Mental Capacity, Human Rights, and the UN's Convention on the Rights of Persons with Disabilities

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In 2018, Robert L. Trestman argued in these pages that treatment of mental illness is a human right.[1] Trestman presented a compelling argument, noting that those among us who see the consequences of untreated mental illness must continue to advocate for access to evidence-based, integrated care. This advocacy is especially needed for people who are not in a position to advocate for themselves and whose rights are threatened through either action or inaction on the part of governments or other parties. Certain people with severe mental illness fall into this category, especially within our correctional systems.

At the global level, the United Nations' (UN) Convention on the Rights of Persons with Disabilities (CRPD) is one of the most significant developments in this area over the past two decades.[2] The CRPD entered into force on May 3, 2008, and now has 164 signatories, although fewer states have ratified it (i.e., consented to be bound by it). The United States signed the CRPD on July 30, 2009, but has not ratified it.

The CRPD outlines extensive rights, as noted in Table 1. The purpose of the CPRD "is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments wh2ich in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Ref. 2, Article 1).

The "general principles" of the CRPD are "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; nondiscrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women [and] respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities" (Ref. 2, Article 3).

Equal Recognition Before the Law

While many aspects of the CRPD have generated significant discussion, Article 12 ("equal recognition before the law") arguably holds greatest relevance to the topic of mental capacity. Among other provisions, Article 12 requires states to "reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law"; "recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects

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Table 1. Key Areas Covered by the United Nations' Convention on the Rights of Persons With Disabilities

Article Number	Areas for Which Specific Rights Are Outlined
5	Equality and nondiscrimination
6	Women with disabilities
7	Children with disabilities
8	Awareness-raising
9	Accessibility
10	Right to life
11	Situations of risk and humanitarian emergencies
12	Equal recognition before the law
13	Access to justice
14	Liberty and security of person
15	Freedom from torture or cruel, inhuman, or degrading treatment or punishment
16	Freedom from exploitation, violence, and abuse
17	Protecting the integrity of the person
18	Liberty of movement and nationality
19	Living independently and being included in the community
20	Personal mobility
21	Freedom of expression and opinion, and access to information
22	Respect for privacy
23	Respect for home and the family
24	Education
25	Health
26	Habilitation and rehabilitation
27	Work and employment
28	Adequate standard of living and social protection
29	Participation in political and public life
30	Participation in cultural life, recreation, leisure, and sport

of life"; and "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity" (Ref. 2, Article 3).

In 2014, the UN Committee on the Rights of Persons with Disabilities, which monitors implementation of the CRPD, published a "General Comment" on Article 12.[3] In the course of its remarks, the Committee appears to call for the abolition of the concept of mental capacity and the elimination of substitute decision-making, involuntary mental health care, and the insanity defense.

In relation to mental capacity, the Committee draws an important distinction between legal capacity and mental capacity:

> Legal capacity and mental capacity are distinct concepts. Legal capacity is the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency). It is the key to accessing meaningful participation in society. Mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including environmental and social factors (Ref. 3, Paragraph 13).

The Committee expresses the view that "mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity" (Ref. 3, Paragraph 14). The Committee recommends that "the provision of support to exercise legal capacity should not hinge on mental capacity assessments; new, nondiscriminatory indicators of support needs are required in the provision of support to exercise legal capacity" (Ref. 3, Paragraph 29(i)).

Turning to "substitute decision-making," the Committee states that "support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making" (Ref. 3, Paragraph 17). As a result, states' "obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives" (Ref. 3, Paragraph 28).

The Committee also dismisses the concept of involuntary mental health care:

> States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment (Ref. 3, Paragraph 42).

Finally, the Committee questions the notion of an insanity defense:

> States have the ability to restrict the legal capacity of a person based on certain circumstances, such as bankruptcy or criminal conviction. However, the right to equal recognition before the law and freedom from discrimination requires that when the State denies legal capacity, it must be on the same basis for all persons. Denial of legal capacity must not be based on a personal trait such as gender, race, or disability, or have the purpose or effect of treating the person differently (Ref. 3, Paragraph 32).

A Path Forward

The UN Committee's interpretation of the CRPD presents real challenges to many aspects of

accepted forensic practice in North America and elsewhere. It is highly critical of the way that most forensic psychiatrists and others view their work in diagnosing and treating mental illness, sometimes using legislation or court orders to treat people without their consent, and presenting expert testimony in court, often linked with mental capacity or the insanity defense. All of these concepts are called into question by the UN Committee's interpretation of the CRPD, creating challenges to reconciling these views with the experience of forensic psychiatrists.

When approaching these topics, it is important to bear in mind that, regardless of any particular group's interpretation of the CRPD, the convention itself is an important document that presents a once-in-a-generation opportunity to advance the rights of individuals with mental illness and protect their legal capacity. Moreover, the interpretation of Article 12 by the UN Committee has been strongly contested.

Freeman and colleagues argue that the Committee's interpretation might well increase stigma and discrimination and lead to violations of rights and increased harm to self or others.[4] They argue in favor of retaining the concept of decision-making capacity, once appropriate checks and balances are in place. They also write that there are times when informed consent is not possible owing to the condition of the person and must be superseded, especially when life is at risk. Proceeding without informed consent already occurs when, for example, a person is in a coma and cannot provide informed consent to treatment. With regard to deprivation of liberty on the grounds of mental illness, Freeman and colleagues note that a short-term deprivation of liberty in a psychiatric hospital might well prevent a longer deprivation in prison, and that when someone commits a crime as a result of serious mental illness, committal to prison is unlikely to be to their benefit. The authors add that they are not alone in their views, with, for example, Germany noting that the UN Committee's interpretation of the CRPD does not appear to be shared by the majority, or even a substantial minority, of states that are party to the convention.

Appelbaum presents a similarly careful, considered, and highly critical opinion.[5] He writes that the Committee's interpretation may well end up hurting the very people that the CRPD purports to help. In a similar vein, Dawson argues for a more realistic interpretation of the CRPD that would not forbid reliance on the concept of mental capacity, substitute decision-making, or involuntary treatment.[6] He notes the view that failing to take a person's disability into account may be discriminatory, especially in relation to the insanity defense.

Even within the UN, there is a diversity of views about how the CRPD is to be interpreted.[7] The UN Human Rights Committee, for example, accepts deprivation of liberty under specific circumstances:

> The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual (Ref. 8, Paragraph 19).

The UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment accepts treatment without consent under specific circumstances:

> Exceptionally, it may be necessary to medically treat a person deprived of liberty without her or his consent if the person concerned is not able to: (a) Understand the information given concerning the characteristics of the threat to her or his life or personal integrity, or its consequences; (b) Understand the information about the medical treatment proposed, including its purpose, its means, its direct effects and its possible side effects; (c) Communicate effectively with others (Ref. 9, Paragraph 14).

The Subcommittee adds that, "in such a situation, the withholding of medical treatment would constitute inappropriate practice and could amount to a form of cruel, inhuman or degrading treatment or punishment" (Ref. 9, Paragraph 15).

Against this background, several countries have moved forward with implementation of the CRPD, notwithstanding this diversity of interpretations. Ireland ratified the CRPD in 2018 but declared "its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards" (Ref. 10, Declaration: Articles 12 and 14). Ireland also declared "its understanding that the Convention permits supported and substitute

decision-making arrangements which provide for decisions to be made on behalf of a person, where such arrangements are necessary, in accordance with the law, and subject to appropriate and effective safeguards" (Ref. 10, Declaration and reservation: Article 12).

While these interpretations flatly contradict the position of the UN Committee, Ireland nonetheless ratified the CRPD on the basis of these understandings. Ireland's decision is one approach to implementing the CRPD; i.e., focusing on the CRPD itself rather than the Committee's interpretation, entering reservations for areas that appear unclear, and then getting on with the important work of implementing the provisions of the convention and better protecting the rights and legal capacity of individuals with mental illness. It is imperative that specific, contested interpretations of the convention do not delay this task.

Other countries have taken different approaches to advancing matters. India, for example, commenced its Mental Health Care Act 2017 on May 29, 2018.[11] This piece of legislation states in its preamble that it was crafted explicitly "to align and harmonise the existing laws" with the CRPD (Ref. 11, preamble), making it one of the most interesting developments in mental health law in several decades.[12]

The new Indian legislation introduces many important innovations including, most notably, a legally binding right to mental health care for all 1.3 billion people in India (one-sixth of the planet's population).[13] Consistent with a desire to align with the CRPD, the legislation refers to a patient's "capacity to make mental health care and treatment decisions" rather than "mental capacity" more broadly (Ref. 11, Section 4). The legislation also has a section devoted to "supported admission" (rather than involuntary admission), which emphasizes the provision of support to optimize patient autonomy (Ref. 11, Section 89(1)(c)). If, however, the "person with the mental illness admitted under this section requires nearly hundred per cent support from his nominated representative in making a decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf" (Ref. 11, Section 89(7)).

India's initiative represents the most ambitious effort to date to draft mental health legislation that meets the requirements of the CRPD and even goes beyond these requirements by articulating a right to mental health care. Implementation will be a challenge, but India's 2017 Act is still an excellent example of how the provisions of the CRPD can be used to move mental health legislation and practice in new and positive directions.[14]

In practice, forensic psychiatrists already promote human rights in their day-to-day work by providing high-quality, evidence-based forensic psychiatric care, giving specialist evidence in court, and participating in patient-centered service-development in correctional and health care settings.[15] The advent of the CRPD highlights the additional importance of social awareness, engagement, and activism to further promote rights. Legislative initiatives such as India's new mental health law point a way toward using the CRPD to further protect rights, including the much-neglected right to treatment.[1]

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