

# The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives

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Contemporary mental health laws are embedded in basic human rights principle, and their ongoing evolution is influenced by contemporary human rights discourse, international declarations and conventions, and the authoritative jurisprudence of the European Court of Human Rights (ECtHR). The *Convention on the Rights of Persons with Disabilities* (CRPD)<sup>2</sup> is the most recent expression of international human rights applicable to people with disability including people with mental illness.<sup>3</sup> It provides a fresh benchmark against which to assess the human rights compatibility of domestic mental health laws.

The CRPD emphasises social entitlement and a positive right to 'treatment' understood broadly as encompassing the social determinants of health. This is an innovative and powerful contribution. Historically, human rights law accepted that the obligations to respect the (negative) rights expressed in the *International Covenant on Civil and Political Rights*<sup>4</sup> were immediately realisable, whereas the obligations to respect the (positive) rights expressed in the *International Covenant on Economic, Social and Cultural Rights*<sup>5</sup> are subject to the principle of progressive realisation.<sup>6</sup> Underpinned by this distinction, arguments in support of a positive right to psychiatric treatment, have interpreted it either as derivative

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2. *Convention on the Rights of Persons with Disabilities*, opened for signature Dec. 13, 2006, 46 I.L.M. 443. [Entered into force 3 May 2008, ratified by the United Kingdom of Great Britain and Northern Ireland on 8th June 2009]

3. *Id.* art. 1.

4. *International Covenant on Civil and Political Rights*, opened for signature Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force 23 March 1976).

5. *International Covenant on Economic, Social and Cultural Rights*, opened for signature Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976).

6. Henry Steiner & Philip Alston, *International Human Rights in Context* 275 (2d ed. 2000).

of negative rights,<sup>7</sup> as arising from the principle of reciprocity,<sup>8</sup> or as an extension of the prohibition of torture and cruel, inhuman or degrading treatment.<sup>9</sup> Despite these cogent arguments, acceptance by the Courts of the artificial distinction between the two types of rights appears to have contributed to the reluctance to accept positive rights and entitlements as justiciable matters.<sup>10</sup>

This paper argues that the CRPD moves toward a conceptual fusion of social, economic and cultural rights with civil and political rights,<sup>11</sup> through its adoption of a social model of health. Accordingly, the CRPD sets out positive obligations on State parties to provide timely and appropriate treatment to people with mental illness, including the provision of adequate community and social services and a coherent system of integration between community and institutional facilities. The CRPD also supports a strict limitation on the provision of involuntary medical treatment, and reconciles these apparently competing objectives through an emphasis on autonomy, self determination and supported decision making. This interpretation of the CRPD, set out below, is based on an analysis of the thematic interconnections between the CRPD framework, the right to equal recognition before the law in Article 5 and Article 12, right to enjoyment of the highest attainable standard of health in Article 25, and the right to respect for physical and mental integrity in Article 17. It reads the CRPD as embedding a 'new age' of mental health law in the social model of health, and a recovery model of mental health.<sup>12</sup>

## The Convention Framework

The CRPD is the first convention to be drafted with the full participation of people with disabilities.<sup>13</sup> This brings a unique dimension to the text. It lends an interpretive weight that recognises the contribution of participating organisations, and the aspirations of the broader disability community.<sup>14</sup> The slogan accompanying implementation of the CRD is 'nothing about us, without us.'

The guiding framework for the CRPD is found in the general principles in Article 3. These are:

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- (b) Non-discrimination;
- (c) Full and effective participation and inclusion in society;
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

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7. Gerard Quinn, *Civil commitment and the right to treatment under the European Convention on Human Rights* 5 *Harv. Hum. Rts. J.* 1 (1992).

8. Geneva Richardson UK Department of Health, *Report of the Expert Committee, Review of the Mental Health Act 1983* (1999).

9. Peter Bartlett, *et al*, *infra* note 39

10. Amita Dhanda, *The Right to Treatment of Persons with Psychosocial Disabilities and the Role of the Courts*, 28 *Int'l J. L. & Psychiatry* 155, 157 (2005).

11. Penelope Weller, *Human Rights and Social Justice: the Convention on the Rights of Persons with Disabilities and*

*the quiet revolution in international law*, 4 (2) *Pub Space* 17,18 (2009)

12. Anna Lawson, *The United Nations Convention on the Rights of Persons with Disabilities: New Age or False Dawn?* 34(2) *Syracuse J. Int'l L. & Com.* 563, 563 (2007).

13. Don MacKay, *The United Nations Convention on the Rights of Persons with Disabilities* 34(2) *Syracuse J. Int'l L. & Com.* 323, 324 (2007).

14. Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34(2) *Syracuse J. Int'l L. & Com.* 429, 430 (2007).

- (e) Equality of opportunity;
- (f) Accessibility;
- (g) Equality between men and women;
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Importantly, the first principle is respect for inherent dignity and individual autonomy including the freedom to make one's own choices. This statement poses a close link between inherent human dignity, which is a foundation human rights principle, and the freedom to make one's own choice. It is followed by the principle of non-discrimination. Together these principles emphasise the abilities of people who experience disability, their capacity for individual autonomy, and the burden which is imposed upon them by discriminatory environments and the attitudes of people around them.<sup>15</sup> In relation to mental health, discrimination may manifest, among other things, as misplaced determinations of incapacity, or an assumption that decisions should be overridden on paternalistic 'best interests' grounds. It may be expressed as an arbitrary categorization of people with mental illness as appropriately subject to compulsory treatment, or as intrinsically dangerous. It may be evident in the structure and organisation of mental health systems, the content of mental health law, and in the under-resourcing of facilities and institutions. It may manifest as unwarranted intervention or as neglect.

In recognising the salience of discrimination for people with disability, the CRPD addresses the interaction between the person and their environment, emphasising the obligations upon State parties to modify the hostile environments in which people with disability may find themselves. It exhorts State parties to support the abilities of people with disabilities, and to counter embedded discriminatory attitudes and practices by raising community awareness, developing strategies for social inclusion and creating human rights compliant health and legal systems.

When the different treatment of people with disability is the result of discrimination, human rights law recognises an immediate obligation to reinstate equality, whether or not the rights in question are characterised as negative or positive rights.<sup>16</sup> The embedded nature of discrimination against people with mental illness requires a careful examination of many taken-for-granted practices. With this requirement in mind, the following sections discuss supported decision making, the nature of the obligation to provide appropriate health services and the overarching obligation to respect the physical and mental integrity of the person.

### Supported decision making

The CRPD conceptualises people with disabilities as equal subjects of law who are entitled to benefit from modifications in practices and systems that have traditionally excluded them. In setting out the obligation to promote equality before the law, the CRPD addresses the substance of decision making processes.

Article 5 sets out a legal framework for people to be 'equal before and under the law' and to be entitled 'to the equal protection and equal benefit of the law'. Article 5(1) requires that all persons be recognised

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15. Gerard Quinn & Therese Degener, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (United Nations Publications, 2002).

16. Paul Hunt, *The Health and Human Rights Movement: Progress and Obstacles*, 15 J.L. & MED. 714 (2008).

before the law. Article 5(2) requires the effective provision of legal protection against discrimination. Article 5(3) requires that appropriate steps be taken to ensure 'reasonable accommodation' as defined in Article 2, and Article 5(4) requires that specific measures to achieve or accelerate equality are not regarded as discriminatory. These requirements underpin the obligations in Article 12 to enable people with disability to participate in legal processes.

Article 12(1) affirms that 'persons with disabilities have the right to recognition everywhere as persons before the law' and Article 12(2) requires that people with disabilities 'enjoy legal capacity on an equal basis with others in all aspects of life'. People with disabilities, including people with mental illness, complain that they are not infrequently denied legal capacity on erroneous or spurious grounds, either because a disability is automatically equated with incompetence and incapacity, or because there is failure to accommodate the disability in a way that would enable the person to exercise their legal capacity. Thus, Article 12(3) requires State parties to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Article 12(3) recognises that decision making is a process of communication and that decision making ability is a variable human attribute. The vast majority of persons, whether or not they have a disability, are more or less able to reason and understand the content and consequences of a course of action depending on how much information they receive, in what form the information is received, in what context the information is received, how much time is provided to process the information, and how much opportunity there is to discuss or test the information with trusted persons. This is especially so in relation to health information. In mental health, the complexity of communication processes may be burdened by the effects or side effects of medication and other treatments, and the cyclic or unstable nature of the condition. A range of strategies, some of them already familiar in developed mental health systems, could easily facilitate a supported decision making approach if their practice was informed by and oriented toward the achievement of supported decision making. A culture of supported decision-making could be enhanced by:

- the education of mental health professionals around the concept of informed consent and their obligations in law
- the education of mental health professionals around the processes of reasoning
- the appointment and involvement of advocates in decision making
- the involvement of support persons
- the development of case managers as facilitators
- the effective use of treatment plans
- the effective use of psychiatric advance directives, or
- substituted decision making arrangements where the substituted decision maker is clearly bound by the wishes of the patient.

Given the complexity and ongoing nature of the decision-making process, and the importance of understanding the particular problems faced by a person who seeks support in decision making, the involvement of a person who is nominated by and is acceptable to the person with a mental illness is often seen as the most practical and effective way of ensuring that the outcome of a supported decision making process is acceptable to the person with mental illness.

The extension of personal support arrangements for people with impaired decision making ability,

however, raises some difficulties in practice. The law of informed consent, which provides the legal basis for the provision of voluntary medical treatment, requires that the person is competent, informed and is voluntarily giving their consent.<sup>17</sup> When a person is dependent upon others for assistance with decision making, the assumption that they are rational, independent and freely choosing people, as required by the law, is easily displaced. While clinicians must remain alert to the problem of undue influence in any clinical situation, they must also be confident that the support person understands their facilitative role, and is not compromised by competing interests or motivations. Similarly, the person with a disability must understand the support role and process. Development of a culture of supported decision making in mental health is likely to require the implementation of a range of strategies including the development of training programs and practice guidelines to ensure that people with disabilities, clinicians, and support people fulfil their respective roles in a supported, communicative process.

The nature and extent of the support that may be necessary will vary from person to person, and may sometimes require high levels of support. The operation of the principle of 'reasonable accommodation', although yet to be tested, may work to limit the level of support that could reasonably be expected to be provided to persons with disabilities. Whether or not 'reasonable accommodation' has been provided is also relevant to a determination of whether the conduct in question was discriminatory. Ultimately, the expected standard will depend on the standard of medical care that is generally available. In developed western health systems it is not unusual for very high levels of communicative support to be provided to people with, for example, gross communication deficits. The principle of non-discrimination requires that persons with mental illness should be provided with similarly high levels of support.

In CRPD terms, the goal of supported decision making in health decisions is to achieve full and informed consent. People with mental illness complain that the willingness to attribute capacity to them evaporates when they seek to refuse medical treatment, or express a preference for an alternative medical treatment, often on the basis that they 'lack insight' into their illness and the benefits of treatment. McSherry refers to the uneven determinations of capacity as a 'Catch 22'.<sup>18</sup> The circularity of reasoning associated with capacity determinations in mental health is encouraged in jurisdictions where mental health laws rest treatment decisions with the discretion of the clinician.<sup>19</sup> In these jurisdictions, unless the clinician accepts the legitimacy of a person's refusal of treatment, the person's legitimate exercise of legal capacity may be overridden. As is demonstrated in health research,<sup>20</sup> a person's treatment preferences are more likely to be respected when there is optimal communication between the person and the clinician. In CPRD terms, legal frameworks that unduly limit the legitimate exercise of capacity are unacceptable.

The CRPD acknowledges that people who are unable to achieve capacity, even with the provision of support, may benefit from substituted decision making arrangements that are closely tailored to the needs

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17. *Loane Skene, Law and Medical Practice Rights, Duties, Claims and Defences* ch. 3 (2d ed. 2004). See discussion in *Gillick v. West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (HOL); *Secretary, Department of Health and Community Services v. JMB and SMB* ['Marion's case'] (1992) 175 C.L.R. 218 (Aus.); *Glass v. United Kingdom*, (2004) 39 E.H.R.R. 15.

18. Bernadette McSherry, *Monash University, Opening Minds not Locking Doors, Address at the 50th Anniversary Public Lecture, Education 08, (Oct. 9, 2008)* (transcript available at

<http://www.law.monash.edu.au/rmhl/50-anniversary.html>).

19. For e.g., *Mental Health Act, 1983 (England and Wales) as amended by the Mental Health Act, 2007 (England and Wales)*, provides, *inter alia*, that a person with mental disorder (s.1) may be detained and treated in the interests of their health or safety or to protect other persons (s.2/s.3). In certain circumstances a second opinion must be obtained if the person lacks capacity or refuses certain treatment (s.58; s.58A) (s.58).

20. *David Silverman, Communication and Medical Practice: Social Relations in the Clinic* (1987).

of the person. Article 12(4) requires that any ‘measures that relate to the exercise of legal capacity’

- respect the rights, will and preferences of the person,
- be free of conflict of interest and undue influence,
- be proportional and tailored to the person’s circumstances,
- apply for the shortest time possible, and
- be subject to regular review by a competent, independent and impartial authority or judicial body.

Article 12 exhorts State parties to accommodate an individual’s requirement for assistance. When a person is unable to make decisions for themselves, including medical decisions, Article 12(4) sets out a finely articulated process that balances the need to intervene with a range of safeguards that are guided by respect for the rights, will and preferences of the person, are proportionate to the degree to which such measures affect the person’s rights and interests, and are sensitive to the deeply embedded discriminatory attitudes that can colour determination for capacity. Article 25 applies similar principles to express the obligation upon State parties to attend to systemic deficits.

Articles 5 and 12 indicate that decision making processes must always attend to the particular abilities and requirements of the person at the centre of the process. In relation to mental health, this suggests, in the absence of an examination of the substance of the decision making process, that the traditional legal safeguards of second medical opinion, review or appeal are useful, are useful but insufficient strategies to ensure CRPD compliance.

### **The obligation to provide appropriate health services**

In respect of the right to enjoyment of the highest attainable standard of health, Article 25 requires State parties to ensure that health professionals give substance to the human rights of people with disabilities, including people with mental illness, by providing high quality health care, without discrimination, on the basis of free and informed consent and according to the principles of accessibility and acceptability. It requires that the health services that are provided are accessible, gender sensitive and of the ‘same range, quality and standard’ as those that are provided to other persons.<sup>21</sup> Services must address both general and disability specific health needs of people with disability and include the provision of sexual and reproductive health and population-based public health programmes. Services are to be provided ‘as close as possible to people’s own communities’.<sup>22</sup> State parties are also required to assist and support health professionals to provide services of the same quality as are provided to other persons on the basis of free and informed consent.<sup>23</sup> They are required to raise the awareness amongst health professionals about human rights issues and to support the development and promulgation of ethical standards in both public and private health care. The non-discriminatory obligation extends to the provision of health and life insurance and prevents the denial of services, food or fluids on a discriminatory basis.<sup>24</sup>

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21. *Convention on the Rights of Persons with Disabilities, supra note 2, art. 25(a).*

22. *Id. art.25(c).*

23. *Id. art.25(d).*

24. *Id. art. 25(e) & (f).*

Article 25 must be read in light of General Comment 14 which is an authoritative statement on the scope of the right to health published by the United Nations Committee on Social, Economic and Cultural Rights.<sup>25</sup> The right to the highest attainable standard of health is governed by the principles of availability and accessibility. Availability refers to quantity, distribution and functioning of public health and care facilities, goods and services,<sup>26</sup> whereas accessibility refers to physical accessibility in terms of location, safety and disability access, and economic accessibility in terms of cost and access to equitable funding and insurance structures. Health care information must also be accessible and available, and supported by a right to seek, receive and impart information and ideas concerning health information. Health services must be available on a non-discriminatory basis to all members of the community including the most vulnerable and marginalised,<sup>27</sup> in a culturally appropriate manner which is mindful of gender and life cycle issues<sup>28</sup> and utilises appropriate scientific and medical technology. The principles of availability and accessibility are particularly important in mental health where access to both mental health and general health information can be limited by a range of individual or systemic issues. The right to enjoyment of the highest attainable standard of health and mental health requires the provision of medical care which is available, accessible, acceptable and of good quality. People with mental illness are equally entitled to exercise control over their own bodies and equally entitled to health protection and health care.

Importantly for mental health, Article 25(b) requires the provision of

*those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.*

In developed western jurisdictions the chronic under-resourcing of mental health systems following global de-institutionalisation in the context of neoliberal economic policies<sup>29</sup> has compounded the inadequate provision of appropriate community services,<sup>30</sup> placed stress on acute services resulting in inappropriate discharge practices and limited access to appropriate general health care.<sup>31</sup> The overall reduction in services breaches the entitlement to health protection and health care,<sup>32</sup> increases reliance on coercive interventions, engenders fear in potential users and entrenches discriminatory community attitudes toward people with mental illness.

Article 25, in contrast, looks to the provision of timely, appropriate services that are provided on the basis of free and informed consent, or appropriately fashioned substituted decision making arrangements, where respect for the integrity of the person is an integral part of the service delivery culture.<sup>33</sup>

25. General Comment No 14: *The Right to the Highest Attainable Standard of Health*, U.N. Comm. on Econ., Soc. & Cult. Rights, 22nd Sess., U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

26. *Id.* para 12(a).

27. *Id.* para 12(b).

28. *Id.* para 12(c).

29. Terry Carney, *The mental health service crisis of neoliberalism – An antipodean perspective* 31(2) *Int'l J. L. & Psychiatry* 101 (2008).

30. Sev. A. Ozdowski, *Time for Governments to Act on Mental Health Care*, 14 *Health Soc. Rev.* 203 (2005).

31. Special Rapporteur for Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005).

32. Amita Dhanda, *The Right to Treatment of Persons with Psychosocial Disabilities and the Role of the Courts*, 28 *Int'l J. L. & Psychiatry* 155, 157 (2005).

33. Amita Dhanda, *The Convention on the Rights of Persons with Disabilities, Conference Workshop Presentation at Australian & New Zealand Association of Psychiatry, Psychology and Law 28th Annual Congress* (Oct. 2008).

## Protecting the integrity of the person (Article 17)

The principle of non-discrimination animates Article 17 which protects the ‘right to respect for his or her physical and mental integrity on an equal basis with others’. Its truncated text is the product of a ‘negotiated silence’ during the drafting of the CRPD which was aimed at reinforcing an implied prohibition against involuntary treatment in the CRPD.<sup>34</sup> Article 17 draws attention to a range of taken-for-granted practices in psychiatric care that compromise the physical and mental integrity of the person. The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment identifies these as:<sup>35</sup>

- Poor conditions of detention;
- The use of restraints, including the use of medication as a form of chemical restraint;
- Drugs administered as punishment or restraint;
- The use of seclusion and isolation;
- Experimentation or experimental treatment without consent;
- Forced treatments that are intended to correct and alleviate particular impairments;
- Intrusive or irreversible treatment, such as lobotomy and psychosurgery;
- Forced abortion or sterilisation without free informed consent;
- Modified electroconvulsive therapy without free and informed consent. (Informed consent must include information about ‘the secondary effects and related risks such as heart complications, confusion, loss of memory and even death’);
- Forced psychiatric interventions that amount to political or social repression;
- Forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental conditions especially in the presence of extreme and debilitating side effects;<sup>36</sup>
- Involuntary commitment to psychiatric institutions on an arbitrary basis. Involuntary detention may be arbitrary where the criteria for involuntary admission includes only the diagnosis of mental disability coupled with additional arbitrary criteria such as being a ‘danger to oneself and others’ or in ‘need of treatment’; and
- Violence, including sexual violence.<sup>37</sup>

Although developed western nations may regard their mental health systems as free from the worst instances of abuse, some of the practices listed above remain common. At the very least, Article 17 works to confine these practices.<sup>38</sup>

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34. *Id.* See also Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34(2) *Syracuse J. Int'l L. & Com.* 429,432 (2007).

35. *Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [Special Rapporteur on Torture], Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or*

*Degrading Treatment or Punishment*, U.N. Doc. A/63/175 (July 28, 2008), para 45.

36. *cf Grare v. France*, (1993) 15 E.H.R.R.C.D. 100.

37. *Special Rapporteur on Torture*, *supra* note 35, paras 52-69.

38. Bernadette McSherry, *Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment*, 26(2) *L. In Context* 1 (2008).

It can be argued that Article 17 may encompass a positive right to have treatment choices respected. As discussed above, the circular reasoning associated with determinations of capacity may render a person with mental illness vulnerable to an assessment of incapacity on the basis that they fail to appreciate the benefits of treatment. While there may be legitimate reasons to refuse all recommended medical treatment, refusal is usually associated with preference for one form of treatment over another.<sup>39</sup> In these situations, the right to respect for the physical and mental integrity of the person, considered in light of the importance of autonomy and non-discrimination in the CRPD framework, requires that the person's views be given proper consideration. Where these are relevant and adequately expressed, they should displace the objectively determined 'best interests' standard. Giving scope to Article 17 allows credence to be given to the subjectively determined choices of the person who is subject to treatment. This reasoning may have surprising results. For example, a person who has cogently expressed a preference to remain free from medication, even if the choice will invoke the imposition of a restriction of physical liberty on public safety grounds, would be entitled to do so. Conversely, a person who has not or is unable to express a treatment preference is entitled to the best possible care, including active intervention, provided the intervention is appropriately limited by respect for the physical and mental integrity of the person.

## Conclusion

Mental health laws in England and Wales have responded specifically to the determinations of the European Court of Human Rights.<sup>40</sup> The legislature is now bound to do so following the adoption of the *Human Rights Act 1998* which incorporates the European Convention on Human Rights into the law of the United Kingdom. The United Kingdom is also a party to the major international conventions including the CRPD.<sup>41</sup> International human rights obligations are embedded in the common law as an integral part of the legal system in common law jurisdictions. International covenants also influence the interpretation of European Convention of Human Rights and the development of the 'living tree' of human rights law.<sup>42</sup>

As outlined above, the CRPD expresses a positive right to service provision and appropriate treatment. A positive right to treatment, does not equate with an obligation to accept treatment, nor an obligation to impose treatment. Rather, the right to respect for physical and mental integrity in the CRPD aligns the elements of the decision making process in mental health care in a way that incorporates subjective determinations of wellbeing into the decision making process. This shift in the decision making process does not entirely resolve the question of involuntary treatment. Instead, it recognises the different needs of people who seek mental health care, allowing maximum recognition of individual decisions at the same time as it enhances the obligation to provide appropriate, but limited, treatment to those people who are (temporarily) unable to consent to treatment. Ultimately, the balance between the obligation to support and the obligation to intervene in a social model of health is dictated by the ongoing process of recovery.

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39. Peter Bartlett, *Oliver Lewis & Oliver Thorold, Mental Disability and the European Convention on Human Rights 29* (Martinus Nijhoff Publishers) (2007).

40. For example, see *X v United Kingdom*, Application No 7215/75, judgement, 5 November 1981; (1981) 4

E.H.R. 188; *H.L. v the United Kingdom*, Application No 45508/99. Judgment 5 October 2004, (2005) 40 E.H.R.R 32.

41. See above note 2.

42. Bartlett et al, above note 39, p17.

Mental health legislation in England and Wales has recently witnessed the introduction of compulsory measures in the community in the form of community treatment orders (CTOs).<sup>43</sup> The Mental Health Alliance (UK) reported that in the first 12 months of operation 4,000 CTOs had been issued under the new provisions<sup>44</sup> While CTOs may ensure access to community treatment, they do not guarantee access to appropriate community services. It seems unlikely that they will enhance the development of self directed pathways to recovery. While a closer examination of the operation of CTOs is clearly required, the reliance on coercive interventions engendered by the new provisions appears to offend the CRPD principles of equal recognition before the law, the provision of appropriate services and respect for the physical and mental integrity of the person, outlined above.

Mental health laws are more than symbolic. As Clive Unsworth noted more than two decades ago,

*'[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions.'*<sup>45</sup>

The current experience in England and Wales suggests that this is so. Laws that remain inured to emerging human rights principles, stymie the development of innovative practice in the care and treatment of people with mental illness. The challenge ahead is to read the CRPD as a model for a new generation of mental health laws.

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43. ss.17A-G and Part 4A Mental Health Act 1983 (as amended by the Mental Health Act 2007).

44. Detentions in hospital have increased from 28,100 in 2007/08 to 28,700 in 2008/09, Mental HealthAlliance (UK), 3rd Nov 2009. <http://www.mentalhealthalliance.org.uk/news/practanniversary.html>, accessed 22/3/2010.

45. Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) p 5.