

Paradigm shifts or mirages?

The [Concluding Observations](#) of the Committee on the Rights of Persons with Disabilities on the compliance of United Kingdom with the CRPD makes a very substantial number of hard-hitting, difficult to read (or refute) observations and recommendations about the ways in which the United Kingdom is letting down the rights of the disabled.

The report can also, usefully, be read with the newly-adopted General Comment on Article 19: the right to independent living, with its host of detailed observations as to how states can and should take steps to ensure that individuals with disabilities are given a genuine choice as to how and where they wish to live their lives (at time of writing the General Comment has yet to appear in its final form on the Committee's website, but will do [here](#)).

There is a huge amount in the Concluding Observations with which it is impossible to take issue. However, in the areas where the Committee – unsurprisingly – took on our mental health and mental capacity regimes the recommendations are, respectfully much more problematic.

In material part, the Committee observed:

Equal recognition before the law (art. 12)

30. The Committee is concerned about:

- a. The legislation restricting legal capacity of persons with disabilities on the basis of actual or perceived impairment;***
- b. The prevalence of substituted decision-making in legislation and practice, and the lack of full recognition of the right to individualized supported decision-making that fully respects the autonomy, will and preferences of persons with disabilities;***
- c. The insufficient support to all asylum seekers and refugees with psychosocial and/or intellectual disabilities, in exercising their legal capacity; and***
- d. The high number of black people with disabilities compulsorily detained and treated against their will.***

31. The Committee recommends that the State party, in close consultation with organisations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee's general comment no. 1 (2014), abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in line with the Convention to initiate new policies in both mental capacity and mental health laws. It further urges the State party to step up efforts to foster research, data and good practices

of, and speed up the development of supported decision-making regimes. It further recommends that the State party ensure that asylum seekers and refugees with disabilities can exercise all rights enshrined in the Convention.

[...]

Liberty and security of the person (art. 14)

34. The Committee is concerned that the State party legislation provides for involuntary, compulsory treatment and detention both inside and outside hospitals on the basis of actual or perceived impairment.

35. The Committee recommends that the State party:

- a. Repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment; and*
- b. Take appropriate measures to investigate and eliminate all forms of abuse of persons with disabilities in institutional facilities.*

[...]

Protecting the integrity of the person (art. 17)

40. The Committee is concerned that persons with disabilities, including women, intersex people, girls and boys with disabilities, are reported to continue to be subjected to involuntary medical treatment, including occurrences of forced sterilization, and conversion surgeries.

41. The Committee recommends that the State party repeal all types of legislation, regulations and practices allowing any form of forced intervention and surgeries, and ensure that the right to free, prior and informed consent to treatment is upheld and that supported decision-making mechanisms, and strengthened safeguards are provided, paying particular attention to women, intersex people, girls and boys. (emphasis in original)

None of what the Committee says here comes as a surprise to those who have been following developments in this area.

Nor will it come a surprise to know that that there is – as far as anyone can tell – no realistic prospect that either the MCA or the MHA will be ripped up, even if both may well be amended (and possibly substantially) in the years to come. So to some extent all of what follows is academic. However, it means we will be in the position where one of the original driving forces at the UN remains resolutely out of kilter with what is said to be a core set of

obligations. That does matter - at least to lawyers like me for whom (international) human rights matter.

Let me start with a number of essentially procedural regrets, namely that the Committee declined to engage with a number of core issues in this field that arise in the specific context of the United Kingdom, including:

1. The different legislative regimes in the various parts of the United Kingdom (for instance, the very different regime shortly to come into force in Northern Ireland – presumably failing to meet the tests set by the Committee);
2. The proposals advanced by the Law Commission to strengthen s.4 MCA 2005 and also to introduce regulation-making powers to enable supported decision-making schemes to be brought in;
3. The very expansive interpretation given to deprivation of liberty for our domestic purposes *Cheshire West*. Put another way: does the Committee consider that MIG is deprived of her liberty with her 'mummy' in her adult foster placement? If so, on what basis could this be justified on its interpretation of Article 14? If not, then how does the Committee's interpretation of Article 14 CRPD differ from that given to Article 5 ECHR by the Supreme Court?
4. Evidence from those with (in Convention terminology) psychosocial disabilities that does not reject compulsory treatment in hospital out of hand. I note, here, in particular, the recent [report](#) of the Mental Health Alliance: *A Mental Health Act fit for tomorrow*, and would not presume to put any form of editorial spin upon the voices and views outlined therein.

That the Committee did not, in essence, do more than recite what is now a conventional 'mantra' in relation to Articles 12, 14 and 17 might – uncharitably – be said to show a concerning lack of interest in considering evidence before it as to the present, and potential future, regimes in place in the United Kingdom.

The explanation for this may well be that, politically, there is no desire to engage with the current legislative frameworks because that would be to give them credibility at a point when we should not be seeking to shore them up, but rather to rip them up and start again.^[1]

In the circumstances, however, it seems to me to be a distinct misstep (at a minimum) to fail to descend to the detail of (1) precisely what is wrong with the law and practice in the UK; (2) precisely how to achieve the goals set by the Committee; and (3) how and why these goals are, in fact, derived from the obligations imposed by the Convention.

^[1] See in this vein also the recent [statement](#) by the Human Rights Commissioner of the Council of Europe on the failure of member states of the Council to 'internalise' the new paradigm.

Put another way, it is clear that the truths the Committee suggests are to be found in Articles 12, 14 and 17 are ones that do not appear to be self-evident, not only to Governments with arguably vested interests, but to courts concerned with fundamental rights (see, most recently, the decision in [AM-V v Finland](#)).

The failure to descend to the details, further, makes it all too easy to reject the Committee's assertions as internally inconsistent. Some of these internal inconsistencies have already identified in other reports (see, for instance, the [work](#) of the Essex Autonomy Project). One particular issue here is that the Committee's interpretation of the obligations imposed by Article 12(4) is focused solely upon respecting the will and preferences of the individual concerned, whereas the actual obligations imposed by Article 12(4) are to ensure that measures relating to legal capacity respect the rights, will and preferences of the individual. Those rights can include – for instance – the right to be protected (under Article 16 CRPD) against exploitation, violence and abuse. Steps taken to secure the right under Article 16 may, on their face, infringe the individual's will and preferences. Moreover, Article 12(4) requires that safeguards be "*proportional to the degree to which such measures affect the person's rights and interests*" (emphasis added). So protection of the rights of persons with disabilities on its face requires that their interests (not just their will and preferences) be taken into account. In reality, therefore (and hardly surprisingly), the obligations imposed by the CRPD on the State in respect of individuals with disabilities in this area do not all point in one direction. From a whole range of different sources, I detect an increasing groundswell of real concern at the attempt by the Committee to impose a unity of obligation here which simply does not match the experiences of those seeking conscientiously to bring the Convention to life in practice.

I note here another internal inconsistency arising from the concluding observations. In a point that was not presaged in the list of issues, the Committee had this to say in relation to the right to life guaranteed by Article 10 of the CRPD:

26. The Committee observes with concern the substituted decision-making in matters of termination or withdrawal of life-sustaining treatment and care that is inconsistent with the right to life of persons with disabilities as equal and contributing members of society.

27. The Committee recalls that the right to life is absolute from which no derogations are permitted and recommends that the State party adopt a plan of action aimed at eliminating perceptions towards persons with disabilities as not having "a good and decent life", but rather recognising persons with disabilities as equal persons and part of the diversity of humankind, and ensure access to life-sustaining treatment and/or care. (emphasis in original)

It is not obvious precisely what the Committee were referring to by "substituted decision-making" here. If they were referring to situations in which (for instance) DNACPR notices have been placed in the records of individuals with disabilities (egregious examples including those with Down's Syndrome) without consultation and on the basis of pre-conceptions by

medical and other professionals, I could not agree more that such is wrong. But the courts have already made clear that such is wrong – see, for instance, the decision in [Winspear](#), and on a proper analysis these do not represent substituted decisions but impositions.

On its face, though, the Committee's observations would seem to go further to encompass, for example, the case of [Mr Briggs](#), and then into in a very difficult place indeed.

Mr Briggs self-evidently could not give "free, prior and informed consent" to the invasive treatment (CANH) that he was receiving. On the basis of the Committee's interpretation of Article 17, he should not have been provided with this treatment. But on the basis of the Committee's interpretation of Article 10 he had to be given this treatment – and should have been indefinitely ("the right to life is absolute from which no derogations are permitted") – notwithstanding the fact that those who loved him most were clear that this was the last thing that he would have wanted.

Assuming that the Committee is not advocating for this frankly terrifying situation, it is arguable that the only coherent way through is to recognise the reality of the situation. Mr Briggs was not functionally capable of making the decision whether to continue to receive CANH. His legal capacity – his agency – had to be exercised by another. It was, in this instance, exercised by the Court of Protection on his behalf, through a decision-making process that sought to construct a decision on his behalf which took as its starting point his identified wishes and feelings (his 'will and preferences'). The MCA 2005 and the mechanisms it contains therefore did not deny him legal capacity but responded to his lack of mental capacity to support his legal capacity.

The blanket statements by the Committee, however, seem to rule this approach out. This leaves those who are sympathetic to the goals of the CRPD without any very sensible way forward to draft laws which are not intellectually dishonest ('100% supported decision-making') or take health and social care professionals and lawyers into zones which appear to them not just problematic but actively unethical, without any countervailing and convincing ethical justification. The seemingly incredible (in the true sense of the word) claims made by the Committee in this regard, further, undermine the position of those who are seeking to uphold the real goals of the CRPD and gains that it promises.

In the circumstances, however, I am hopeful that with work that continues to be done to operationalise in a grainy and grounded fashion, not least through the Mental Health and Justice project, the real task of securing full recognition for those with cognitive impairments (from whatever source) as subjects, not objects, we can move forwards on solid ground, not pursuing what can appear to be potentially illusory – if not actively dangerous – mirages.

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(A version of this article appeared in the [39 Essex Chambers Mental Capacity Report](#) for September 2017)

