as coercive. While such an interpretation stands at odds with the ethos against compulsion contained in the remainder of the Convention, making it very difficult to know how to advise states in situations where non-coercive interventions do not yield the good outcomes envisaged by the Convention.

### *A New Mental Health Law?*

There is much in the CRPD for mental health advocates to be enthusiastic about. Traditional mental health law has focused on rights concerning detention and compulsory treatment;<sup>25</sup> the CRPD opens mental disability law to a wide variety of new fields involving social inclusion, including rights relating to employment, housing, community inclusion, and education.<sup>26</sup> This refocusing can only be to the advantage of people with mental disabilities, who in general no longer spend long periods of time in psychiatric facilities in the United Kingdom. As such, the refocusing of lawyers and legal academics towards their community rights is long overdue. The UK is further in a strong position to respond to these challenges. The Equality Act 2010, building on the Disability Discrimination Act 1996, includes many of the key concepts required by the CRPD. There is of course much to be done by way of implementation. Unemployment rates of people with mental disabilities remain stratospheric, and decent social housing is scarce and becoming scarcer.<sup>27</sup> While there have long been formal requirements to make reasonable adjustments to conditions of employment to take into account the needs of persons with mental disabilities, academic and jurisprudential

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<sup>24</sup> Art 16(1). For a discussion of these competing values in the context of decisions relating to consent to sexual activity, see S. Doyle, 'The Notion of Consent to Sexual Activity for Persons with Mental Disabilities' (2010) 31 *Liverpool Law Review* 111.

<sup>25</sup> See the standard texts in the field, e.g., P. Bartlett and R. Sandland, *Mental Health Law: Policy and Practice*, 3<sup>rd</sup> ed. (Oxford: OUP, 2007); B. Hale, *Mental Health Law*, 5<sup>th</sup> ed (London: Sweet and Maxwell, 2010); P. Fennell, *Mental Health Law and Practice*, 2<sup>nd</sup> ed. (Bristol: Jordans, 2011).

<sup>26</sup> The right to education in Article 24 includes the right to be educated in the general education system, in schools located in their community. Sadly, the UK Government issued a reservations on both these aspects of the right, so that special schools can remain in the United Kingdom, and students with disabilities may be sent to them even if they are not in the local community.

<sup>27</sup> Regarding employment, see United Kingdom, National Mental Health Development Unit, *Work, Recovery and Inclusion* (London: NMH DU, 2009). According to this source, only 13.5 per cent of people with a mental illness, and 3.0 per cent of people receiving secondary mental health services, are employed for 16 hours per week or more, compared 72.5 per cent of the population as a whole: figure 2. Regarding homelessness, see Homeless Link, *Survey of Needs Provision 2011* (London: Homeless Link, 2011); S. Rees, 'Mental Ill Health in the Adult Single Homeless Population: A Review of the Literature' (London: Crisis/PHRU, 2009).

analysis of what is actually required remains scant.<sup>28</sup> For persons with mental disabilities, this is a particularly complex issue, since each will experience his or her disability slightly differently, and will therefore have different needs that are required for reasonable adjustment to occur: there is nothing for people with mental disabilities that corresponds to installing a wheelchair ramp for people with mobility-related disabilities, where one response will benefit a significant number of people. So while there remains much to do, there is the makings of a good framework in which to do it.

The realms of traditional mental health and mental capacity law pose quite different problems. In these areas, the paradigms and presuppositions of the law do not chime as readily with the social model of disability and the focus on support rather than compulsion that is the basis of the CRPD. It is to these traditional bodies of mental health law that this paper now turns.

### Mental Capacity

Issues relating to mental capacity are dealt with in Article 12 of the CRPD. Article 12 was an extremely contentious article in the negotiations.<sup>29</sup> Some understanding of the international context is helpful in understanding the debates. In much of the world, there can be little doubt that the use of incapacity law remains oppressive. People with mental health problems are often found to lack capacity on the flimsiest of evidence, sometimes without notice that the proceedings are occurring. Partial guardianship, where it exists in all in law, is often not used, so that the incapacity determination results in the removal of all the individual's rights and decision-making authority. They may, for example, be legally forbidden from being employed. Often, they will be placed in institutional care, sometimes for life, where their guardian may well be the director of the institution.<sup>30</sup>

Given this background, it is unsurprising that the CRPD includes fundamental alterations to laws relating to mental capacity. The intrusiveness of guardianship law on the individual's life means that implementation of Article 12 has been identified as a particular priority by the UN High Commissioner for Human Rights.<sup>31</sup> Consistent with the social model of disability adopted in the CRPD as a whole, the focus is on provision of support, so that people with disabilities can make their own decisions. The issues under the Convention text can be divided into three related questions –

1. To what extent can incapacity as a concept still be used at all?
2. Can decisions ever be made by an individual on behalf of a person with disabilities, and if so on what criteria?
3. Insofar as the exercise of legal capacity may be limited, what safeguards are required?

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<sup>28</sup> On reasonable adjustments/accommodation, see A. Lawson. 'People with Psychosocial Impairments or Conditions, Reasonable Accommodation and the Convention on the Rights of Persons with Disabilities', in McSherry (ed), *International Trends in Mental Health Laws*, (Sydney: Federation Press, 2008) 62.

<sup>29</sup> For discussion of the negotiations, see A Dhandu, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2006-7) 34 *Syracuse J Int'l Law & Com* 429.

<sup>30</sup> Regarding issues of capacity and guardianship, see the reports of the Mental Disability Advocacy Center on Serbia, Russia, Kyrgyzstan, Hungary, the Czech Republic and Bulgaria, available at <http://www.mdac.info>. See also *Shtukaturov v Russia* application no. 44009/05, 27 June 2008 (ECtHR).

<sup>31</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009), [43-45].



All of these are open questions in the analysis of the CRPD. Canada, the Netherlands, and a number of Arab states issued reservations to the convention to ensure that systems of substitute decision-making could remain for people lacking capacity, suggesting that these countries took seriously the notion that the CRPD would require fundamental change in the approach to capacity law.<sup>32</sup> The United Kingdom made no such reservation.

*To what extent can incapacity as a concept still be used at all?*

This question will come as a surprise to many UK mental health advocates, since in this country we have for a number of years seen a move to greater reliance on capacity as progressive, precisely because it is perceived as non-discriminatory and relatively non-oppressive.<sup>33</sup> For reasons that will be clear given the international context noted above, this is not the starting point of the CRPD.

Article 12(2) provides that people with disabilities may enjoy legal capacity 'on an equal basis with others in all aspects of life'. The High Commissioner for Human Rights interprets this as meaning '[w]hether the existence of a disability is a direct or indirect ground for a declaration of legal incapacity, legislation of this kind conflicts with the recognition of legal capacity of persons with disabilities enshrined in article 12, paragraph 2.'<sup>34</sup>

On the face of Article 12(2), and consistent with the High Commissioner's reading, it may be possible to continue to use incapacity as a concept, so long as it is sufficiently divorced from disability. This would require significant alterations to the Mental Capacity Act 2005 (hereinafter 'MCA'), however. That Act defines incapacity as inability to make a decision 'because of an impairment of, or a disturbance in the functioning of, the mind or brain.'<sup>35</sup> This approach is directly related to the presence of a disability. Indeed, this disability threshold was intended as 'diagnostic', placing the approach within the medical model of disability.<sup>36</sup> For compliance with the High Commissioner's reading of Article 12(2) and if a move is to be made away from the medical model of disability, this approach would have to be abandoned.

Abandonment of this statutory test would not necessarily pose insurmountable problems. The diagnostic threshold has always had its critics, based on its stigmatising potential.<sup>37</sup> The

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<sup>32</sup> For an interpretation that the CRPD sets no bounds to legal capacity, see T. Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' (2006-7) 34 *Syracuse J Int'l Law & Com* 405 at 411.

<sup>33</sup> See, eg., J. Dawson and G. Szmukler, 'Fusion of mental health and incapacity legislation', (2006) 188 *British Medical Journal* 504, N. Rees, 'The Fusion Proposal: A Next Step?', in B. McSherry and P. Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart, 2010), and the papers in the J. Horne and G. Richardson (eds), *A Model law fusing incapacity and mental health legislation – is it viable; is it advisable?*, being a special issue 20 *Journal of Mental Health Law* (2010). A significantly enhanced role for capacity was proposed by the Richardson Committee on reform of the Mental Health Act 1983: United Kingdom, Department of Health, 'Review of the Mental Health Act 1983: Report of the Expert Committee' Chair: G. Richardson. (London: DOH, 1999). This enhanced role was ultimately rejected by the Government.

<sup>34</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) [45].

<sup>35</sup> Mental Capacity Act 2005, s 2(2).

<sup>36</sup> See United Kingdom, Law Commission, *Mental Capacity (LawCom 231)* (London: Queen's Printer, 1995) [3.8] and United Kingdom, Department of Health, *Explanatory Notes to the Mental Capacity Act* (London: Queen's Printer, 2005) [22].

<sup>37</sup> See, eg., D. Carson, 'Disabling Progress: The Law Commission's Proposals on Mentally Incapacitated Adults' Decision-making', (1993) *Journal of Social Welfare and Family Law* 304.

Department of Health has been giving the provision a broad reading to include conditions such as drunkenness,<sup>38</sup> even though this was almost certainly not the intent of the legislature.<sup>39</sup> Further, if the MCA is read literally, incapacity caused by the effects of medications would be outside the scope of the MCA, and presumably still covered by common law. Distinguishing between effects of medications and effects of impairments in the causation of incapacity seems impractical to the point of fanciful, particularly in cases where both might be expected to have significant causal roles. It is difficult to see this as sensible, and abolition of the express connection with a medicalised concept of disability might be desirable for reasons even outside the CRPD requirements.

It is less clear whether this solves the discrimination problem that appears to be of concern in the High Commissioner's opinion. If the test of incapacity still refers to inability to understand relevant information, to retain it, to weigh the information as part of a process of decision-making and to communicate it – the remaining core criteria under the current MCA<sup>40</sup> – it seems inescapable that the mental disabilities of some people will be relevant as to whether they meet these criteria. In the interpretation of the High Commissioner, this would appear to be impermissible. If there is a problem of discrimination in mental capacity law, the fact that the statute is neutral on its face will not address it if a prohibited criterion – disability, in this case – is still relevant to the decision taken. Express discrimination has merely become implied discrimination. Even if the decision-maker does not consider disability explicitly (as when, for example, he or she considers 'ability to make a decision' rather than psychosis, diagnosis, or limited intellectual ability) this will not address the problem if the criteria differently affect disabled people – it merely moves the problem from direct to indirect discrimination.

Is the use of capacity or a similar concept necessarily discriminatory? The fact that it is used inappropriately in large parts of the world – perhaps including England and Wales<sup>41</sup> – does not necessarily mean all its uses are discriminatory. Kayness and French note that a failure to acknowledge real difference leads to merely superficial equality, and are particularly critical of Article 12 'which border[s] on a complete denial of the instrumental limitations associated with cognitive impairments.'<sup>42</sup> Certainly, it does seem that the mental condition of the individual may in some circumstances be relevant to the appropriate social response to that individual's care: the individual in the coma is but a particularly clear case of a wider range of situations where the person's mental situation will, it would seem, be unavoidably relevant.

The scholarly debate on Article 12 views these questions not in terms of a debate about the use of capacity as a concept, but instead as matters relating to the nature of support offered to individuals in making decisions. It is to these questions that this paper now turns.

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<sup>38</sup> United Kingdom, Department of Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (London: TSO, 2005), at eg., [4.9] and [4.12].

<sup>39</sup> See the differential treatment by the MCA of mental incapacity and drunkenness in its amendment of s 3(2) of the Sale of Goods Act 1979: MCA sch 6, para 24. This removes the jurisdiction of the Sale of Goods Act over decisions made by people lacking capacity to contract, but leaves it in place for people who are drunk. This would make no sense if incapacity caused by drunkenness were meant to be within the scope of the MCA.

<sup>40</sup> See s 3(1).

<sup>41</sup> As there is no requirement under the MCA to notify anyone when decisions are made on behalf of persons lacking capacity, it is not really possible to know how the Act is being implemented.

<sup>42</sup> R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 HRLRev 1 at 7.

*Can decisions ever be made by an individual on behalf of a person with disabilities, and if so on what criteria?*<sup>43</sup>

Consistent with the overall ethos of the CRPD, Article 12 emphasises the social involvement of people with disabilities. Article 12 is not merely about the right to have a legal status, it is about actually being able to make decisions. This is evident on the face of the text, which as Mégret points out refers to legal 'capacity', not merely legal 'personality' as is contained for example in the ICCPR.<sup>44</sup> It is also clear from the drafting history, where there was considerable dispute as to whether 'legal capacity' meant the capacity to have rights or the capacity to exercise rights. The latter seems to have been accepted in the negotiations, resulting in some of the national reservations noted above. Further, Article 12(2) provides a right to 'enjoy' legal capacity, suggesting the latter interpretation, albeit with some ambiguities remaining in Article 12(4), which refers expressly to the possibility that the exercise of legal capacity may be curtailed in some circumstances.<sup>45</sup>

The enjoyment of legal capacity is to be accomplished through the use of appropriate supports provided to the person with disabilities, so that the individual is never formally deprived of legal capacity, but may rely ever more or less heavily on supports to decision-making, as their circumstances require.<sup>46</sup> In this way, the argument goes, the individual never loses their autonomy, the problems associated with the current laws relating to capacity can be avoided, and the needs of people with disabilities can be appropriately taken into account. In the words of Bach and Kerzner, 'The language of Article 12 represents a shift from the traditional dualistic model of [mental]

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<sup>43</sup> Before proceeding, a linguistic shift should be recognised. Traditionally, incapacity law has drawn a dichotomy between best interests decision-making, where an individual makes a decision on behalf of a person lacking capacity according to the objective best interests of that individual whether or not it is what that individual would have chosen, and substitute decision-making, where the decision-maker endeavours to reach the decision that the incapable individual would have made if he or she were capable. The language in the academic literature surrounding the CRPD is rather different. 'Substitute' decision-making is taken to mean decision-making by someone other than the person with disability. It would seem generally to be based on an objective best interests of the individual rather than what that individual would have chosen, and is thus similar to the 'best interests' approach in the old language. It is generally viewed as anathema to the Article 12 approach. 'Supported' decision-making means helping the individual reach his or her own decision, even when the required support is considerable. It does not appear that there is a category in the CRPD literature for an individual making a decision on behalf of the disabled person, but endeavouring to reach the decision he or she would have made – the old 'substitute' approach.

<sup>44</sup> F. Mégret, 'The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?' (2008) 30 *Human Rights Quarterly* 494 at 511.

<sup>45</sup> Regarding the debate in the drafting history on this point, see A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 596; A. Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2006-7) 34 *Syracuse J Int'l Law & Com* 429 at 453-454; A. Kanter, 'The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities' (2006-7) 34 *Syracuse J Int'l Law & Com* 289 at 301.

<sup>46</sup> On these issues, see J. Lord, D. Suozzi, A. Taylor, 'Lessons from the Experience of the U.N. Convention on the Rights of Persons with Disabilities: Addressing the Democratic Deficit in Global Health Governance' (2010) *Journal of Law, Medicine & Ethics* 564 at 573, A. Dhanda, 'Constructing a New Human Rights Lexicon: Convention on the Rights of Persons with Disabilities' (2008) 5 *International Journal on Human Rights* 43 at 47 (available on open access at <http://www.surjournal.org>); A Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2006-7) 34 *Syracuse J Int'l Law & Com* 429 at 441; T. Minkowitz, 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities', in B. McSherry and P. Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart, 2010) at 156-8.

capacity versus [mental] incapacity and is viewed as an equality-based approach to legal capacity.<sup>47</sup> However intensive the supports may be, they are always directed to the realisation of the will of the person with disability. Article 12 stops short of prohibiting any interference with the exercise of legal capacity, instead requiring that such interferences be tailored to the individual's circumstances, for the shortest time possible, subject to safeguards, and 'respect the rights, will and preferences of the person'.<sup>48</sup>

Some of this approach fits closely with the MCA. The MCA for example requires that all reasonable steps to help the individual to reach a decision be taken before the Act's more intrusive provisions take effect.<sup>49</sup> While this appears similar to a supported decision-making system, there is no published research on how, if at all, this provision is being implemented. Provisions of the MCA are designed to ensure that intervention occurs only on specific decisions where the individual is unable to make a decision (defined in the statute in terms of incapacity), tailoring intervention to the individual's specific needs and situation. The MCA further requires that the decision reached on behalf of a person lacking capacity must take into account the individual's past and present wishes and feelings, the beliefs and values he or she would have brought to the decision if competent, and any other factors he or she would have been likely to consider, if able to do so.<sup>50</sup> The object, here and elsewhere in the Act, is to keep the individual as involved as possible in the decisions affecting him or her. All this suggests a considerable degree of overlap with the CRPD approach.

There are complications however. The above list of decision-making criteria is not exhaustive: the decision-maker must take into account all circumstances relevant to the decision,<sup>51</sup> not merely the subjective factors noted above. Objective assessments of best interests often figure large in the jurisprudence under the statute. The significance of this objective test in practice is not entirely obvious. It seems likely that most people would, in fact, consider what is in their objective best interests as a significant factor in decision-making; but the express inclusion of factors unrelated to the views and preferences of the individual is at marked contrast with the approach of the CRPD. The CRPD approach may allow other factors to be considered when the will or preferences of the person with disability cannot in practice be ascertained,<sup>52</sup> but these will be in only rare cases, and much less frequently than envisaged by the MCA. If the ethos of Article 12 is to be implemented, it would seem that legislative amendment will be required in this respect.

This has knock-on effects regarding the role of the person making the decision in the MCA on behalf of the person with disability. Under the MCA, this person actually makes the decision: it is not a case of supported decision-making, but rather decision-making made on behalf of the person with disabilities. A move to the more subjective criteria envisaged by Article 12 makes the person

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<sup>47</sup> M. Bach and L. Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, (Toronto: Law Commission of Ontario, 2010) at 30. Parentheses in original. Available online at [www.lco-cdo.org/disabilities/bach-kerzner.pdf](http://www.lco-cdo.org/disabilities/bach-kerzner.pdf). Bach and Kerzner's work is the most extended and considered attempt to date to devise a pragmatic programme of implementation for Article 12. Sadly, space does not permit an extended discussion of it here.

<sup>48</sup> Art 12(4).

<sup>49</sup> See s 1(3).

<sup>50</sup> s 4(6).

<sup>51</sup> s 4(2).

<sup>52</sup> See T. Minkowitz, 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities', in B. McSherry and P. Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart, 2010) at 157-8; M. Bach and L. Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, (Toronto: Law Commission of Ontario, 2010) at 91-95.

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much more an agent for the person with disabilities. This again would be a significant epistemic shift in the interpretation of the MCA.

The big issue that is largely unexamined in the CRPD itself is how the shift to a pure supported decision-making structure will work in practice. Certainly, there are some partial models that exist, such as representation agreements in British Columbia<sup>53</sup> and a mentoring system used in parts of Sweden,<sup>54</sup> but these have tended to be used in specific contexts, or alongside more conventional guardianship legislation.<sup>55</sup> Will the sort of system required by the CRPD, in practice, solve the problems inherent in a capacity-based framework? For some individuals, the intensity of support that will be necessary is likely to be such as to raise fundamental questions, such as whether the decision is the will of the person with disabilities or the supporter, whether the person with disabilities is empowered any more than under a well-developed capacity-based system, and how one is theoretically to understand the roles of supporter and supported in this system, and how to practically provide appropriate protections in the event that the supporter is taking advantage. That said, these difficulties all exist equally in capacity-based systems; would a movement from capacity make them any worse?

While the CRPD expressly allows limitations to the exercise of legal capacity, subject to the limitations noted above, it is silent on when those limitations can or should take effect. If incapacity is able to be separated from disability, it could perhaps still be used; but as discussed above, it is difficult to see how this is practical. This would appear to be an awkward silence at the core of Article 12.

*Insofar as the exercise of legal capacity may be limited, what safeguards are required?*

The safeguards required when exercise of legal capacity is limited are articulated by Article 12(4):

States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

In some aspects, the MCA goes a considerable distance towards compliance with these requirements. Interventions are determined according to the specific decisions that an individual is unable to make, tailoring the interventions to the individual's circumstances, and at least in theory, making them as minimally intrusive as possible in the individual's life. While both the criteria for intervention (incapacity as it relates to the decision) and the criteria for making decisions (which

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<sup>53</sup> See Representation Agreement Act, R.S.B.C. 1996, c 405.

<sup>54</sup> This is discussed in A Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2006-7) 34 *Syracuse J Int'l Law & Com* 429 at 434-435.

<sup>55</sup> For a detailed proposal on a CRPD-compliant system, see M. Bach and L. Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, (Toronto: Law Commission of Ontario, 2010). Space does not permit a detailed discussion of it here, whatever its considerable intellectual merits, as yet, their proposed system has nowhere been put into effect.

include an objective best interest criterion) are problematic, at least the MCA limits the range of interventions reasonably narrowly.

As to procedural safeguards however, the MCA is manifestly lacking. Most decisions under the Act are made pursuant to the general power to make decisions in the best interests of persons lacking capacity.<sup>56</sup> For these decisions, there are no routine checks to see how decisions are being taken under the Act; indeed, there is no requirement to notify anyone when decisions are taken in reliance on the Act, nor when an individual is considered as lacking capacity to make a decision. It is therefore difficult to have any systematic sense as to how the Act is being implemented, or whether its criteria are being followed at all. The MCA contains no prohibitions of conflicts of interest between decision-makers and people with disabilities. Certainly, the Court of Protection now exists as a specialised court dealing with issues under the MCA, but it considers only the matters that are brought before it. This means it considers mainly cases where disputes have arisen between carers, cases where legal certainty is required (as for significant financial transactions), and cases where a decision-maker is in significant doubt as to how to proceed. It is far from obvious that this will include all cases where the system is abused.

While the provisions of the Article 12(4) are manifestly desirable, it is not obvious how they are to be implemented in a system such as that of the MCA, which is designed to allow a multiplicity of specific decisions rather than wholesale deprivations of rights. While it is easy to say that the MCA does not comply in its procedural safeguards with the provisions of Article 12(4), it is much more difficult to say what processes would be appropriate, that would not force the system to collapse under its own administrative weight. Here, as elsewhere, the CRPD poses profound practical problems.

### *Conclusion*

The government's approach to Article 12 has been to say that the MCA and comparable Scots and Northern Irish legislation are compatible, since decisions are only taken when individuals lack capacity and safeguards are in place to protect the individual in how such decisions are made.<sup>57</sup> No consideration is offered to whether the capacity/incapacity divide and the criteria for decision-making are consistent with Article 12, and the discussion of safeguards, at least in an English context is unconvincing.

At the same time, Article 12 leaves a variety of questions hanging. Does it effectively preclude any use of capacity as a concept, based on what would seem to be an inevitably close relationship with the condition of the disabled person in how it is assessed? If Article 12 requires us to move away from a dualist approach where the divide between capacity and incapacity is no longer absolute to a system based entirely on supported decision-making, how is a new system to function?

Addressing issues related to capacity is essential in considering the implementation of the CRPD as a whole, since capacity is so pivotal to the relationship of mental disability to other aspects

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<sup>56</sup> MCA, s 5-6.

<sup>57</sup> United Kingdom, Office for Disability Issues, UK Initial Report on the UN Convention on the Rights of Persons with Disabilities (London: ODI, 2011) at [102-117]. This line of argument is particularly inadequate in the case of Northern Ireland, where it would seem that there is currently no legislation covering personal decision-making by people lacking capacity, although law reform in this regard is in the works.

of law. Capacitous consent is the standard legal requirement prior to the provision of medical treatment, for example, and key aspects of criminal law such as the defence of insanity and the determination of fitness to plead are based on concepts akin to capacity. The issues in this section therefore will recur in the remainder of this paper, where discussions of the scope of permissible compulsion will resonate with the discussions of capacity above.

### Compulsory Medical Treatment

The academic literature tends to view issues of involuntary treatment in the context of the right to integrity in Article 17. As noted above, the phrasing of this article is new in international law. While many human rights provisions seem at least implicitly bound up with the concept of integrity, this is the first international treaty to include it expressly as a specific right. In its final formulation, it is a short provision:

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Although as it stands the article makes no mention of enforced treatment, it is perceived in the academic literature as being the primary article concerning involuntary treatment. This can be explained by its drafting history. At one point, the draft article continued:

2. States Parties shall protect persons with disabilities from forced intervention or forced institutionalisation aimed at correcting, improving or alleviating any actual or perceived impairment.
3. In cases of medical emergency or issues of risk to public health involving involuntary interventions, persons with disabilities shall be treated on an equal basis with others.
4. States Parties shall ensure that involuntary treatment of persons with disabilities is:
  - (a) Minimised through the active promotion of alternatives;
  - (b) Undertaken only in exceptional circumstances, in accordance with procedures established by law and with the application of appropriate legal safeguards;
  - (c) Undertaken in the least restrictive setting possible, and that the best interests of the person concerned are fully taken into account;
  - (d) Appropriate for the person and provided without financial cost to the individual receiving the treatment or to his or her family.<sup>58</sup>

These clauses, and paragraph 4 in particular, were hotly contested. Disabled people's organisations objected that the inclusion of paragraph 4 expressly permitted compulsion of people with disabilities in situations where non-disabled people would not be compelled – a clear violation of the non-discrimination principle. States party were reluctant to allow the removal of the paragraph, as they wished to retain their power to treat without consent people with mental disabilities who had capacity to consent to treatment and refused treatment, but were nonetheless a risk to themselves

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<sup>58</sup> Ad Hoc Committee, Report of the Seventh Session, A/AC.265/2006/2 (13 Feb 2006).

or to other people.<sup>59</sup> The eventual compromise was a removal of paragraphs 2 to 4 entirely, leaving the bare right to integrity.

This peculiar drafting history makes interpretation of the provision uncertain. One reading is that it accomplishes virtually nothing. In the words of Kayness and French, '[t]he result is that one of the most critical areas of human rights violation for persons with disability – the use of coercive State power for the purpose of 'treatment' – remains without any specific regulation.'<sup>60</sup> At the same time, while the scope of the article may be open to interpretation, it is a new provision, not reflected expressly in other international law, and it does presumably mean something. The question is what? So far, the Committee on the Rights of Persons with Disabilities has found non-consensual physical treatment to violate this article (surgery in the case of Tunisia, sterilisation in the case of Spain).<sup>61</sup> It has registered concern about the provision of non-consensual psychiatric treatment, but has stopped short so far of finding a violation.<sup>62</sup>

Weller has used a report of the UN Special Rapporteur on Torture as an aid in interpreting Article 17.<sup>63</sup> In this view, the article is engaged by concerns including conditions of detention, use of restraints (both physical and chemical), seclusion, experimental treatment, enforced treatment (particularly when intended to alleviate disability-related impairments, and specifically including psychiatric drugs and electro-convulsive therapy), and particularly intrusive treatments such as lobotomy, sterilization, and 'unmodified'<sup>64</sup> electro-convulsive therapy. The difficulty with this approach is that the Special Rapporteur, quite properly, is considering the meanings of torture and inhuman or degrading treatment. Those rights are protected separately under the CRPD, in Article 15.<sup>65</sup> The right to integrity in Article 17 must mean something different.

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<sup>59</sup> On the drafting history, see A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 609; R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *HRLRev* 1 at 30.

<sup>60</sup> R. Kayness, P. French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *HRLRev* 1 at 30.

<sup>61</sup> UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia, CRPD/C/TUN/CO/1 (13 May 2011) at [29]; UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain, CRPD/C/ESP/CO/1 (19 October 2011) at [37-38].

<sup>62</sup> UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia, CRPD/C/TUN/CO/1 (13 May 2011) at [30]

<sup>63</sup> P. Weller, 'The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives', [2011] (Spring) *Journal of Mental Health Law* 74 at 81-82. Weller refers to the Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, General Assembly A/63/175 (28 July 2008).

<sup>64</sup> That is, electro-convulsive therapy provided without the use of anaesthetics and muscle relaxants. Unmodified ECT is not practiced in the United Kingdom.

<sup>65</sup> For an interpretation of Article 15 of the CRPD, including consideration of the Special Rapporteur's report, see T. Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' (2006-7) 34 *Syracuse J Int'l Law & Com* 405 at 413-426. While the report does raise matters of concern in the UK context (eg., the continued availability of non-therapeutic sterilisation of people with mental disabilities, albeit following a court order), it generally couches its language in terms of areas where violations may occur depending on the circumstances, rather than areas where violations are clear. The application of the report in a UK context is therefore a significantly larger debate than can be accommodated in this paper.



Quite how Article 17 will be given meaning remains to be seen. The reference in the Article to 'physical and mental' integrity suggests a holistic attitude to personhood, and of the self. This in turn may suggest a connection with the capacity issues in Article 12, although precisely how that connection would be articulated, it is too early to say.

Can it be taken that state action which would not have been consistent with the draft article cited above would therefore not be consistent with the article as it appears in the final text? As the objection to the draft article was that it did not go far enough in protecting against compulsion, this might be a coherent position; and if it turns out to be correct, English and Welsh law is open to considerable challenge. Of particular concern would be draft sub-paragraphs 17(4)(b) and 17(4)(c), where both process and substance are open to challenge. Under s 63 of the Mental Health Act 1983 [hereinafter, 'MHA'], persons detained in psychiatric hospitals may be given virtually any treatment<sup>66</sup> for their mental disorder for up to three months without their consent. There are no procedural or substantive restrictions on this enforced treatment. After three months, a second opinion by an independent doctor appointed through a statutory scheme is required for compulsory treatment, but the statutory criterion for the compulsion is merely that the treatment be 'appropriate'.<sup>67</sup> It is at best questionable whether this meets the test of 'exceptional circumstances' in the draft Article 17(4)(b). These provisions affected almost 46,000 people in 2009; less than 9000 benefitted from the second opinion procedure.<sup>68</sup> Rather astonishingly, the government makes no reference to these MHA provisions in its initial assessment of compliance with the Article 17.<sup>69</sup>

While Article 17 is ambiguous in its meaning, Article 25 on the right to health is much less so. Much of the article concerns the duty to provide equal access to health care to people with disabilities – itself an important point in the UK and across the world. Article 25(d) however obliges States Parties to require health professionals 'to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent...'. This appears to provide an unambiguous steer that the non-discrimination provisions of the CRPD apply to medical consent. The current general rule is that people with capacity can consent to or refuse treatment as they please. The degree to which this standard will be affected by the reading of Article 12, and the discussion above in that regard will not be repeated here. Suffice it here to say that whatever resolution is made of those issues, Article 25 makes it clear that consent rights will have to apply equally to people with mental disabilities.

Article 25 does provide a further and direct challenge to the MHA treatment provisions, which single out treatment of mental disabilities for compulsion, where treatment of other disorders is left to the realm of capacity. Uniquely, competent people with mental disabilities cannot refuse treatment for mental disorders. The Article 17 debates would suggest that States Parties were concerned about the cases of people who had capacity to make treatment decisions, but

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<sup>66</sup> The most significant exceptions are psychosurgery (which may only be given with consent and a second opinion), and electro-convulsive therapy (which may not be given if the patient either offers a competent refusal of the treatment, or has made an advanced refusal of the treatment when competent): see MHA s 57 and 58A.

<sup>67</sup> MHA, s 58.

<sup>68</sup> For an extended discussion of these provisions, see P Bartlett, 'The Necessity must be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983, (2011) 19 *Medical Law Review* 514.

<sup>69</sup> United Kingdom, Office for Disability Issues, UK Initial Report on the UN Convention on the Rights of Persons with Disabilities (London: ODI, 2011).

nonetheless suffered from disorders that made them dangerous to themselves or others.<sup>70</sup> Insofar as this is the concern of the UK government (and it should be noted that there is no such criterion in the current compulsory treatment provisions of part 4 of the MHA, which governs compulsory treatment), it might be possible to pass legislation allowing treatment of people without their consent if they were affected by a condition that put themselves or others at risk, so long as that legislation applied to everyone, not merely to people with mental disabilities. While that would meet the CRPD's concerns about non-discrimination, it might well prove politically unpalatable as an undue infringement on the civil rights of individuals. That begs the non-discrimination question, however: if it is not justified for society as a whole, why would it be justified for competent people with mental disabilities?

### Civil Detention

The right to liberty is dealt with in Article 14 of the CRPD. Much of this article is uncontroversial, protecting people with disabilities from arbitrary detention and requiring that when detained, reasonable accommodation must be provided, reflecting their disabilities. More challenging is the second half of Article 14(1)(b), which holds that 'the existence of a disability shall in no case justify a deprivation of liberty'. As currently interpreted, this does not mean simply that disability cannot be the only ground for detention; it means that disability cannot be a factor in determining detention at all. In the words of the High Commissioner for Human Rights,

Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.<sup>71</sup>

Consistent with this, the Committee on the Rights of Persons with Disabilities has called on both Tunisia and Spain to reform their mental health laws, moving from a system of detention based on disability.<sup>72</sup>

While the High Commissioner states that detention cannot be based on disability, as is the form in virtually all domestic mental health legislation including that of the United Kingdom, she was at pains to say that this did not necessarily preclude persons with disabilities from being subject to preventive detention. The above quote continues:

This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds

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<sup>70</sup> A. Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-7) 34 *Syracuse J Int'l Law & Com* 563 at 609.

<sup>71</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [48].

<sup>72</sup> UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia, CRPD/C/TUN/CO/1 (13 May 2011) at [24-25]; UN, Committee on the Rights of Persons with Disabilities, Concluding observations of the Committee on the Rights of Persons with Disabilities: Spain, CRPD/C/ESP/CO/1 (19 October 2011) at [35-36].

upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.<sup>73</sup>

Presumably, this would mean passage of a general law for preventive detention. If it is dangerousness that is of concern, for example, a disability-neutral law could be introduced to detain people who are perceived as dangerous, irrespective of disability. While this might satisfy the problems of interpretation of article 14, it is difficult to see that it is a good idea. It is difficult to see that it would be wise in human rights terms to encourage autocratic regimes to introduce laws allowing detention of people perceived as dangerous (whether mentally disabled or not), as such a law invites political abuse. At the same time, this re-phrases the question of discrimination that is at the core of the CRPD. If the law is open to abuse if applied to the general population, presumably because 'dangerousness' is such an unclear category and is so difficult to predict, why would it be acceptable to apply it to people with mental disabilities?

The statement of the High Commissioner further suggests that many (most?) of the people currently detained could still be detained, so long as the law was phrased in a neutral fashion. This would be at best problematic. In much of the world, the move to community-based treatment has not occurred, and any policy of making rights real for people with disabilities must include the removal of these people from hospitals and similar institutions to community-based alternatives. The CRPD should be interpreted to achieve this end by both providing a right to live in the community (Article 19)<sup>74</sup> and restrictions on institutional detention. Disability-neutral detention legislation does not imply a move to that end, however; it merely changes the justification for detention. For people internationally in institutions who would benefit from community living, this result would be cold comfort indeed. It is fair to expect considerably more from Article 14, but CRPD is an international convention and the interpretation that would bring about a good result internationally must also apply to the UK.

A disability-neutral preventive detention statute further poses particular problems for countries that are signatories to the European Convention on Human Rights. Article 5 of the ECHR prohibits deprivations of liberty except in specific circumstances, including the 'lawful detention of ... persons of unsound mind'.<sup>75</sup> No other exception in Article 5 could be used to justify a preventive detention statute, and for States Parties to the ECHR, the High Commissioner's generalist approach cannot be implemented. To comply with both Conventions, if the prevailing interpretations are correct, it would seem that preventive detention of people with mental disabilities is not legally possible. People with mental disabilities could admit themselves into hospital if they wished to do so, but there would be no mechanism to compel them to do so. This would be a hard sell to governments, to medical stakeholders, to many family carers, and to broader society. Certainly, a great deal more can be done by way of engagement with people with mental disabilities on a voluntary basis, but the overwhelming social perception at this time is that in hard cases, this may not be enough. If people are actually acting in a fashion dangerous to others, criminal law could presumably be invoked to control them; but this will result in a detention in a police cell, gaol or prison – not a particularly humane place to detain someone with a mental disability. It is also fair to ask whether in these circumstances it really makes sense to process someone through the criminal

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<sup>73</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [48].

<sup>74</sup> For a discussion of this Article, see C. Parker, L. Clements, 'The UN Convention on the Rights of Persons with Disabilities: a new right to independent living?', [2008] 4 EHRLR 508. Somewhat surprisingly, while advocating the demise of institutional care particularly when people are able to be cared for in their own homes (see, eg, p 521), Parker and Clements make no mention of Article 14.

<sup>75</sup> Art 5(1)(e).

system, giving them a criminal record that will affect their prospects in the community on release: potential landlords and employers are not necessarily sympathetic to people with criminal records. Is it really the intention of Article 14 to make it harder for people with mental disabilities to integrate into the community upon release, when such community integration is meant to be at the heart of the Convention?

It is tempting to read the CRPD as creating an interrelated basket of rights, with article 14 entering into effect in tandem with the community services required in Article 19 and elsewhere in the Convention. This has its appeal, as it would allow full deinstitutionalisation to remain as a goal, and monitor progress towards it. It would keep the potential for real content to be retained in article 14, progressing beyond the previous international law, and keeping in view that the object of the convention is the provision of community living for people with mental disabilities. It would place deinstitutionalisation in a hand-in-glove relationship with the development of community services, and this makes some practical sense: the experience of countries where major deinstitutionalisation has occurred in the last decades is that closure of institutions without provision of appropriate community services can lead to profoundly unfortunate results for people with mental disabilities. There are various difficulties with this approach, however. First, it makes the right to liberty subject to a progressively realisation, a precedent that human rights advocates would quite rightly not want to see. Second, while the monitoring mechanisms of the CRPD do mean that progress towards implementation is more visible than for other conventions, it is not obvious that they would keep sufficient pressure on States Parties to move towards non-institutional solutions. And finally, it is not the approach adopted by the Committee in its recent reports on Spain and Tunisia. They instead call for non-compulsory mental health law, with no express link to the provision of community alternatives.

While Article 14, like so much of the CRPD, is challenging to interpret and problematic to implement, the UK government's response is singularly disappointing:

Under the 1983 Act [i.e., the MHA], a person with a mental disorder may be detained and treated (or be made subject to certain other restrictions) without his or her consent where that is justified by the risk that the mental disorder poses to him or her or to other people. Safeguards ensure that any such deprivation of liberty is not arbitrary and complies with the law (including Article 5 of the ECHR). ... Individuals have the right to have their case reviewed by an independent and impartial Mental Health Tribunal. They also have the right to receive support from statutory Independent Mental Health Advocates.<sup>76</sup>

The response correctly acknowledges that detention under the MHA is directly related to mental disability, but seems to take the view that because safeguards are available to ensure that the diagnosis of medical disability and risk are accurate, Article 14 is not infringed. It is difficult to see that this is remotely consistent with the readings of the Article discussed above.

### Criminal Law

Issues of mental disability arise in criminal law primarily in the contexts of fitness to plead, the defence of insanity, and the partial defence to murder of diminished responsibility. These are generally related to issues of capacity, in the first case capacity to engage with the processes of trial,

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<sup>76</sup> United Kingdom, Office for Disability Issues, UK Initial Report on the UN Convention on the Rights of Persons with Disabilities (London: ODI, 2011) at [134].

and in the second two, whether the individual had the requisite mental elements to be held responsible at all, in the case of insanity, or fully responsible, in the case of diminished responsibility. The issues therefore are primarily relevant to Article 12.

While the Committee for the Rights of Persons with Disabilities has been silent on criminal law issues in its two state reports, the High Commissioner for Human Rights has taken the view that current legal approaches must be changed:

In the area of criminal law, recognition of the legal capacity of persons with disabilities requires abolishing a defence based on the negation of criminal responsibility because of the existence of a mental or intellectual disability. Instead disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant. Procedural accommodations both during the pretrial and trial phase of the proceedings might be required in accordance with article 13 of the Convention, and implementing norms must be adopted.<sup>77</sup>

The requirement that criminal law move away from engagement with mental disability is counter-intuitive. Usually, the argument has been that people with mental disabilities are already over-represented in criminal law generally and in the prison population in particular,<sup>78</sup> in circumstances where their real responsibility for the crime at issue is at best questionable. Insofar as a move away from disability-based criminal law will reduce the scope of these defences, this problem will be exacerbated. If this is true in the United Kingdom, the perceived injustice is even more pronounced in other countries, where conditions of detention may be profoundly substandard, and where fewer legal protections (such as an effective system of legal aid) assist people with mental disabilities in the criminal justice system.<sup>79</sup> The situation in countries that retain capital punishment is even more stark: if disability-based defences are removed without provision of equally extensive alternatives, more people will be executed who are doubtfully responsible for the crimes of which they are accused.

That in turn would appear to mean that the development of non-discriminatory alternative formulations must be of paramount importance. The difficulties here mirror those in the discussions of capacity and detention, above. Certainly, one could remove express diagnostic criteria from the definitions of relevant defences, but if the claim is that an individual is unable to conduct a defence or is not responsible for their actions, it is likely for people with mental disabilities that the reason for this will be directly associated with their mental disability. If the existing law is discriminatory, therefore, the amended law will also be discriminatory. And insofar as the issue becomes focussed on developing co-extensive and non-discriminatory versions of existing law, there is a serious risk that the actual situation of people in the criminal law system is lost track of. The argument remains compelling that criminal law is already overly controlling of people with mental disabilities, as evidenced by the numbers in prisons. In many countries of the world, their legal position, as well as their conditions of detention, are indefensible. It would be a sorry situation indeed for these matters to be marginalised, with all efforts focussed on rewording of legislation.

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<sup>77</sup> UN High Commissioner for Human Rights, Annual Report, A/HRC/10/48 (26 January 2009) at [47].

<sup>78</sup> It would seem that roughly half of prisoners have primary or secondary mental health needs upon admission: see United Kingdom, Her Majesty's Inspectorate of Prisons, 'The mental health of prisoners' (London: HM Inspectorate of Prisons, 2007) at [1.14].

<sup>79</sup> See, eg., Mental Disability Advocacy Center (MDAC), 'Liberty Denied: Human Rights Violations in Criminal Psychiatric Detention Reviews in Hungary' (Budapest: MDAC, 2004).

The government's response to the CRPD makes no mention of these aspects of criminal law.<sup>80</sup> Amendments to the law of diminished responsibility in 2009 have endeavoured to engage more closely with the provisions of modern medicine, but there has been no movement away from mental disability as the core of the defence.<sup>81</sup> Consultation by the Law Commission on amendments to the law of fitness to plead are now underway,<sup>82</sup> and on amendments to the law of insanity will begin soon. Initial indications are that these, too, will rely directly on mental disabilities. It is therefore difficult to see that these will be consistent with the analysis of the High Commissioner.

## Conclusion

At its inception, the CRPD was greeted with an almost revolutionary joy. UN Secretary-General Kofi Annan for example referred to 'the dawn of a new era – an era in which disabled people will no longer have to endure the discriminatory practices and attitudes that have been permitted to prevail for all too long.'<sup>83</sup> And there can be no doubt that the CRPD does make a significant in the promotion of human rights for people with disabilities. Rights to community living and all the supportive services and mechanisms required to make community integration a reality have moved from semi-official guidance and statements of good practice to the centre of an international convention. Nowhere will these developments be felt more keenly than in mental disability law, which must now be taken to be about so much more than the regulation of involuntary admission and treatment, and the law relating to people lacking capacity.

The party celebrating the passage and ratification of the CRPD is now over, however, and on the morning after, as we look out (perhaps slightly hung over) on this brave new world that has been created, we need to figure out how to live in it, how to make the CRPD actually work in practice. That is not just a matter of buttressing the services that will promote social integration (vital though that task is); it is also about asking the hard questions that relate to the laws relating to compulsion that are based on disability, including those relating to mental capacity, the compulsory treatment and detention permitted by mental health legislation, and issues of mental disability in the criminal law.

In assessing the way forward, it will be necessary to take into account several guiding principles. First, the CRPD is an international treaty. While the solutions we reach need not be applicable outside the UK, the interpretation we give to the treaty must be defensible in international law. Second, the fact that we have always done things a certain way is not in itself a justification for continuing in that way. In ratifying the CRPD, the UK signed up to a paradigm shift, and implementing that shift does not occur without the challenge to fundamental assumptions about how we have acted in the past. Third, particularly if we wish to move beyond on in a different direction to the interpretations of the CRPD that we have received from the High Commissioner and the developing interpretations of the Committee on the Rights of Persons with Disabilities, we will need to be clear why, based on the wording of the Convention, our readings are justified. Proper

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<sup>80</sup> United Kingdom, Office for Disability Issues, UK Initial Report on the UN Convention on the Rights of Persons with Disabilities (London: ODI, 2011).

<sup>81</sup> See amendments to Homicide Act 1957, s 2, introduced by the Coroners and Justice Act 2009. Regarding the justifications for these changes, see United Kingdom, Law Commission, Partial Defences to Murder, LC 290 (London: Law Commission, 2004).

<sup>82</sup> United Kingdom, Law Commission, Unfitness to Plead, Consultation Paper No. 197 (London: Law Commission, 2010).

<sup>83</sup> UN Doc SG/SM/10797 (13 December 2006).

and detailed theoretical analysis matters. Good evidence will also be vital to the way forward, and that evidence at the moment is often minimal, and often ignored.

The implementation of the CRPD raises legitimately difficult questions, and they will not be solved easily or quickly. It is however clear that UK law does not comply with the current interpretations of the CRPD in key respects, and the government's unconvincing avoidance of those issues is disappointing and unhelpful. The UK has a strong and impressive history at the forefront of mental health law; it is well-placed to lead on these issues.