

International Journal of Mental Health and Capacity Law

Letters to the Editor

Rejoinder and Response on 'Decision-Making Capacity and the Victorian Mental Health Tribunal'

Articles and Comment

The 'Tricky Dance' of Advocacy: A Study of non-legal Mental Health Advocacy

The Right to Independent Living and Being Included in the Community:
Lessons from the United Nations

Psychosocial Disability and Deprivation of Liberty:
the Case of Qatar in light of the Convention on the Rights of Persons with Disabilities



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and Alex Ruck Keene

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Hal (Zhan) Brinton

Editorial

There is an Antipodean theme to this, the fifth issue of the Journal in its new guise. As editors, we were delighted that a paper published in the fourth issue provoked a reaction from the President of the Tribunal whose work was under scrutiny. Christopher Maylea and Christopher James Ryan's article 'Decision-Making Capacity and the Victorian Mental Health Tribunal' ([2017] *International Journal of Mental Health and Capacity Law* 87) had proposed an interpretation of how the *Mental Health Act 2014* in Victoria, Australia, should work, before turning to two empirical studies which analysed the decisions of the Statements of Reasons of the Victoria Mental Health Tribunal to gain some appreciation of how the Act was working. Maylea and Ryan argued that the Tribunal had an obligation to consider the assessment of a compulsory patient's decision-making capacity when determining whether or not to make a compulsory Treatment Order, and that the Tribunal was falling into error by not meeting this positive obligation to take this matter into consideration.

The President of the Tribunal, Matthew Carroll, in a rejoinder published in this issue, suggests that this criticism was based on: a fundamental misinterpretation of relevant law, a misunderstanding of the processes of the Tribunal, and a lack of sufficient recognition of the distinctive features of the legislation that establishes the Tribunal and its processes. Carroll further suggests that Maylea and Ryan generated a misconception that by not focusing on their decision-making capacity, the perspectives of mental health consumers are not being considered as part of Tribunal hearings in Victoria.

So as not to leave readers in suspense, this issue also contains a response by Maylea and Ryan, to the effect, broadly, that the President's understanding of the way that the Tribunal should operate is understandable, but does not, in their view, reflect the best reading of the legislation. Many may wish to follow their suggestion of returning to the analysis presented in their original paper and review it in light of Carroll's criticism. Should the President wish to continue the debate, the pages of the Journal are firmly open, and the editors would be delighted to facilitate further debate on what is undeniably a very important, yet perhaps, penumbrous topic within the Tribunal jurisdiction.

Next is a stimulating article by Bennetts, Maylea, McKenna and Makregiorgos on the 'tricky dance' of advocacy, a study of non-legal mental health advocacy in Victoria, Australia. The article serves the useful purpose both of reviewing some of the underpinning drivers and models of advocacy in the context of the Convention on the Rights of Persons with Disabilities ('CRPD'), and describing the application of the model of non-legal representational advocacy within the Victorian context, drawing on in-depth qualitative interviews with advocates and other key stakeholders. The authors state that this is not an evaluation of this model or its impact, but rather a descriptive illustration of its intent and approach. This is exactly the sort of illustration which is required to flesh out what can otherwise become sterile exchanges of slogans.

We then have a review paper by Piers Gooding on recent United Nations activity concerning Article 19 CRPD. As Gooding highlights, Article 19 produces an unusual

consensus: "*commentators across the spectrum – from those who see a role for coercion and substituted decision-making, to those who think they should be eliminated – appear to agree on the need for more resources for people with intellectual, cognitive and psychosocial disabilities to exercise their right to live independently and participate in the community.*" In the personal experience of one of the editors (Ruck Keene) on the independent review of the Mental Health Act 1983 in England and Wales under way at the time of writing, this consensus is not merely shared by commentators, but also by those seeking to take forward law reforms in this area. Gooding's article, therefore, serves the invaluable purpose of placing the recent 'General Comment' No. 5 (August 2017) on Article 19 in its context, summarising its content, and critically analysing its key provisions.

Remaining focused on the CRPD, the final paper relates to an entirely different part of the world and is a valuable spotlight on a jurisdiction based on a mixture of civil law and Shari'a law. Patricia Cuenca Gómez, María del Carmen Barranco Avilés and Pablo Rodríguez del Pozo review the provisions of Qatari law relating to deprivation of liberty in the context of psychosocial disability in the light of the CRPD. They find the provisions substantially lacking, and propose reforms to ensure that persons with psychosocial disabilities enjoy the right to liberty on equal terms with others.

We are grateful to the peer reviewers for their prompt and thorough comments, the proofreading assistance provided by Hal (Zhan) Brinton of the University of Leeds, the ongoing support of the library staff of Northumbria University, and the overall guidance provided by Kris Gledhill as the IJMHL Editor-in-Chief.

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REJOINDER (RESPONSE TO ARTICLE BY CHRISTOPHER MAYLEA AND CHRISTOPHER RYAN)

MATTHEW CARROLL *

In 'Decision-Making Capacity and the Victorian Mental Health Tribunal' ¹ Drs Christopher Maylea and Christopher Ryan argue that the Victorian Mental Health Tribunal ('Tribunal') has an obligation to consider the assessment of a compulsory patient's decision-making capacity when determining whether or not to make a compulsory Treatment Order. Based on their interpretation of relevant legislation (the *Mental Health Act 2014* (Vic)) and a review of the Tribunal's published statements of reasons (that is, reasons for decision), the authors contend that the Tribunal makes an error by not meeting this positive obligation to take this matter into consideration.

This criticism is based on a fundamental misinterpretation of relevant law and a misunderstanding of the processes of the Tribunal. The authors failed to sufficiently recognise the distinctive features of the legislation that establishes the Tribunal and its processes. Their article also generates a misconception that by not focusing on their decision-making capacity, the perspectives of mental health consumers are not being considered as part of Tribunal hearings in Victoria.

The Tribunal welcomes scrutiny of its decisions and encourages investigation of its procedures and decision-making by actively co-operating with researchers and publishing de-identified statements of reasons. ² However, the published article misinterprets the relevant law and misrepresents decision-making by the Tribunal and must therefore be corrected.

INTERPRETATION OF THE MENTAL HEALTH ACT 2014 (VIC) (Austl)

As the authors acknowledge, some Australian jurisdictions have chosen to make decision-making capacity a central focus of the legislative criteria governing when a person can or cannot be compelled to receive treatment for a mental illness. After a lengthy, consultative review of the former *Mental Health Act 1986* (the former Mental Health Act'), Victoria chose not to do this. The Tribunal is very aware that this approach remains contested, and some stakeholders would have preferred an approach similar to that adopted elsewhere. For example, the West Australian *Mental Health Act 2014* (WA) expressly makes decision-making capacity a central consideration in determining

* Matthew Carroll is President of the Victorian Mental Health Tribunal.

¹ Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' [2017] *International Journal of Mental Health and Capacity Law* 87.

² Statements of reasons are prepared at the request of a party. In 2016-17, such requests were made in only 2.9 percent of conducted hearings. Statements of reasons are published on the AustLII website in accordance with the Tribunal's publication policy (<http://www.mht.vic.gov.au/statements-of-reasons/>) – Published statements of reasons account for an even smaller proportion of hearings. In 2016-17, 43.55 percent of statements of reasons were published, a figure that equates to 1.25 percent of the total hearings conducted by the Tribunal during that time period.

whether involuntary treatment orders can be made.³ However, like any other court or tribunal, the role of the Victorian Mental Health Tribunal is to interpret and apply the law as it is written, and not to reconfigure a clear legislative framework to introduce tests or provisions that were not included when the Victorian Parliament passed the Act.

The *Mental Health Act 2014* (Vic) ('the Act') is the legislation under which the Tribunal operates. Section 5 of the Act sets down four criteria that must be satisfied before a person can be the subject of a compulsory Treatment Order. In brief, these criteria specify that:

- (a) the person must have mental illness (section 5(a));
- (b) because of that mental illness the person must require immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or another person (section 5(b));
- (c) immediate treatment will be provided if an Order is made (section 5(c));
- (d) and there is no less restrictive means reasonably available to enable the person to receive the immediate treatment (section 5(d)).

None of these criteria include an assessment of a person's decision making capacity.

Nevertheless, the authors argue that the Tribunal must read into section 5 (and, in particular section 5(d), the 'least restrictive' criterion) a requirement to consider a person's decision-making capacity when deciding whether or not to make a compulsory Treatment Order. While their preferred approach to the conditions under which persons may receive compulsory mental health treatment is understandable, it is simply inconsistent with the language and structure of the Act as well as with the legal principles governing the interpretation of legislation.

Key principles of statutory interpretation in the context of the Act were recently addressed by the Supreme Court of Victoria. In *Daniels v Eastern Health* (*Daniels'* case) the Court identified four conditions that must be satisfied in order to read (or import) words into a statutory provision namely⁴:

- (a) the court must know the mischief with which the Act was dealing;
- (b) the court must be satisfied that by inadvertence Parliament has overlooked an eventuality which must be dealt with if the purpose of the Act is to be achieved;
- (c) the court must be able to state with certainty what words Parliament would have used to overcome the omission if its attention had been drawn to the defect; and
- (d) the modified construction (with the additional words) must be reasonably open and not be unnatural, incongruous or unreasonable and must be consistent with the statutory scheme.

Notably, the second and third conditions identified in *Daniels'* case make it inappropriate to adopt Maylea and Ryan's approach of importing a requirement of 'carefully considering' a person's decision-making capacity when determining whether

³ *Mental Health Act 2014* (WA) ss 25(1)(c), 25(2)(c).

⁴ *Daniels v Eastern Health* [2016] VSC 148 [11] (per McDonald J) quoting *Birmingham v Corrective Services Commission of New South Wales* (1988) 15 NSWLR 292, 299 (per McHugh JA) quoting *Wentworth Securities v Jones* [1980] AC 74, [105-6] (per Lord Diplock).

or not to make a compulsory Treatment Order.

Regarding the second condition, as previously noted, the Victorian Parliament did not include decision-making capacity as one of the criteria governing compulsory Treatment Orders, but this was not an inadvertent omission; instead, it expressly opted for a different formulation of the criteria for compulsory treatment. The deliberate nature of the omission of decision-making capacity as a criterion governing the making of compulsory Treatment Orders is demonstrated or reinforced by the fact that elsewhere the legislation includes provisions that do incorporate the consideration of decision-making capacity and/or the provision of informed consent:

Firstly

Decision-making capacity and the provision (or withholding) of informed consent must be considered in the context of the actual provision of treatment.⁵ Despite the contention of the authors these provisions do not bear upon the making of Treatment Orders by the Tribunal.

Secondly

When determining applications for an electroconvulsive treatment ('ECT') Order for an adult compulsory patient,⁶ the first question the Tribunal must consider is whether or not the person has capacity to give (or by implication withhold) informed consent for ECT.⁷ If the Tribunal decides a person has capacity it must refuse the application.⁸

Thirdly

In relation to the authorisation of neurosurgery for mental illness, the Tribunal cannot grant an application unless it is satisfied that the person who is to be treated has given informed consent in writing to the procedure.⁹

Fourthly

The Tribunal must consider decision-making capacity or the withholding of informed consent when determining applications concerning interstate transfer of treatment orders or interstate transfer orders.¹⁰

⁵ *Mental Health Act 2014* (Vic) ss 70, 71.

⁶ Decision-making capacity is also relevant to ECT applications beyond those concerning adult compulsory patients but this is the single largest group and the relevant point can be sufficiently illustrated by focusing on this cohort.

⁷ *Mental Health Act 2014* (Vic) s 96.

⁸ In 2016/17 the Tribunal refused 100 (14.5%) ECT applications, of those 41% were refused on the basis that the person had capacity to provide informed consent.

⁹ *Mental Health Act 2014* (Vic) s 102.

¹⁰ *Mental Health Act 2014* (Vic) ss 321, 323.

It is also relevant to note that the criteria for involuntary Treatment Orders enshrined in the former Mental Health Act did require consideration of a person's ability to consent to necessary treatment.¹¹ The particular approach in the former Mental Health Act was strongly criticised and was unlikely to have been replicated in the treatment criteria of a new Act. What is relevant for present purposes is that Parliament not only abandoned that approach, it also did not replace it with a differently formulated criterion regarding decision-making capacity. This, alongside Parliament's inclusion of specific provisions relating to decision-making capacity and/or informed consent elsewhere in the Act, demonstrates the absence of such an inclusion in the criteria governing compulsory Treatment Orders simply cannot be regarded as something that was inadvertently overlooked.

Additionally, the third condition identified in *Daniels'* case presents a further hurdle to the authors' suggestion that decision-making capacity be incorporated into the Tribunal's decision-making regarding compulsory Treatment Orders. As explained above, the Act is not silent in relation to decision-making capacity and informed consent – these concepts are incorporated in various parts of the Act. But where they are the Act employs very different formulations or approaches.¹² Consequently, it would be impossible to conclude with the requisite degree of certainty what words or approach Parliament would have employed if it were to include decision-making capacity within the criteria governing the making of compulsory Treatment Orders.

Thus, principles of statutory interpretation, including the implications of the *Charter of Human Rights and Responsibilities Act 2006* (Vic),¹³ do not support reading in decision-making capacity to section 5 of the Act as contended by the authors.

Consequently, it is unsurprising that the majority of Statements of Reasons published by the Tribunal which were examined by the authors did not refer to the 'decision-making capacity' of the person. In summary, this is not a relevant criterion listed in the Act nor is it legitimately imported by principles of statutory interpretation.

CONSIDERING THE VIEWS OF MENTAL HEALTH CONSUMERS

It is important to note that although the Act does not include decision-making capacity of the person as a requisite consideration for the making of compulsory Treatment Orders, the Act does not disregard the views and preferences of the person. Indeed,

¹¹ *Mental Health Act 1986* (Vic) s 8(d).

¹² For example, in some cases the Tribunal's task is to determine whether the person has given informed consent rather than whether they have capacity to give informed consent (noting that capacity to give informed consent is merely one of the requirements of informed consent (see — s 69(1)(a))). Examples of such sections include: s 102(2)(a) pertaining to the Tribunal's powers in respect of an application for neurosurgery for mental illness and s 96(2)(a)(i) relating to ECT applications involving young persons who have capacity to give informed consent. In other cases, the test the Tribunal must apply is drafted in terms of 'the person does not have capacity to give informed consent or does not consent...' Examples of such provisions are ss 321(4)(ii) and 323(4)(a)(ii) involving applications for interstate transfer for community patients and inpatients respectively.

¹³ See —*Daniel's case*, paras (7) and (8).

the Act requires the Tribunal, in its decision making, to consider the views and preferences of the person receiving treatment and those who support them.¹⁴ To meet this obligation the Tribunal is committed to conducting *solution-focused* hearings. The Tribunal's *Guide to Solution-Focused Hearings in the Mental Health Tribunal*¹⁵ is based on the work of Dr Michael King, a former West Australian and now Victorian Magistrate who has been instrumental in articulating a framework of practice for the specialist 'problem-solving' lists in Magistrates' Courts.¹⁶

A solution-focused approach recognises that a unique series of experiences and events precedes a person being a compulsory patient at a particular point in time, and if they are willing or wish to explain some of that, it is relevant and important for them to have the opportunity to do so. A solution-focused approach also challenges everyone to remember that compulsory treatment should never be regarded as an ongoing norm for any individual. Where possible there should be exploration of a pathway to less restriction and greater autonomy for individuals – including what voluntariness truly means in the context of each person's circumstances, taking into account that people should be allowed to make decisions that involve a degree of risk.¹⁷

An important clarification regarding solution-focused hearings is that the Tribunal is not to be regarded as the source of solutions. Rather a solution-focused approach facilitates a process that can provide an opportunity for those involved in hearings (mental health consumers, their support people and clinicians) to explore issues and potential strategies to address difficulties. In some cases it may simply be about timing – seizing an opportunity to discuss issues that hasn't presented itself before.

Two case studies illustrate this approach and how the views and preferences of mental health consumers are taken into account.

Rebecca* was distressed by the side-effects of her antipsychotic medication, in particular its impact on her artistic work; she was also concerned about the lack of a referral to a psychologist as part of her treatment plan, and that her clinical history contained incorrect information. Rebecca's treating team had asked the Tribunal to make a 12-month Community Treatment Order. Based on the discussion at the hearing where Rebecca and her treating team agreed on a strategy to address her concerns,

¹⁴ For instance, among other factors, s 55(2) requires the Tribunal, to the extent that is reasonable in the circumstances, to have regard to (a) the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve; and (e) the views of the person's carer, if the Tribunal is satisfied that making the Order will directly affect the carer and the care relationship. Similar provisions requiring the Tribunal to have regard to the views of patients and carers are contained in ss 65(4), 93(2), 94(3), 281(4), 291(2), 321(3) and 323(3). (Many of these refer to obligations of the authorised psychiatrist but provisions specifying the Tribunal's powers make it clear that the Tribunal must also consider these factors)

¹⁵ The *Guide to Solution-Focused Hearings in the Mental Health Tribunal* is available on the Tribunal's website: www.mht.vic.gov.au/forms-and-publication/guidance-materials/

¹⁶ Dr King's *Solution-Focused Judging Bench Book* is available here: aija.org.au/wp-content/uploads/2017/07/Solution-Focused-Judging-Bench-Book.pdf.

¹⁷ *Mental Health Act 2014* (Vic) s 11(1)(d).

the Tribunal made a much shorter 12-week Order, as Rebecca should be able to be treated voluntarily if these issues were resolved.

Jacob's* treating team asked the Tribunal to make an Order that would require him to remain in hospital for at least another three weeks. Jacob was desperate to leave hospital for a number of reasons, including upcoming events that were of deep cultural significance to him and his family. The Tribunal hearing was the first occasion Jacob's mother and father had been available to participate in a meeting with Jacob and his treating team. The discussion that took place identified a collaborative strategy between Jacob, his family and treating team that meant the Tribunal made an Order that would allow Jacob to be treated while living at home (and participating in the cultural events) rather than staying in hospital.

The Victorian Mental Health Tribunal is able to work in such a way because it has been resourced at a level that allows it to conduct hearings where there is a reasonable amount of time to discuss the perspective of all participants. The Tribunal allocates at least one hour to each of its hearings whereas in many other jurisdictions, mental health tribunals will conduct up to three hearings in the same amount of time.

In addition, since the establishment of the Tribunal in 2014 it has worked closely with mental health consumers and carers on the design and development of its processes and procedures. Consumer and carer advisors have an influential role. A particularly significant initiative led by our consumer and carer Tribunal Advisory Group that will be rolled out in the second half of 2018 is a mechanism by which consumers and carers can provide feedback about the extent to which they did or did not feel listened to in the course of a Tribunal hearing.

CONCLUSION

It is entirely appropriate that ongoing policy-level discussion and debate occur concerning whether or not capacity should be the core issue that determines whether compulsory Treatment Orders can be made. Mental health law is neither fixed nor unchangeable but must evolve in response to changing expectations and our understanding of many factors, including international human rights law.

However, it is inappropriate to misinterpret the existing statutory framework in which a tribunal operates and to criticise a tribunal for failing to adopt a policy preference which cannot legitimately be imported into its governing legislation. Mental health law has a profound impact on people's lives. It is essential, therefore, that when research is published which addresses tribunal processes and decision-making that it is accurate and comprehensive.

RESPONSE TO CARROLL – PRESIDENT OF THE VICTORIAN MENTAL HEALTH TRIBUNAL

CHRISTOPHER MAYLEA AND CHRISTOPHER JAMES RYAN*

In his rejoinder to our recent contribution to the *International Journal of Mental Health and Capacity Law*,¹ Carroll suggests that our criticism of the day-to-day operation of the Victorian Mental Health Tribunal (which we based on review of its statement of reasons) is invalid because, in his words, it is premised on a “fundamental misinterpretation” of the *Mental Health Act 2014* (Vic) (the Act).² Specifically, Carroll rejects our view “that in order to ensure treatment is provided in this least restrictive way, the Tribunal must have careful regard to the decision-making capacity of people brought before it and only authorise the involuntary treatment of a person over their competent objection in very limited circumstances”.³

Carroll’s objection to our interpretation seems to be based on a belief that our view depends on reading (or importing) words into the Act’s statutory provisions. As a consequence, the bulk of his rejoinder is concerned with why this would not be justified. Unfortunately, Carroll has not grasped that our view of the way that the Tribunal should perform its functions in the relevant regard does *not* depend on reading words into the Act, but rather is based upon a reasonable interpretation of the what the Tribunal should do based on the Act’s actual wording. We read the provisions and made judgements as to what ought to be the proper approach of the Tribunal, taking account the Act’s objects and principles, the intention of the Parliament, the impact of human rights legislation and the United Nations Convention on the Rights of Persons with Disabilities⁴, and the approach taken by an appeal Tribunal which overturned one of the Mental Health Tribunal’s decisions. Carroll’s response does not actually address any component of our analysis.

Ultimately statutory interpretation is an area where reasonable minds can, and frequently do, differ. Carroll’s understanding of the way that the Tribunal should operate is understandable, but does not, in our view, reflect the best reading of the legislation. Interested readers may return the detailed analysis presented in our paper and review it in the light of Carroll’s criticism. Ultimately, though, the matter can only be decided by a Court.

* Dr Christopher Maylea, School of Global, Urban and Social Studies, RMIT University, Melbourne, Australia; Dr Christopher James Ryan, Dr Christopher James Ryan, Clinical Associate Professor and Psychiatrist, University of Sydney and Westmead Hospital, Sydney, Australia.

¹ Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2018) 24 *International Journal of Mental Health and Capacity Law* 87.

² Matthew Carroll, 'Rejoinder (Response to Article by Christopher Maylea and Christopher Ryan)' (2018) 24 *International Journal of Mental Health and Capacity Law* (2018) [3-8].

³ Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2018) 24 *International Journal of Mental Health and Capacity Law* 87, [89].

⁴ United Nations [UN] 2515 UNTS 3, UN Doc A/Res/61/106, Annex, GAOR 61st Session Supp 49, 65. (Adopted) 13 Dec 2006, (Opened for Signature) 30 May 2007, (Entered Into Force) 3 May 2008.

The Act provides that questions of law arising from proceedings before the Tribunal may be referred to the Victorian Supreme Court, but only with the consent of the President.⁵ Since many agree with the interpretation of the Act presented in our peer-reviewed paper, the wisest course of action would be to allow a referral of the issue to the Court. At the very least, this would provide some clarity for the Tribunal's members, which, as we reveal in the second part of our paper, approach this matter inconsistently.

Irrespective of the question of statutory interpretation, Carroll makes no effort to respond to this issue of inconsistency - the Tribunal sometimes *did* consider a person's capacity when making decisions. The rejoinder also makes no mention of the ways in which our research identified how the Tribunal is considering capacity as evidence of mental illness. Nor does it address the Tribunal's practice of using assessments of capacity (often confused with 'poor' judgement or lack of 'insight') to determine if a person has a mental illness which itself risks maintaining the myth that all people with serious mental health problems lack capacity. This omission, pared with the admission that the Tribunal has so far operated without guidance from a consumer advisory group, reinforce the issues we raise in our article. People who are able to make their own decisions should be allowed to do so and must be supported in this.

⁵ *Mental Health Act 2014* (Vic) s 197.

THE 'TRICKY DANCE' OF ADVOCACY: A STUDY OF NON-LEGAL MENTAL HEALTH ADVOCACY

WANDA BENNETTS, CHRIS MAYLEA, BRIAN MCKENNA, AND HELEN MAKREGIORGOS*

ABSTRACT

Advocacy in compulsory mental health settings is complex and contested, incorporating legal, non-legal, representational and best interests advocacy. This paper presents an approach to non-legal representational advocacy used by Independent Mental Health Advocacy (IMHA), in Victoria, Australia, drawing on in-depth qualitative interviews with advocates and other key stakeholders. After outlining the Victorian context and the IMHA model, this paper shows how IMHA privileges the consumer voice using representational advocacy, which is rights-based and works for systemic change. Using a supported decision-making model, the paper highlights the enablers and challenges which exist, before discussing the implications in terms of rights, power, capacity building and systemic change. The participants saw IMHA as working to address one of the most troubling tensions in mental health care, between the perceived need for coercion and the need to support people to make their own decisions. Representational advocacy provides a clear, easily transferable and tested framework for engaging in supported decision-making processes with people in the mental health system.

Keywords: IMHA; Independent Mental Health Advocacy; mental health; advocacy; Victoria Australia; non-legal advocacy; compulsory treatment; involuntary treatment; supported decision-making

I. INTRODUCTION

Advocacy in compulsory mental health settings is a complex and contested affair, incorporating legal, non-legal, representational and best interests advocacy with a raft of other concepts in diverse contexts.¹ For many who are subject to compulsory treatment, the experience is frightening, disempowering and can lead to lasting trauma, and advocacy can offer a supportive and empowering salve to distress. For decades, debate has raged between those who prioritise the 'rights' of consumers – often lawyers, and those who prioritise their 'interests' – often psychiatrists.² Over time, this debate has evolved into a complex and nuanced dialog, with mental health legislation across the globe taking away people's right to make their own decisions, while seeking to protect their right to participate in those decisions. This occurs with both legal and non-legal advocates trying to balance rights to health, to personal and community

* Wanda Bennetts, Senior Consumer Consultant, Independent Mental Health Advocacy, Chris Maylea, Lecturer, RMIT University, Brian McKenna, Professor in Forensic Mental Health, Auckland University of Technology and the Auckland Regional Forensic Psychiatry Services, Helen Makregiorgos, Manager, Independent Mental Health Advocacy.

¹ Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* [90]; Julie Ridley et al, *Independent Mental Health Advocacy - The Right to Be Heard: Context, Values and Good Practice* (Jessica Kingsley Publishers, 2015); Eleanore Fritze, 'Shining a Light behind Closed Doors' (Victorian Legal Aid, 2015).

² Alan A Stone, 'The Myth of Advocacy' (1979) 30(12) *Psychiatric Services* [819].

safety, to self-determined recovery and to dignity. We argue that advocacy can play a key role in balancing or resolving this tension.

This tension is perhaps best encapsulated in the limited application of the United Nations Convention on the Rights of Persons with Disabilities³ (CRPD), which upholds the right of people to be supported in making their own decisions. The independent expert Committee on the Convention⁴ has interpreted this to mean that people cannot be forced to receive treatment.⁵ However, this has not resulted in a worldwide ban on compulsory treatment, on the contrary. Australia, for example, ratified the Convention, while declaring that it understands 'the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability...'.⁶ As is to be expected, all Australian States and Territories have mental health legislation which allows for people who meet certain criteria to receive compulsory treatment, but only two, Victoria and Western Australia, have independent representational non-legal advocacy.⁷ This represents a shift away from a purely substituted decision-making regime, where professionals assume decision-making responsibility based on a perception of the inability of the person to make 'good' decisions. The shift is towards a rights based representational advocacy approach, where professionals assist people to make whatever decisions they can, using supported decision-making approaches.

This paper presents an approach to non-legal representational advocacy that describes the application of this model within the Victorian context, drawing on in-depth qualitative interviews with advocates and other key stakeholders. This is not an evaluation of this model or its impact, but rather a descriptive illustration of its intent and approach.

II. NON-LEGAL REPRESENTATIONAL ADVOCACY IN MENTAL HEALTH

Historically, people receiving compulsory mental health treatment have been subject to the 'myth of incompetence'⁸, and 'silenced on the grounds of irrationality'.⁹ Mental

³ (United Nations [UN] 2515 UNTS 3, UN Doc A/Res/61/106, Annex, GAOR 61st Session Supp 49, 65. (Adopted) 13 Dec 2006, (Opened for Signature) 30 May 2007, [Entered Into Force] 3 May 2008.

⁴ Established virtue of Article 34 of the Convention.

⁵ Christopher Maylea and Asher Hirsch, 'The Right to Refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities' (2017) 42(2) *Alternative Law Journal* [149]; Tina Minkowitz, 'Prohibition of Compulsory Mental Health Treatment and Detention Under the CRPD' (SSRN Scholarly Paper ID 1876132, Social Science Research Network, 30 June 2011, <http://papers.ssrn.com/abstract=1876132>)

⁶ *Convention on the Rights of Persons with Disabilities Declaration 2009* (Cth) Sch 2. Instrument of Ratification.

⁷ Chris Maylea et al, 'Review of the Independent Mental Health Advocacy Service (IMHA)' (Centre for Applied Social Research, RMIT University, 2017).

⁸ Lawrence O Gostin, Lance Gable, 'Global Mental Health: Changing Norms, Constant Rights' (2008) 9(1) *Georgetown Journal of International Affairs* 83, [84].

⁹ Karen Newbigging et al, 'Right to Be Heard, A Review of Independent Mental Health Advocacy Services in England (Research Report, University of Central Lancashire, June 2012), [20].

<https://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf>.

health advocacy seeks to address this by giving voice to people subject to compulsory treatment. With origins in the consumer movement,¹⁰ and links to concepts such as supported decision-making and recovery-oriented practice, mental health advocacy seeks to ensure that the rights of people subject to compulsory treatment are maintained, and that they are, in so much as is possible within legislative frameworks, involved in decisions about their treatment, care and recovery. Foley and Platzer define advocacy as:

... any action to assure the best possible services or intervention in the service system on behalf of an individual or group. Specifically, advocacy is the activity of an individual to pursue and act in the interests of another, where the latter defines his or her own interests and through the process of advocacy gains a certain degree of power to pursue them.¹¹

In the mental health context, non-legal advocacy is focused on establishing, protecting and maintaining a person's fundamental rights, including rights to choose and refuse treatment, freedom of movement, communication, due process and to full participation in society. These rights have not been consistently maintained by mental health services,¹² and independent advocates play an important part in ensuring that clinical considerations are balanced with a person's rights. Stomski et al. highlight four main ways in which this is done in non-legal mental health advocacy:

negotiating on behalf of consumers during meetings with health professionals; liaising between consumers and health professionals outside of meetings; supporting consumer decision-making without the involvement of health professionals; and involvement in legal processes.¹³

Legal advocacy, conversely, focuses on Tribunal representation, appeals, and is often means or merits tested.¹⁴ Representational advocacy has been defined as advocacy which:

ensures that people are supported to speak for themselves and have someone 'on their side' who can represent their views, wishes and concerns. Advocates take their instruction from the [Patient] and ensure that they do not take action without the [Patient's] express permission. Representational (or instructed) advocacy promotes what the [Patient] wants for his or herself not what other people think they should have or not have.¹⁵

The central role of the non-legal representational mental health advocate is to give voice to the person subject to compulsory treatment in negotiating the infringements on their rights. In this way, the notion of advocacy relies on the idea that people who

¹⁰ Janet Wallcraft, J Read and Angela Sweeney, *On Our Own Terms: Users and Survivors of Mental Health Services Working Together for Support and Change* (2003).

¹¹ Ronan Foley and Hazel Platzer, 'Place and Provision: Mapping Mental Health Advocacy Services in London' (2007) 64(3) *Social Science & Medicine* 617, [618].

¹² Kathleen M Griffiths, John Mendoza and Bradley Carron-Arthur, 'Where to Mental Health Reform in Australia: Is Anyone Listening to Our Independent Auditors?' (2015) 202(4) *The Medical Journal of Australia*, [172].

¹³ Norman Stomski et al, 'Advocacy Processes in Mental Health: A Qualitative Study' (2017) 14(2) *Qualitative Research in Psychology* 200, [200].

¹⁴ Fleur Beaupert et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law in Context* [125].

¹⁵ Maylea and Hirsch, above n 5.

are receiving services should be in control of decisions regarding their treatment and recovery, or at the very least be involved in decisions about their treatment.

Respect for an individual's autonomy has historically not been upheld in the mental health context, when people may struggle to make decisions due to their experiences of mental distress, constraints of statutory and risk-based practice frameworks, or other cognitive, social or functional barriers.

Despite these barriers, consumers of mental health services have consistently identified autonomy as a vital aspect of recovery.¹⁶ Eades writes; 'Through autonomous action we demonstrate that we are empowered and that we have a sense of self, which we value.'¹⁷

A growing understanding of the importance of supporting autonomy for people in a mental health setting has resulted in a variety of approaches to decision-making, represented as a continuum in Figure 1:

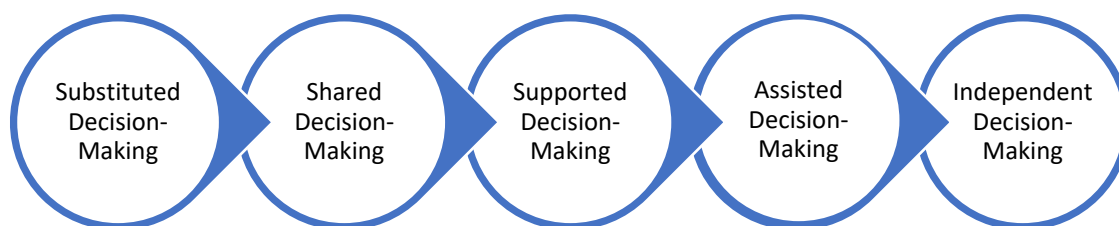


Figure 1 - A continuum of decision-making

Most decisions people make about treatment require some form of assistance, if only in the form of information from expert professionals. Consequently few decisions are purely independent, uninfluenced by social norms or advice from experts. In this way, most decisions made by people will engage in independent or rather assisted decision-making to exercise their autonomy.

In a mental health context, people may require support to exercise their autonomy. Autonomy can be understood as an interactive but self-determined position, where

¹⁶ Fauzia Knight et al, 'Supported Decision-Making: The Expectations Held by People With Experience of Mental Illness' [2018] *Qualitative Health Research* 1049732318762371; Louise Byrne, Stephanie Schoeppe and Julie Bradshaw, 'Recovery without Autonomy: Progress Forward or More of the Same for Mental Health Service Users?' [2018] *International Journal of Mental Health Nursing*; Patricia Deegan, 'Recovery as a Journey of the Heart' (1996) 19(3) *Psychiatric Rehabilitation Journal* [91].

¹⁷ Susan Eades, 'Impact Evaluation of an Independent Mental Health Advocacy (IMHA) Service in a High Secure Hospital: A Co-Produced Survey Measuring Self-Reported Changes to Patient Self-Determination' (2018) 22(1) *Mental Health and Social Inclusion* [53].

people maintain ownership and control over decisions that affect their lives.¹⁸ Supported decision-making supports the right of people to achieve autonomy, with a structured process to assist people in making their own decisions.¹⁹ This may include assisting with small steps of the decision-making process, such as goal setting or providing information. This assistance is often necessary for people irrespective of their mental health, but can be particularly important in ensuring people who need support with making decisions are included, and not discriminated against based on their diagnosis. Supported decision-making is considered consistent with the CRPD, and is endorsed by the United Nations Committee on the Rights of Persons with Disabilities.²⁰ This same Committee has called for the abolition of substituted decision-making regimes. Substituted decision-making entirely takes away a person's right to make decisions, although decision-makers may be required to involve people in decisions or take their views into account.²¹

In a shared decision-making approach, the decision-making process maintains collaborative partnerships and is person centred, however there is no emphasis on the person having the final say over treatment decisions.²² This means shared decision-making may be undertaken within a substituted decision-making framework.

Unlike shared or substituted decision-making, supported decision-making, when done properly, allows people the final say over their decisions, including the ultimate right to refuse treatment.²³ This is obviously inconsistent with the very notion of compulsory treatment, which relies on substituted decision-making, and a tension emerges in attempts to engage in supported decision-making in compulsory mental health settings.²⁴ Unlike shared decision-making, which focuses on 'good' health outcomes for consumers, supported decision-making makes no assessment of the outcome, instead it promotes the right to make decisions, whether 'good' or 'bad'.²⁵

Representational advocacy is closely linked to supported decision-making, while shared and substituted decision-making are more aligned with best interests approaches. Not all advocacy is representational, with much advocacy undertaken with a view to furthering a person's best interests, rather than based on an interpretation of their will and preferences regarding treatment. An Independent Mental Capacity Advocate acting under s 4 of the Mental Capacity Act (England and Wales) 2005, is an example of a

¹⁸ Eades, above n 17.

¹⁹ Gavin Davidson et al, 'Supported Decision Making: A Review of the International Literature' (2015) 38 *International Journal of Law and Psychiatry* [61].

²⁰ Committee on the Rights of Persons with Disabilities, General Comment No 1: Article 12: Equal recognition before the law, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014).

²¹ E.g. – *Mental Health Act 2014* (Vic) (Austl) s 71.

²² MB Simmons and PM Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health' [2017] *Irish Journal of Psychological Medicine* 1.

²³ *Ibid.*

²⁴ Maylea et al, above n 7.

²⁵ Simmons and Gooding, above n 23.

best interests advocate, although these roles are required to take into account the person's preferences.²⁶

Supported decision-making also means different things to different consumers. Some view themselves as experts in their own recovery, and others identify the need for high levels of support from others.²⁷ Using a supported decision-making approach, people must also be allowed to choose who supports them to make decisions, and to delegate decisions to other people, while retaining the right to override them. People must be supported to, and allowed to, make decisions – even about the way in which they are supported in making decisions.

In addition to the support advocates can offer around decision-making and maintaining rights, other studies have identified a preference for advocates to assist in providing information, goal setting and building a person's capacity to self-advocate.²⁸ They also prioritised interpersonal qualities in their advocates such as passion, strength and determination, as well as empathy, understanding and cultural appropriateness.

Advocacy in the sense defined above is distinct from, but intrinsically linked with, systemic advocacy, which is focused on system change, rather than representation. This distinction is somewhat confusing, as a 'consumer advocate' may be a consumer who is advocating for system change, or a person who represents on behalf of a consumer. For the purpose of this paper, systemic advocacy is not automatically a function of representational advocacy, although it may be incorporated into some models.

Advocacy also has a long and similarly contested history in other practice contexts, such as homelessness,²⁹ older people,³⁰ dementia care,³¹ and disability more broadly³²

²⁶ Marcus Redley et al, 'Mental Capacity Act (England and Wales) 2005: The Emergent Independent Mental Capacity Advocate (IMCA) Service' (2010) 40(6) *The British Journal of Social Work* [1812].

²⁷ Knight et al, above n 16.

²⁸ Daniel Van der Pluym, 'Consultation Report - Supported Decision Making under the Mental Health Act 2014 - What Consumers Want' (Consultation Report, Independent Mental Health Advocacy, Victoria Legal Aid, 2016); D Barnes, and T Brandon, 'Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice' (Monograph, University of Durham, 2002, <http://dro.dur.ac.uk/4356/>).

²⁹ Kirsi Juhila, 'Forms of Advocacy in Social Welfare Work with Homeless Women' (2008) 11(3) *European Journal of Social Work* [267].

³⁰ David P Moxley, 'The Logic of Personal Advocacy with Older Adults and Its Implications for Program Management in Community-Based Gerontology' (2004) 27(4) *Administration in Social Work* [5].

³¹ Caroline Cantley, "'Feeling the Way": Understanding How Advocates Work with People with Dementia' (2004) 3(2) *Dementia* [127]; Moxley, above n 30; David P Moxley, 'The Advocate's Compromise: Strategies and Tactics to Improve the Well-Being of People with Diminished Status' (2014) 8(3) *Ethics and Social Welfare* [277].

³² Eilionóir Flynn, 'A Socio-Legal Analysis of Advocacy for People with Disabilities – Competing Concepts of "Best Interests" and Empowerment in Legislation and Policy on Statutory Advocacy Services' (2010) 32(1) *Journal of Social Welfare and Family Law* [23]; Eilionóir Flynn, 'Making Human Rights Meaningful for People with Disabilities: Advocacy, Access to Justice and Equality before the Law' (2013) 17(4) *The International Journal of Human Rights* [491].

and has been theorised in multiple professional frameworks including nursing³³ and social work,³⁴ where it is seen as a key element of professional practice. This role of advocate within a broader context of care and control, such as in mental health nursing or mental health social work, stems from the assertion that those who have the most contact with people are those who are best placed to advocate for them.³⁵ This inevitably leads to notions of best interests advocacy, as these professionals are tasked with both caring for and controlling people, rather than representing their will and preferences. This has led to criticisms that these professionals are adopting the position of advocate not for altruistic reasons, but as a way of bolstering the power and professional status of the professional.³⁶ There are obvious conflicts of interest where clinical staff responsible for implementing compulsory treatment also assume the role of advocate. Clinical staff may also owe a legal duty of care to act in the best interests of consumers.³⁷ As a result, there is an emerging trend for independent advocates, who sit outside the mental health services and do not experience these conflicts.³⁸

III. VICTORIAN CONTEXT

In the State of Victoria in south-eastern Australia, people who are subject to compulsory mental health treatment, or at risk of being made subject to it, are eligible for non-legal advocacy from the Independent Mental Health Advocacy (IMHA). IMHA was launched in 2015, it is state-wide, and is funded by the Victorian Government Department of Health and Human Services (DHHS) and run by Victorian Legal Aid (VLA). IMHA uses a representational advocacy model with an embedded supported decision-making approach, both in the community and in inpatient settings. IMHA is not a statutory body, unlike the Mental Health Advocacy Service in Western Australia,³⁹ but is part of the broader reform agenda heralded by the new *Mental Health Act 2014* (Vic) (Austl.) (the Act). In 2015, the Minister for Mental Health, the Rt Hon Mary Wooldridge MP, noted the role of advocacy;

Funded advocacy was an important addition. Advocacy services are vital to support patients in public mental health services so that they can understand their rights and understand how to exercise them. ⁴⁰

³³ N Carver and J Morrison, 'Advocacy in Practice: The Experiences of Independent Advocates on UK Mental Health Wards' (2005) 12(1) *Journal of Psychiatric and Mental Health Nursing* 75; Clare Cole, Sally Wellard and Jane Mummery, 'Problematising Autonomy and Advocacy in Nursing' (2014) 21(5) *Nursing Ethics* [576]; Mick McKeown et al, 'Conflict of Roles: A Conflict of Ideas? The Unsettled Relations between Care Team Staff and Independent Mental Health Advocates' (2014) 23(5) *International Journal of Mental Health Nursing* [398].

³⁴ Paul Freddolino, David Moxley and Christine Hyduk, 'A Differential Model of Advocacy in Social Work Practice' (2004) 85(1) *Families in Society: The Journal of Contemporary Social Services* [119]; Juhila, above n 29; Jane Dalrymple and Jane Boylan, *Effective Advocacy in Social Work* (SAGE, 2013).

³⁵ Cole, Wellard and Mummery, above n 33.

³⁶ *Ibid.*

³⁷ Eades, above n 17.

³⁸ Griffiths, Mendoza and Carron-Arthur, above n 12; Newbigging et al, above n 9.

³⁹ *Mental Health Act 2014* (WA) (Austl) s 20.

⁴⁰ Victoria, *Parliamentary Debates*, Legislative Council, 7 May 2015, 1289 (Mary Wooldridge).

Prior to the introduction of IMHA, limited formal advocacy was provided by consumer advocates with lived experience through the Victorian Mental Illness Awareness Council (VMIAC), and best interests mental health advocacy was and is still provided by Community Visitors through the Office of the Public Advocate, although only in inpatient settings.⁴¹ Informal advocacy, from friends, family and other professionals is also an important part of the advocacy context.⁴² At inception, IMHA was the first funded state-wide non-legal representational mental health advocacy service in Australia, although IMHAs have existed in the United Kingdom for some years,⁴³ and Western Australia has since introduced a representational model.⁴⁴

IV. THE IMHA MODEL

IMHA operates across four sites in Victoria, and services are delivered via phone and in person with “outposts” established in inpatient mental health units. Each IMHA team consists of a Senior Advocate, and a number of Advocates. The staff team also includes a Manager, Administration Officer and Senior Consumer Consultant. IMHA is also guided by, and regularly consults with, Speaking From Experience, VLA’s consumer advisory group.

IMHA explicitly adopts a representational model, with a focus on recovery and maintaining the rights of people under the Act. The IMHA model consists of a combination of information provision, referral, advocacy or support for self-advocacy, and is informed by the principles in the Act.⁴⁵ These principles include a ‘least restrictive’ approach; a recovery orientation with a view to full participation in community life; upholding the right of people subject to compulsory treatment to participate in decisions about their assessment, treatment and recovery; and respect for their rights, dignity and autonomy. The IMHA model is also informed by espoused values of integrity, respect, being person-centred, curiosity and reflectiveness, and explicitly adopts a recovery focus.⁴⁶

The remainder of this paper draws on a qualitative study to illustrate this model.

Method

This study applied a descriptive qualitative research methodology to allow a general inductive approach. Research data was collected through semi-structured interviews of

⁴¹ OPA, ‘Community Visitors Annual Report 2016-2017’ (Office of the Public Advocate, 2017) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/strategic-plans-and-annual-reports/community-visitors-annual-reports/442-community-visitors-annual-report-2016-2017>>.

⁴² Beaupert et al, above n 14.

⁴³ Karen Newbigging et al, “When You Haven’t Got Much of a Voice”: An Evaluation of the Quality of Independent Mental Health Advocate (IMHA) Services in England’ (2015) 23(3) *Health & Social Care in the Community* [313].

⁴⁴ *Mental Health Act 2014* (WA) (Austl) s 20.

⁴⁵ *Mental Health Act 2014* (Vic) (Austl) s 11.

⁴⁶ Maylea et al, above n 7.

approximately 45 minutes duration with a purposive sample of IMHA advocates and stakeholders (n = 13). Interview questions focused on three areas:

- A. 'Who are the advocates'
- B. 'What do the advocates do'
- C. 'How do they do it'

The project undertook a qualitative descriptive research approach,⁴⁷ and interviews were undertaken by the chief investigator, who is the senior consumer consultant with IMHA.

A co-produced approach underpinned the research process, led by an experienced consumer consultant supported by mental health academics and the IMHA manager. This was chosen to capture the applied nature and theoretical underpinnings of the model and to give insight into both the context which shaped the model and the ideals it sought to promote. In addition, a number of the participants had a lived experience of using mental health services, and prioritising their voice was an important feature of the approach.

Interviews were conducted at a time and place suitable for the participant and were taped via a digital recorder. Participants were recruited from a variety of backgrounds, classified for the purpose of this analysis as stakeholders, advocates and other IMHA staff. Four stakeholders were from the department of health and human services (DHHS) and were instrumental in the conceptualisation; policy implementation, procurement, and service provider selection process for the development of the IMHA. Two stakeholders were from the Victorian Mental Illness Awareness Council (VMIAAC), the peak consumer body in mental health in Victoria, who were involved in the consultation process and advisory committee at the time of the development of the IMHA. Seven were IMHA staff, including five employed as senior advocates or advocates and two staff employed in management and project management roles. Participants were from diverse employment and educational backgrounds, and a number have lived experience of using mental health services.

⁴⁷ Margarete Sandelowski, 'Whatever Happened to Qualitative Description?' (2000) 23(4) *Research in Nursing & Health* [334].

Thematic analysis of the transcripts was carried out by two members of the research team following the phases of conducting thematic analysis; becoming familiar with the data through in-depth reading of the transcripts, generating initial codes, searching for themes, defining and naming themes and producing a report. Initial codes were generated by analysing the transcripts.⁴⁸ The codes were then reviewed to identify any common patterns or variations.

Quotes from participants are distinguished in this paper by a number enclosed in parenthesis.

Ethics approval for this study was obtained through the Swinburne University Human Research Ethics Committee (SUHREC).

Findings

Four key themes which describe the IMHA model emerged from the data analysis:

1. Privileging the consumer voice
2. Representational advocacy
3. Supported decision-making
4. Enablers and challenges

Each of these themes will be explored using illustrative quotes, with interview identifiers in parentheses.

(1) Privileging the consumer voice

There was consensus from participants that first and foremost, IMHA exists to serve the consumer – the person wanting or needing the advocacy. The language varied at times from consumer, to person, to client, but there was no doubt whatsoever that it was about the person seeking the service and what that person wanted. This was summed up as “I absolutely serve consumers”. (10) One stakeholder expressed it in the following way:

There is a phrase that a friend of mine uses and it fits perfectly here. He is a religious man and he talks about a servant’s heart. That, in religious terms, is somebody who lives to assist others, to serve God and other people... with the main responsibility being to put the representation of people at the fore, ...but to, at the end of the day, subordinate that to the goal of the consumer is one of the most important skills there. (6)

There was also consensus that IMHA is funded to serve people who are subject to compulsory treatment under the Act, with a focus on people who are most disadvantaged. Currently advocates are only funded to work with people who are subject to, or at risk of, compulsory treatment, however participants expressed a desire to ensure access to advocacy for all people who access mental health services, including

⁴⁸ Douglas Ezzy, *Qualitative Analysis: Practice and Innovation* (Psychology Press, 2002).

formally voluntary people who may be subject to coercion or duress. This IMHA staff member expressed this desire:

... but ideally I would like to think that in some point in time, IMHA's scope would probably ...try to prevent people being subject to involuntary treatment... if advocacy's are involved it's less likely people will be subject to involuntary treatments down the track. (13)

Advocacy was also described in terms of being an independent voice of the person, particularly in settings where the person may feel disempowered. This was linked to a strong feeling from participants of 'having the person's back', 'being on their side' or 'walking alongside the person'. In so doing, they sensed that people felt supported through having somebody on their side who would privilege their voice or support them to voice their own wishes.

(2) Representational advocacy

All people interviewed were adamant that IMHA's advocacy model is about the person – what they want, what they need, addressing their goals, issues and concerns. Various terminology was used to describe this as: representational advocacy, directions based advocacy or taking instructions from the person, as this stakeholder noted:

... it is really anchored in what the person wants and so the advocates are taking their instruction - if that's the right word - from the person themselves, regardless of what the advocate thinks should or shouldn't be happening. (5)

It was also very clear that representational advocacy at IMHA is not 'best interests' advocacy, and that advocates were not giving advice or offering opinions. Advocates were clear that they were not there to make assessments of a person's decisions:

... not actually making those judgements because that's not our role. There are other professionals in the space we work in, who are doing that all the time and so I think that that's the key thing that defines our model of advocacy. In a way that is different to quite a lot of other advocacy services working in this space. (7)

This theme included two subthemes; a rights-based approach and systemic advocacy.

(2) (a) Rights-based

The first subtheme was a strong alignment between a representational approach and a rights-based approach, viewing the advocate as the mechanism for upholding rights as expressed by the person. There was some variation from participants on this issue, as some saw rights as informing, underpinning or overarching their approach to advocacy and others saw rights being upheld as a result of the advocacy being in place. This included the work being informed by consumer rights-based frameworks such as the CRPD; advocacy as a right given the theme of supported decision-making in the Act, and others saw it as a check and balance in ensuring services are consumer focused and people's rights are recognised and upheld. In this sense, the advocate was seen to be an accountability mechanism prompting services to give effect to the rights articulated in the Act. There was also some concern expressed that consumer rights may not always be met as intended by the Act. This stakeholder noted the CRPD and

the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Austl), linking the supporting of rights to systemic change:

There's a number of rights under the disability convention, under our human rights charter, that that [advocate] role facilitates them in and supports the person to be able to enforce their rights and protect their rights. I see those things as connected, intimately connected... I think it's fair to say that through the work that individual advocates do across the state and through the learnings that the program has and feeding back to services of learning, that those things do end up having a systemic effect of improving supported decision making generally across the state, of shifting the power dynamic in the way that the system itself works. While that's not a primary function I think that's a consequence of an effectively working independent advocacy program. (3)

This clearly demonstrates the function of systemic advocacy as critically related to representational advocacy and emphasising a culture of maintaining rights across the mental health system.

(2) (b) Systemic advocacy

Participants saw the primary function of IMHA advocates as being individual advocacy – one participant recalled conversations in the establishment phase where the service was being envisaged as individual advocacy. This stakeholder was clear in their understanding of what was and is required:

This was very much individual advocacy and ...there was whole lots of folks saying 'dreadful, 'dreadful. It should be systemic'...But I had a brief that it was never going to do anything else but individual advocacy...the data will be individual but you aggregate that individual data up and look what you've got...and that's what you need if you're going to do systemic advocacy. (8)

Most respondents believed that individual and systemic advocacy were more intricately linked. They saw individual advocacy both as a way to collate issues to raise with services and as a way to change culture and the system more broadly. An IMHA staff member summed this up:

I guess it's all about culture change where you've got incredibly unequal power imbalance between the treating team and a person and I just see advocacy as being like one little thing to just slightly tip that (more up), but it's not the only thing and it will have to be a lot of other systemic change as well. (11)

This is suggestive of the IMHA model as including an oversight function, or perhaps a subversive reform agenda, cloaked in individual advocacy. Systemic advocacy is also a function of VLA more broadly, which is required to take action to minimise the need for individual legal services in the community.⁴⁹ One advocate indicated this 'other truth':

Then the other truth from my perspective is actually IMHA is much more about changing a culture than it is about individual outcomes. (10)

This culture change was viewed as a key aspect of systemic advocacy, and a key function of IMHA. Systemic advocacy was seen as valuable and even essential by most participants, although there was some variation in who held ultimate responsibility for leading change. Some saw systemic advocacy as the responsibility of the advocates,

⁴⁹ *Legal Aid Act 1978* (Vic) (Austl) s 4(d).

while others saw it as the responsibility of the senior advocates, the IMHA manager, inpatient unit managers or service leaders. One IMHA staff member also identified the importance of privileging the consumer voice when undertaking systemic advocacy within a framework of representational advocacy:

... if we don't have lived experience we should all actually be using the consumer's voice when we actually have conversations about advocacy... so it's not just about the voice in your individual advocacy or at the system level... when you have conversations, that consumer voice should always be paramount. (13)

This need to prioritise the consumer voice (even when the consumer is not present to give instructions) is not a straightforward process. Representing the variety and diversity of consumer voices at the systemic level is another step in the tricky dance of advocacy.

(3) Supported decision-making

IMHA was established as a mechanism of supported decision-making, in conjunction with a number of other aspects of the Act and the broader reform agenda. This IMHA staff member linked these aspects:

So I guess the vision under the Act was that people who are receiving treatment, whilst they're being treated against their will would still have a role in decisions made about what was happening to them and that in itself is a really challenging idea because the whole underpinning – everything underpinning what the person's situation is, is that they haven't had a say in that decision. (11)

The importance of advocacy within this context was acknowledged by another advocate:

... if you want to have a mental health system that really is committed to supported decision-making I think you have to have a service like IMHA because I think the reality is that we don't all start from the same place when we're making those decisions. (7)

Supported decision-making was associated with providing information so that people can make informed choices, and then communicating the preferences of a person with decision-makers. This was conceptualised as being 'behind' the person, not leading them, by giving people space to make their own decisions and trusting them. Participants viewed IMHA as crucial to bringing supported decision-making into mental health services. As this IMHA staff member noted however, service providers did not always demonstrate supported decision-making approaches:

I don't think people have that grasp of what supported decision-making actually is in those settings... It's still substituted decision-making and maybe shared sometimes. (13)

Advocates, on the other hand, demonstrated a high level of nuanced understanding of supported decision-making:

My understanding of what supported decision-making is, is that the person who is using the mental health services should be able to – even in the context of compulsory mental health treatment, should be defining the goals that they want and services should be directed an allocated to the extent that they get them towards those particular goals; that's opposed to maybe best interests, where someone else defines the outcome. (1)

Supported decision-making was often related to issues of power and control, with a strong sense that it could be used to address the power imbalance between people subject to compulsory treatment and their treating teams. This was also seen to relate to informal coercion, where people might not be formally subject to compulsory treatment but were threatened with it, or where other forms of duress were applied, such as through family members or support services. Advocacy was seen by this advocate to be key in these situations:

Because someone might have mentioned to them that if they don't comply with this or don't do this you'll be put under an order. (2)

Participants noted that this required careful navigation by advocates, to ensure that they did not simply replace one form of coercion with another, as this advocate noted:

... they're really being empowered to make the decision that feels right for them without a kind of pressure or coercion from other sources, then that's when you have to have an advocacy service that's not trying to do any of those things or try and encourage somebody to make the right decision because people have very different perspectives on what the right decision is. I think I see our service as very much part of that supported decision-making framework... (7)

One advocate expressed this as helping the person to discover or articulate their decisions that may have become blurred or difficult to articulate because of the power dynamics at play:

I think people really know what their decisions are, but I think when you're in that situation where you're really compromised and feeling really, really powerless you don't actually trust your own – you don't really trust your own voice or your decisions. (9)

In these situations, for this IMHA staff member, the value of an external, independent representational advocate was very clear:

... but that whole relationship is set up in a way that means that the treating team really doesn't have to have much regard to what's going on. Then you have someone independent come in and say 'actually, this is what the person wants and I'm someone from outside this relationship that you're more likely to listen to. (11)

This focus on supported decision-making was not without challenges, as Victorian mental health services are largely entrenched in a substituted or, at best, shared decision-making approaches. The next section highlights some of the enabling factors and identifies the challenges.

(4) Enablers and Challenges

Broadly, enablers and challenges included the need for role clarity and the critical nature of relationships with consumers, services and carers and families.

Advocates were very clear about their role, but felt that external stakeholders and services were less clear and at times confused about IMHA's role. Role clarity was seen as essential to being able to do the job and making it much easier for the advocates to do their job when people know what they do. Role clarity was also mentioned by one participant in respect to service understanding of the distinction between the IMHA advocates and other professionals who might advocate as part of their role, such as consumer consultants, peer support workers, VMIAC advocates or Community Visitors.

Advocates are a relatively new part of an already complex system, and for people experiencing mental distress or busy clinicians, confusion was a common challenge. Role clarity was particularly important in light of the relational nature of the IMHA model. This stakeholder neatly captured this challenge:

... of course they won't understand that... it's a new role. It's not the role of someone – an advocate within VMIAC, it is not that role; it is different from that role. There has not been a role like this in Victoria so in the first instance it's going to be, I would think, very hard for the sector to understand what is their role, what can they do and what can't they do? You have all your... peer support workers... consumer consultants... practitioners have their own view of advocates and everyone's got a view of what an advocate is and they're advocates and everyone's an advocate and blah, blah, blah; this is a different role. (8)

The importance of relationships with clinicians and people receiving advocacy was identified as key to successful advocacy. In Victoria, mental health services cannot prevent IMHA advocates from communicating with people,⁵⁰ but they have no other statutory powers. This means that IMHA advocates must rely on positive relationships with clinicians in order to obtain access to consumers and thereby work towards an advocacy outcome. This tension was recognised by this advocate:

I'm also thinking about our relationship, IMHA, to that service, trying to make sure that that's a positive interaction because I think that if we don't kind of have good relationships with mental health services, we can't really do our job... (7)

Relationships with services were also seen as crucial for building awareness of IMHA and promoting the value of advocacy. One major tension identified by participants was the prospect that good relationships with staff might interfere with representational advocacy, if the advocates' own comfort or need to maintain ongoing relationships with services has the potential to compromise the respect for what the person advocating for needed.

This relational role extended to advocacy which involved support people, such as carers and families. This 'tricky dance' was viewed as important, as they were seen as potentially powerful allies or rich support if the consumer wanted them involved, although this was not always the case. Participants identified the need to be upfront about what will and won't be discussed with carers and families, but advocates also have a role in letting people know that the Act supports their right to have families or carers involved in their care. Participants also acknowledged that at times, carers and families members want different things. There were a number of examples of this tension, including one example of a carer complaining that the consumer had a voice that was counter to their 'best interests'. This stakeholder noted:

... they will have their own views about what the patient wants and needs, all of which will assist in understanding how to advocate for this patient. I think there is an important relationship to build there... (12)

The central relational aspect, however, was the relationship with the person accessing advocacy, with participants consistently identifying this as a fundamental element of mental health advocacy.

⁵⁰ *Mental Health Act 2014* (Vic) (Austl) s 16(2)(f); *Mental Health Regulations 2014* (Vic) reg 5A.

V. DISCUSSION

In general, the findings from this study highlight the priorities identified in the existing literature. Representational advocacy was viewed as a key way in which the IMHA model worked to privilege the consumer voice and is clearly linked to IMHA's adoption of the supported decision-making principle. This study did not attempt to evaluate the effectiveness of this model, which has been undertaken elsewhere,⁵¹ however it does articulate the composition of the model. This consistency is unsurprising, as participants entirely consisted of people who had either designed the model or were responsible for implementing it and was not representative of the broader compulsory mental health workforce. This broader mental health workforce would likely have highlighted some critiques of the rights based, legalistic foundations of the representational model, which has been described as leaving those in mental distress as 'dying with their rights on'.⁵²

A best interest approach seeks to justify intervention on the basis of what 'is good' for a person, or finds a middle ground with seeking to do what the person 'would really want', on the basis that the person is not making 'good' decisions. These complexities and objections were not fully explored by the participants of this study, although within the model explored above a number of points arise which have significant implications for practice and future research. These are explored in this section and include; the need for advocates to protect consumers' rights, the inherent power dynamics and the risk of co-option and the role of capacity building and of systemic advocacy in a representational model.

(V) (a) RIGHTS

The theme of rights was central to the participant's understanding of the advocacy model, however it should be noted that while the Act lays out some clear rights, these rights are commonly not maintained in practice. The rights which compulsory patients are entitled to include the right to receive treatment and assessment in the least restrictive way possible, with voluntary options preferred;⁵³ and the right to be involved in and supported to participate in or make all decisions about their assessment, treatment and recovery,⁵⁴ even when this involves a degree of risk.⁵⁵ Advocates indicated that they facilitate this process of participation and supported decision-making, by maintaining these rights.

That advocates are necessary to enforce these rights raises a fundamentally problematic tension in compulsory mental health treatment. Why are decision-makers and other clinicians not taking it upon themselves to ensure that each person's rights are upheld? Newbigging et al. write that '... the main purpose of advocacy is

⁵¹ Maylea et al, above n 7.

⁵² Carlos d'Abbrera, 'Capacity in Mental Health Law: Are We Heading in the Right Direction?' (2015) 49(9) *Australian & New Zealand Journal of Psychiatry* [843]; DA Treffert, 'Dying with Their Rights On' (1973) 130(9) *The American Journal of Psychiatry* [1041].

⁵³ *Mental Health Act 2014* (Vic) (Austl) s 11(1)(a).

⁵⁴ *Ibid* s 11(1)(c).

⁵⁵ *Ibid* s 11(1)(d).

empowerment, challenging professional paternalism...',⁵⁶ however it seems problematic that external advocacy is required to address professional paternalism, which seems an issue professions should be dealing with directly. Until the mental health system adequately responds to this tension, advocates will be a necessary element of the mental health landscape, and could be seen as a method for achieving a mental health service system, which is both rights based and responsive to need.

It was clear that participants understood that advocates were largely successful in involving people in decisions, albeit not always in achieving tangible outcomes. This is consistent with other studies which have highlighted a similar effect.⁵⁷ These studies also identified high levels of satisfaction from people receiving advocacy, despite fundamental rights such as the right to liberty or the right to choose and refuse treatment, being abridged.⁵⁸ This is difficult to quantify⁵⁹ but nevertheless a potential benefit of models such as employed by IMHA.

(V) (b) POWER AND CO-OPTION

An analysis of the interactions described by the participants is complex, with decision makers, such as psychiatrists, holding statutory power to make decisions, but also the power to reward behaviour, coerce and punish for non-compliance, and power which stems from the expertise and social status of their profession.⁶⁰ Despite this seemingly overwhelming domination of the decision-maker, there are two main ways in which representational advocates identified an ability to exercise power – statutory rights under the Act and, in the absence of statutory powers, relational leverage.

Without statutory powers, the Victorian IMHA model has not been able to rely on legal frameworks to engage mental health services. This is in contrast with the Western Australian model, where advocates have powers to visit persons, inspect any part of a mental health service, make inquiries and copy documents, and where the legislation provides for criminal offences for people who interfere with the exercise of these powers.⁶¹ Operating in this context, the Victorian IMHA module uses a relational approach, as highlighted by the participants in this study. This relational aspect raises questions regarding the independence of the advocates, who must form enduring professional relationships. This may give rise to their own institutionalisation, as the daily human rights infringements of compulsory mental health assessment and treatment become normalised, or as they are potentially co-opted into the best interest model, which dominates the service system. The necessary but potentially corrupting relationship should be the focus of future study, although there was no sense from the participants that this had become a problem, and other studies have shown that

⁵⁶ Newbigging et al, above n 43, 314.

⁵⁷ Newbigging et al, above n 9; Maylea et al, above n 7.

⁵⁸ Ibid Maylea et al, above n 7; Van der Pluym, above n 28.

⁵⁹ Beaupert, above n 1; Maureen C Olley and James RP Ogloff, 'Patients' Rights Advocacy: Implications for Program Design and Implementation' (1995) 22(4) *The journal of mental health administration* 368.

⁶⁰ John RP French Jr. and Bertram Raven, 'The Bases of Social Power.' in *Studies In Social Power*. (Univer. Michigan, 1959) [150].

⁶¹ *Mental Health Act 2014* (WA) (Austl) ss 359, 362.

consumers value their advocates having close relationships with treating teams, as it makes them more effective.⁶² The importance of good relationships was also recognised in the review of the UK IMHA services, which found that close relationships made referral routine, and that:

... effective working relationships reflected a mutual understanding of roles and expectations and the constraints each work under. In these circumstances, professionals drew a clear distinction between independent advocacy and 'best interests', and perceived challenges to professional opinion were met with equanimity.⁶³

IMHA have developed a number of strategies to reduce the risk of co-option or institutionalisation, by maintaining independence from the mental health system, including supervision, support and reporting lines outside of mental health services, and consumer guidance from the VLA's advisory group, *Speaking From Experience*.

(V) (c) CAPACITY BUILDING AND SYSTEMIC CHANGE

Ideas of systemic reform are explicit in the IMHA model, which includes both building the capacity of people to advocate for themselves, and the explicit focus on systemic advocacy. The first of these features, the focus on capacity building, has both pragmatic and ideological aspects. Every person who is better able to self-advocate is less likely to require advocacy support in the future, reducing their reliance on funded advocacy services and freeing up resources for others. Self-advocacy capacity building is also consistent with the recovery approach, which prioritises the subjective, self-defined, person centred approach to mental health.⁶⁴

In addition, while this study shows no definitive evidence of this, it can certainly be imagined that with an increase in self-advocacy skills across the population of people being compulsorily treated, there arises a corresponding tendency in the clinicians and decision makers who are enforcing compulsory treatment to be receptive to advocacy. In this way, people who are better able to self-advocate themselves hold decision makers to account, supporting a systemic reform agenda. This may make self-advocacy capacity building a potent force in system reform, as well as a pragmatic response to resourcing constraints and a key element of recovery-oriented practice.

However self-advocacy capacity building is not in itself a panacea, as even people who are able to self-advocate well under normal conditions may struggle to do so while in mental distress, or while subject to coercion or force. There is also no use in people feeling empowered to express their own opinions if the service system is unresponsive to their wishes. Users of mental health services have long advocated for more inclusion,⁶⁵ and much work remains to be done. IMHA's adoption of a systemic advocacy mandate may go some way to addressing this, representing the voices of consumers in the broader mental health system, in a way that is more difficult for

⁶² Maylea et al, above n 7.

⁶³ Newbigging et al, above n 43, [321].

⁶⁴ Ann McCranie and David Pilgrim, *Recovery and Mental Health: A Critical Sociological Account*. (Macmillan International Higher Education, 2013).

⁶⁵ Nancy Tomes, 'The Patient As A Policy Factor: A Historical Case Study Of The Consumer/Survivor Movement In Mental Health' (2006) 25(3) *Health Affairs; Chevy Chase*, [720].

services and policy makers to ignore. As identified above, this is not a straightforward process, and further research should explore the nature of systemic advocacy processes within a representational model, however the existence of such advocacy services, and the political willingness to fund them, may signal an important next step on the path to inclusive, compassionate and responsive mental health services.

Conversely, the inclusion of non-legal advocacy within a substituted decision-making regime, such as the Victorian context, may simply act as a veneer of a rights-based approach over what is still a best-interests system. The inclusion of advocates does not make the Victorian scheme compliant with the CPRD.⁶⁶ Participants of this study certainly viewed themselves as shifting the system towards a rights-based approach, however this veneer of rights has the potential to legitimise and perpetuate the substituted decision-making regime it exists within. This is particularly problematic when advocacy is framed, as in this paper, as finding a balance in the tensions between the two irreconcilable approaches – one of which being clearly dominant. This is a question of individual and professional ethics but should be considered in assessments of advocacy services' broader systemic impact.

VI. LIMITATIONS

This study does not seek complete objectivity, with three of the authors closely involved with IMHA. This approach was chosen to give the greatest depth and understanding of the model presented in this study. As co-produced, consumer led research, this also allowed for each researcher to guide and support the others in their respective areas of expertise.

This study had a small sample size of 13 participants, and the single interview format and relatively short interviews are reflective of resourcing constraints. The interviews were conducted by the Chief Investigator, whose role as Senior Consumer Consultant has no line management responsibilities for any participants, although this position within the organisation and relationship with participants could be expected to introduce some bias. As with any qualitative research, complete objectivity is not the main research goal, and this research design allows for a rounded and critically reflective illustration of the IMHA model.

Furthermore, this is a study of a single, unique, new and still developing program; one example of representative advocacy which can inform the development of other advocacy programs and approaches in other jurisdictions but should not be taken as a definitive example of mental health advocacy.

VII. CONCLUSION

This paper has focused mainly on the complexities and difficulties associated with representative advocacy, however the main finding of this research is the support this model had from the participants, who saw it as working to address one of the most troubling tensions in mental health care – the perceived need for coercion and

⁶⁶ Maylea and Hirsch, above n 5.

substituted decision-making. Representational advocacy provides a clear, easily transferable and tested framework for engaging in supported decision-making processes with people in the mental health system. This system has so far not succeeded in ensuring peoples' rights are maintained, particularly peoples' rights to be involved in decisions about their treatment, but representational advocacy provides an opportunity to address this basic human right.

THE RIGHT TO INDEPENDENT LIVING AND BEING INCLUDED IN THE COMMUNITY: LESSONS FROM THE UNITED NATIONS

PIERS GOODING*

ABSTRACT

This review will consider recent United Nations activity on article 19 of the Convention on the Rights of Persons with Disabilities (CRPD) concerning the right to live independently and be included in the community. The Committee on the Rights of Persons with Disabilities adopted its 'General Comment' No. 5 in August 2017, which offers guidance to governments on art 19 implementation. This review critically examines content relevant to mental health and capacity law, policy and practice. It considers the strengths and potential limitations of the General Comment with reference to key issues in the field. Gaps include commentary on the rising marketisation of disability services globally and a focus on low and middle-income countries. Yet overall, the General Comment offers useful guidance on implementing this unusual right, including concepts that may help resolve controversies about the role of coercion in mental health and capacity law.

Key words: CRPD; Convention on the Rights of Persons with Disability; disability; independent living; human rights

I. INTRODUCTION

The institutionalisation and exclusion of persons with disabilities has caused – and continues to cause – immense harm to individuals, families and communities. Resistance to this harm in international human rights law led to the development of a 'right of all persons with disabilities to live in the community, with choices equal to others' in art 19 of the Convention on the Rights of Persons with Disabilities ('CRPD').¹

The unusual provision is highly relevant to mental health and capacity law.² On one hand, mental health and capacity laws can serve to deprive people of liberty in hospitals and other places, including locked wards, hospitals and residential facilities.³ On the

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¹ United Nations [UN] 2515 UNTS 3, UN Doc A/Res/61/106, Annex, GAOR 61st Session Supp 49, 65. (Adopted) 13 Dec 2006, (Opened for Signature) 30 May 2007, (Entered Into Force) 3 May 2008.

² I am using 'mental health and capacity law' in this paper to refer to mental health legislation and other laws related to mental capacity and legal capacity, including those that authorise substituted and/or supported decision-making, E.g. – The Mental Capacity Act 2005 (England and Wales) c 9; Assisted Decision-Making (Capacity) Act 2015 (Ireland) No 64 of 2015; Representation Agreement Act 1996 (Revised Statutes of British Columbia R.S.B.C.) c 405.

³ Agnes Turnpenny and colleagues, for example, note in their survey of mental health policy in 35 European countries, how mental health law can serve as a 'pathway into residential institutions'. A Turnpenny, G Petri, A Finn, J Beadle-Brown and M Nyman, *Mapping and Understanding Exclusion: Institutional, coercive and community-based services and practices across Europe* (Mental Health Europe, 2018) [24] <<https://doi.org/10.22024/UniKent/01.02/64970>> (accessed 12/02/2018).

other hand, 'rights-based mental health legislation'⁴ and late 20th Century guardianship/mental capacity laws in middle and high-income countries were partly introduced to help move people *away* from large, standalone institutions and to promote 'community care'. While the success of 'deinstitutionalisation' may be disputed, it is true that liberal law reformers sought to limit interventions to the 'least restrictive means available' and facilitate access to non-institutional, community-based services.⁵ A third dimension in the relevance of independent living is that the absence of community-based support for independent living can contribute to the types of crises that 'warrant' intervention under the terms of mental health and capacity laws. Civil commitment laws may be invoked after a person's mental health crisis is exacerbated by unstable housing or institutional-like community services. Mental capacity and guardianship law may be invoked when a person with cognitive disability faces a major life decision and is in a situation of extreme risk because of their sheer social isolation.

Mental health and capacity law has provoked considerable controversy since the CRPD came into effect, yet Art 19 seems to draw an unusual consensus. Commentators across the spectrum – from those who see a role for coercion and substituted decision-making, to those who think they should be eliminated – appear to agree on the need for more resources for people with intellectual, cognitive and psychosocial disabilities so as to enable them to exercise their right to live independently and participate in the community. As such, the 2017 release by the 'Committee on the Rights of Persons with Disabilities' (hereafter 'the Committee') of its *General Comment no. 5 on art 19*, will be welcomed by many.⁶

The Committee is established by Article 34 of the CRPD and is comprised of a panel of experts that monitors implementation, including by reviewing the compliance of governments that have signed and ratified the CRPD. A 'General Comment' is a quasi-legal document published by United Nations committees, which provides a detailed interpretation of an article or issue relating to their respective human rights treaties. Helen Keller and Leena Grover have described General Comments as 'non-binding norms that interpret and add detail to the rights and obligations contained in the respective human rights treaties'.⁷

⁴ B McSherry and P Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart 2010).

⁵ According to Larry Gostin, statutory duties introduced under rights-based mental health law included those designed to secure individual rights, including rights to access services and refuse medical treatment. L Gostin, 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in P Bean (ed), *Mental Illness: Changes and Trends* (Wiley, 1983) [50].

⁶ Committee on the Rights of Persons with Disabilities, *General Comment No 5: Article 19 (2017) on living independently and being included in the community*, 18th sess, UN Doc CRPD/C/GC/5 (27 October 2017). The Committee is authorised under article 34 of the CRPD to monitor implementation of the CRPD; including reviewing the compliance reports of 'States Parties' (states that have ratified, or have otherwise become party to the CRPD) and offering interpretive guidance on key elements of the CRPD. CRPD Art 34. 'General Comments' allow the relevant UN treaty body, in this case the CRPD Committee, to publicly interpret provisions from their respective human rights treaty. For more information on the legal status of General Comments, see — Michalowski, S, and W Martin, 'MoJ/EAP UNCRPD Project Research Note: The Legal Status of General Comments' (The Essex Autonomy Project, 23 May 2014) <www.autonomy.essex.ac.uk> (accessed 12/02/2018).

⁷ H Keller and L Grover, 'General Comments of the Human Rights Committee and their Legitimacy' in H Keller and G Ulfstein (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy* (Cambridge University Press, 2012) [116], [129].

In this paper I will distil content relevant to mental health and capacity law from the CRPD Committees General Comment no. 5 (hereafter 'the General Comment'). Throughout, I will reflect on, among other issues, the inter-related matters of housing and economic policy, hospital practices, the privatisation and personalisation of welfare services, the issues facing low- and middle-income countries (including countries without mental health legislation).

II. BACKGROUND

The full text of Art 19 is as follows:

Living independently and being included in the community—

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

There is a small but significant body of literature on article 19.⁸ This material builds on a vast literature on disability and 'independent living', which variously refers to: a philosophy of equal opportunities, self-determination and respect,⁹ a global social movement¹⁰ and a framework for developing law, policy and practice.¹¹

Art 19 exemplifies efforts to blend so-called first-and second-generation rights. In other words, the civil and political rights of the provision (particularly, the right to liberty of movement and freedom to choose one's residence) requires the provision of economic, cultural and social rights (for example, the right to an adequate standard of living, including adequate clothing, food and housing). Additional resources are needed to

⁸ E.g. – G Quinn and S Doyle, 'Taking the United Nations Convention on the Rights of Persons with Disabilities Seriously: The Past and Future of the EU Structural Funds as a Tool to Achieve Community Living' (2012) 9 *The Equal Rights Review* [69]; Fundamental Rights Association, *Human Rights Indicators on Article 19 of the CRPD* (2014); Council of Europe Commissioner for Human Rights, "The Right of People with Disabilities to Live Independently and Be Included in the Community", Comm DH/Issue Paper (2012) [3], Strasbourg, 13 March 2012.

⁹ C Barnes, 'Independent Living, Politics and Policy in the United Kingdom: A Social Model Account' (2014) 1(4) *Review of Disability Studies: An International Journal*.

¹⁰ E.g. – P Deegan, 'The Independent Living Movement and People with Psychiatric Disabilities: Taking Back Control over Our Own Lives' (1992) 15 *Psychosocial Rehabilitation Journal* [3].

¹¹ G DeJong, 'Independent Living: From Social Movement to Analytic Paradigm' (1979) 60(10) *Archives of physical medicine and rehabilitation* [435]; Barnes, above n 9.

make civil and political rights real to many disabled people, whereas many non-disabled people take such rights for granted.

The European Commissioner for Human Rights, Thomas Hammarberg, argued that the indivisibility of rights in Art 19 is the key to addressing the devastation caused by institutionalisation and exclusion:

[t]he core of the right, which is not covered by the sum of the other rights, is about neutralising the devastating isolation and loss of control over one's life, wrought on people with disabilities because of their need for support against the background of an inaccessible society. 'Neutralising' is understood as both removing the barriers to community access in housing and other domains, and providing access to individualised disability-related supports on which enjoyment of this right depends for many individuals.¹²

The Commissioner suggests that new regulatory measures and funding priorities are needed to meet this objective. To this end, the European Fundamental Rights Association developed policy indicators to assess Art 19 compliance.¹³ The indicators were drawn upon by the European Parliament, in order to withdraw 'European Structural and Investment Funds' from the funding of disability institutions.¹⁴

However, closing institutions is but one requirement of Art 19. Hammarberg highlighted 'worrying trends' of standalone institutions being replaced by group-based homes and residential facilities; 'targeted exclusively to persons with disabilities'.¹⁵ These facilities, he writes: 'compromise the individual's ability to choose or to interact with and be included in the community'.¹⁶ Gerard Quinn and Suzanne Doyle elaborate on the Art 19 obligations that spread beyond institutional closures and extend to establishing 'a web of personalised supports to meet the personal circumstances of the person'.¹⁷

This is not so much about needs and services – it is more about the silent revolution in traditional understandings of welfare which is to get away from gross proxies of need (with equally gross services) and to focus instead on the life plans and ambitions of the person.¹⁸

From this view, Art 19 operates to both prohibit institutional models of supported accommodation and paternalistic domination, while also requiring national investment in community-based living options.

Statute and case law have been influenced by Art 19 in some jurisdictions. For example, courts have referred to Art 19 in several decisions in the United Kingdom;¹⁹ New

¹² T Hammarberg, 'The Right of People with Disabilities to Live Independently and be Included in the Community' (Issue Paper, Council of Europe Commissioner for Human Rights, June 2012) [8].

¹³ Fundamental Rights Association, *Human Rights Indicators on Article 19 of the CRPD* (2014).

¹⁴ Community Living for Europe, Structural Funds Watch, *Building on the Promise of European Structural and Investment Funds into the Future, Report on roundtable discussions in the European Parliament - 1st December 2016* (2016) <www.communitylivingforeurope.org/2016/12/15/report-on-roundtable-discussions-in-the-european-parliament-on-1st-december-2016-outcomes-and-video-recording/> (accessed 20/5/2017).

¹⁵ Council of Europe Commissioner for Human Rights, above n 8, [9].

¹⁶ *Ibid.*

¹⁷ Quinn and Doyle, above n 8, [73].

¹⁸ *Ibid.*

¹⁹ *Burnip v Birmingham City Council & Anor* [2012] EWCA Civ 629.

Zealand;²⁰ and Australia²¹ – generally to limit interference by health and social services on the living arrangements of disabled people. Some legislation may even incorporate features of Art 19.²² The Department of Health in England, for example, reported that the ‘wellbeing principle’ of the *Care Act 2014*, which guides service delivery by local authorities; ‘is intended to cover the key components of independent living as expressed in the [CRPD and] in particular, Article 19’.²³ It is not clear whether *The Care Act 2014* actually incorporates Art 19 in practice,²⁴ and the CRPD Committee has expressed concern that the United Kingdom has reduced social protection schemes for housing; household income and budgets for independent living, including the ‘Independent Living Fund’.²⁵ Nevertheless, these examples, including European parliamentary steps to divest from institutions, suggest Art 19 is having some impact on law, policy and practice internationally.

Art 19 raises several questions for governments. To what extent must states respect a person’s right to choose where to live, even in the face of grave risks? What level of supports and adjustments need to be guaranteed to meet positive obligations and avoid a charge of neglect and abuse? At what point, if at all, can intervention take place that might violate the right to independent living – for example, in short-term accommodation or hospitalisation? Is Art 19 violated by small group homes and clustered living arrangements, which appear to be fixtures of many disability housing policies affecting persons who fall under mental health and capacity laws? What are good practices for upholding Art 19 for people with mental health, cognitive and intellectual disabilities?

Just prior to the release of the General Comment, the Office of the United Nations High Commissioner for Human Rights (hereafter ‘OHCHR’) published a background paper.²⁶ The publication includes contributions from Member States, regional organisations, disabled peoples’ organisations, broader civil society organisations, the Special Rapporteur on Disability, national human rights institutions and others.²⁷ A day of general discussion in April 2017 also preceded the General Comment, for which written submissions are publicly available.²⁸ Taken together, these materials form a rich

²⁰ *Ministry of Health v Atkinson* [2012] NZCA 184; [2012] 3 NZLR 456 (14 May 2012) [42]; *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345.

²¹ *P J B v Melbourne Health & Anor (Patrick’s case)* [2011] VSC 327 (19 July 2011) [210].

²² Department of Health (United Kingdom), *Guidance: Care and support statutory guidance* (Updated 24 February 2017) <www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> (accessed 5/05/2017); *Care Act (England) 2014* Ch 23 Pt 1 s 1; see also — *Social Services and Well-being (Wales) Act 2014* anaw 4.

²³ Department of Health (United Kingdom), above n 22, (para) 1.19; *Care Act 2014* Ch 23 Pt 1 s 1.

²⁴ L Series, ‘The elusive Article 19’ on L Series, *The Small Places* (24 Nov 2016) <<https://thesmallplaces.wordpress.com>> (accessed 12/02/18).

²⁵ CRPD/C/GBR/CO/1, (para) 44(b).

²⁶ *Thematic study on the right of persons with disabilities to live independently and be included in the community Report of the Office of the United Nations High Commissioner for Human Rights*, 28th sess, UN Doc, A/HRC/28/37, 12 December 2014.

²⁷ For the full text of submissions, see:

<www.ohchr.org/EN/Issues/Disability/Pages/LiveIndependently.aspx> (accessed 5/05/2017).

²⁸ See: <www.ohchr.org/EN/HRBodies/CRPD/Pages/CallDGDtoliveindependently.aspx>

resource in global efforts to reduce exclusion, and promote independent living and inclusive communities.

III. A SUMMARY OF THE GENERAL COMMENT

The General Comment is grouped into four major sections, related to: (1) the normative content of Art 19, (2) the obligations of States Parties, (3) the relationship of Art 19 to other parts of the CRPD, and (4) national implementation. I will summarise these sections here, though readers familiar with the General Comment may wish to jump straight to Part IV.

(a) Normative Content

The General Comment immediately positions Art 19 as a response to the historical denial of the individual choice and control of disabled person across all areas of their lives.²⁹ As the Committee notes:

[i]ndependent living and inclusive life in the community are ideas that historically stemmed from persons with disabilities asserting control over the way they want to live by creating empowering forms of support'.³⁰

For most people with disability: '[s]upport is either unavailable or tied to particular living arrangements'³¹, and the result for many has been 'abandonment, dependence on family, institutionalization, isolation and segregation'.³² The Committee characterise most law, policy and practice as tending to portray individuals with the disability as the problem. Traditionally, efforts have been directed to altering the behaviour of the individual and forcing her or him to fit into social structures that are unaccommodating and even hostile to people with disability. Hence, the Committee emphasise two dimensions of Art 19: the personal (particularly, creating a sphere of protection around the person's home, lifestyle choices, and so on) and the social (particularly, improving the accessibility and inclusivity of communities).

The Committee highlight that Art 19:

[i]s an example of the interrelation, interdependence and indivisibility of all human rights', describing it as 'one of the widest ranging and most intersectional articles of the Convention [which] has to be considered as integral to [its] full implementation'.³³

The Committee also restates from the CRPD Preamble that most persons with disabilities live in poverty, emphasising the material conditions in which independent living can occur. At the same time, the Committee highlight that the 'cost of social exclusion is high as it perpetuates dependency'.³⁴

(accessed 5/05/2017).

²⁹ CRPD Committee, above n 6, [4].

³⁰ Ibid [4].

³¹ Ibid [1].

³² Ibid [1].

³³ Ibid [6].

³⁴ Ibid [5].

Furthermore:

[p]olicies and concrete plans of action for social inclusion of persons with disabilities... represent a cost-effective mechanism to ensure the enjoyment of rights, sustainable development and a reduction in poverty.³⁵

The Committee links Art 19 to previous human rights treaties.³⁶ The Universal Declaration of Human Rights (hereafter “UDHR”), for example, recognises the interdependence of an individual’s personal development and his or her social and community life. Art 29(1) of the UDHR states:

Everyone has duties to the community in which alone the free and full development of his personality is possible.³⁷

For those who have seen—or themselves experienced—the way peoples identities are spoiled in institutional environments, the relevance of free and full development of personality will be immediately obvious. The restatement in Art 19 of the right to choose one’s place of residence also stands as an integral part of several human rights instruments.³⁸

(b) The Obligations of State Parties

The Committee discuss the obligations on States Parties to ‘respect’, ‘protect’ and ‘fulfil’. The first of these obligations, the obligation to *respect* refers to governments refraining from interference in a person’s autonomy and his or her choices about where and with whom to live.³⁹ This obligation includes:

Releas[ing] all individuals who are confined against their will in mental health services or other disability-specific forms of deprivation of liberty. It further includes the prohibition of all forms of guardianship and the obligation to replace substituted decision-making regimes with supported decision-making alternatives.⁴⁰

The second obligation, to *protect*, relates to states preventing ‘third parties from directly or indirectly interfering with the enjoyment of the right to live independently within the community’, which includes ‘family members and third parties, service providers, landowners or providers of general services’.⁴¹ Positive obligations include improving ‘accessibility for persons with disabilities within the community and [raising]

³⁵ Ibid.

³⁶ The Convention on the Elimination of Discrimination against Women UN Doc A/RES/34/180, Annex (CEDAW) is discussed, as is the Convention on the Rights of the Child (United Nations [UN]) 1577 UNTS 3, CTS 1992/3, UN Doc A/RES/44/25, UN Reg No I-27531 (CRC). See — CRPD Committee, above n 6, [10-11].

³⁷ Universal Declaration of Human Rights (United Nations [UN]) UN Doc A/810, 71, UN Doc A/RES/217(III) A, GAOR 3rd Session Part I, 71 (Singed) 10 Dec 1948,[art 29 (1)].

³⁸ E.g. – UDHR, article 13; ICCPR, articles 12, 25.

³⁹ CRPD Committee, above n 6, [47-49].

⁴⁰ Ibid [48].

⁴¹ Ibid [50].

awareness among all persons in society about inclusion of persons with disabilities within the community'.⁴²

The third obligation, to *fulfil*, refers to the creation of 'appropriate legislative, administrative, budgetary, judicial, promotional and other measures' to meet Art 19 requirements, including: 'deinstitutionalising', consulting with disabled peoples organisations in crafting alternatives, ensuring affordable housing, moving away from deficit-focused assessments of impairment as a pre-requisite for services and instead looking to a person's support needs, and personalising services accordingly.⁴³ The Committee also promotes access to justice, including through 'reasonable accommodation' (article 2)⁴⁴ and 'procedural accommodation' (article 13)⁴⁵ so that persons with disabilities can assert their right to independent and community living and have it enforced.⁴⁶

(c) Relationship to other Articles

The General Comment contains a reasonably comprehensive section on the relationship between article 19 and other parts of the CRPD. Particular attention is paid to Art 4(3) (in which consultation with disabled people is required),⁴⁷ Art 5 (equality and non-discrimination),⁴⁸ Art 6 (intersectional barriers facing women and girls),⁴⁹ and so on.⁵⁰ I will discuss in the next Section the Committees view on interactions between Art 19 and key operative articles affecting mental health and capacity law, particularly articles: 12 (equal recognition before the law); 14 (liberty and security of the person), 16 (freedom from exploitation, violence and abuse), 23 (the right to family for children and parents with disabilities), and 25 (health care).⁵¹ The connections between Art 19 and other parts of the CRPD helps to connect the concept of independent living across different points of a person's typical life-course; as a child, a student, a worker, a voter, a family member, senior citizen, and so on.⁵²

⁴² Ibid [57]. See also — Concluding Observations by the CRPD Committee on Kenya (CRPD/C/KEN/CO/1 [23]), Uganda (CRPD/C/UGA/CO/1 [22]).

⁴³ CRPD Committee, above n 6, [54-65].

⁴⁴ 'Reasonable accommodation' is defined in the CRPD as 'necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms'. CRPD, Article 2.

⁴⁵ 'Procedural accommodation' is defined in the CRPD as measures that facilitate a person's 'effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages'. CRPD Article 13.

⁴⁶ Ibid [66] and [81].

⁴⁷ Ibid [70].

⁴⁸ Ibid [71].

⁴⁹ Ibid [72].

⁵⁰ Ibid [73-77].

⁵¹ Ibid [78-91].

⁵² On this point, the Mental Disability Advocacy Centre (now 'Validity') submission is informative. Mental Disability Advocacy Centre, 'The Right to Live Independently and be Included in the Community - Written Comments to the UN Committee on the Rights of Persons with Disabilities in response to its Call for Submissions to the Day of General Discussion on 19 April 2016 <<http://www.ohchr.org>> (accessed 6 February 2018).

(d) Implementation at the National Level

The Committee identify key elements needed for States Parties to realise a 'standardized minimum support level sufficient to allow the exercise of the right to live independently and be included in the community'.⁵³ These elements include: ensuring the right to legal capacity; ensuring non-discrimination in accessing housing ('including the elements of both income and accessibility'); developing action plans for independent living for persons with disabilities within the community; monitoring and sanctioning non-compliance with legislation; developing plans and guidance on accessibility requirements for basic mainstream services; taking steps towards developing and implementing 'basic, personalized, non-shared and rights-based disability-specific support services'; and collecting 'consistent quantitative and qualitative data on persons with disabilities, including those still living in institutions'.⁵⁴ Failure to ensure any of these elements to persons with disabilities counts as a failure to fulfill States Parties' Art 19 obligations, according to the Committee.⁵⁵

The Committee distinguishes between parts of Art 19 subject to 'immediate and progressive realisation'. The Committee note that: '[a]s a civil right, article 19(a), the right to choose one's residence and where, how and with whom to live, is immediately applicable'.⁵⁶ In contrast, both 19(b) and (c) are 'subject to progressive realization',⁵⁷ given that Art 19(b) 'is a classic social right', and Art 19(c) 'is a social and a cultural right, given that many community services, such as cinemas, public parks, theatres and sports facilities, serve cultural purposes'. Nevertheless, States Parties must:

[t]ake steps to the maximum of their available resources .. taken immediately or within a reasonably short period of time .. (and in a way that is) .. deliberate, concrete, targeted and .. (pursued by) .. all appropriate means.⁵⁸

The Committee acknowledge 'advancements in implementing article 19 in the past decade' yet frame the Comment by listing major barriers to this implementation. These barriers are worth citing in full:

- (a) Denial of legal capacity, either through formal laws and practices or de facto by substitute decision-making about living arrangements;
- (b) Inadequacy of social support and protection schemes for ensuring living independently within the community;
- (c) Inadequacy of legal frameworks and budget allocations aimed at providing personal assistance and individualized support;
- (d) Physical and regulatory institutionalization, including of children and forced treatment in all its forms;
- (e) Lack of deinstitutionalization strategies and plans and continued investments in institutional care settings;

⁵³ CRPD Committee, above n 6 [38].

⁵⁴ Ibid [38][a-h].

⁵⁵ Ibid [43], See -- International Covenant on Civil and Political Rights (United Nations [UN]) 999 UNTS 171, UN Doc A/6316, UN Doc A/RES/2200(XXI), Annex, UN Reg No I-14668 [Signed] 19 Dec 1966 [Entered into Force] 23 Mar 1976, [Article 2].

⁵⁶ CRPD Committee, above n 6, [39].

⁵⁷ Ibid. *International Covenant on Civil and Political Rights*, [Article 2(1)].

⁵⁸ CRPD Committee, above n 6, [41].

- (f) Negative attitudes, stigma and stereotypes preventing persons with disabilities from being included in the community and accessing available assistance;
- (g) Misconceptions about the right to living independently within the community;
- (h) Lack of available, acceptable, affordable, accessible and adaptable services and facilities, such as transport, health care, schools, public spaces, housing, theatres, cinemas, goods and services and public buildings;
- (i) Lack of adequate monitoring mechanisms for ensuring the appropriate implementation of article 19, including the participation of representative organizations of persons with disabilities;
- (j) Insufficient mainstreaming of disability in general budget allocations;
- (k) Inappropriate decentralization, resulting in disparities between local authorities and unequal chances of living independently within the community in a State party.⁵⁹

Each of these barriers can be seen to operate in the mental health and capacity law context in some way. Many of these barriers more closely concern policy, including budgets; awareness-raising, and closing institutions and institutional environments. Explicit legal matters are raised at paragraph 15 subsections (a) and (d), regarding legal capacity restrictions and forced treatment.

IV. DISCUSSION

Several features of the General Comment stand out as being immediately relevant to this review.

(a) Definitions

The Committee usefully define terms such as 'independent living', 'community living', and 'personal assistance'.⁶⁰ Independent living is premised upon *interdependence* as the natural state of human being:

Independent living/living independently means that individuals with disabilities are provided with all necessary means to enable them to exercise choice and control over their lives and make all decisions concerning their lives... Independent living is an essential part of the individual's autonomy and freedom and does not necessarily mean living alone. It should also not be interpreted solely as the ability to carry out daily activities by oneself. Rather, it should be regarded as the freedom to choose and control, in line with the respect for inherent dignity and individual autonomy as enshrined in article 3 (a) of the Convention.⁶¹

The Committee was almost certainly influenced in its understanding of interdependence by Jenny Morris and the conceptual inroads of other ethics of care scholars.⁶² The 2017 report of Catalina Devandas, the United Nations Special Rapporteur on the Rights of Persons with Disabilities, on rights-based support also elaborates on interdependence, offering a useful supplement to the General Comment (and an informative report in its own right).⁶³

⁵⁹ CRPD Committee, above n 6, [15].

⁶⁰ Ibid [16](a-d).

⁶¹ Ibid [16](a).

⁶² E.g. – J Morris, 'Impairment and disability: constructing an ethics of care that promotes human rights', (2001) 16(1) *Hypatia* [1].

⁶³ Human Rights Council, 'Report of the Special Rapporteur on the rights of persons with disabilities' UN Doc, 34th sess, A/HRC/34/58 (20 December 2016).

The Committee define the inverse concept of 'institutionalisation' quite broadly:

[i]t is not "just" about living in a particular building or setting; it is, first and foremost, about not losing personal choice and autonomy as a result of the imposition of certain life and living arrangements... [N]either large scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals, *nor even individual homes* can be called independent living arrangements if they have other defining elements of institutions or institutionalization.⁶⁴

Defining elements of institutionalisation include:

[o]bligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and usually also a disproportion in the number of persons with disabilities living in the same environment. Institutional settings may offer persons with disabilities a certain degree of choice and control; however, these choices are limited to specific areas of life and do not change the segregating character of institutions.⁶⁵

This definition expands on Erving Goffman's concept of 'total institution',⁶⁶ and is likely to challenge all governments, whether concerning large-standalone institutions and other largescale sites of congregation, residential facilities, group homes or even family homes with a segregating character.

The definitions in the General Comment are surely valuable. Terminology in this area is often technical, and sector or discipline-specific. 'Person-centred', 'social inclusion', 'empowerment' and 'peer-support', for example, are commonly used in policy, scholarship, advocacy, programming and elsewhere, often without a clear sense of what precisely is meant. Tribunals, courts, policymakers, service providers, may not acknowledge the intended meaning, cloaking the underlying purposes of their use, which remain at best only vaguely stated. Participants in debates risk misunderstanding one another. Even the term 'community' may be misused or used vaguely in ways that describe practices that would fall squarely within the Committees definition of 'institutional'.⁶⁷

⁶⁴ CRPD Committee, above n 6, [15](c) (emphasis added).

⁶⁵ Ibid.

⁶⁶ See — E Goffman, 'On the characteristics of total institutions' in *Symposium on preventive and social psychiatry*, Walter Reed Army Medical Centre, 1961, [312].

⁶⁷ This point is made by the WNUSP in its submission: [t]he use of the term community in [Art 19] must be distinguished from that which may be artificially created within settings that amount to deprivations of liberty. Communities should be identified to be neighbourhoods, integrated schools, free labour market workplaces.' The World Network of Users and Survivors of Psychiatry, in its submission to the Committee, produced a useful annexure on this point. World Network of Users and Survivors of Psychiatry (WNUSP) 'Submission of the World Network of Users and Survivors of Psychiatry (WNUSP) for the Day of General Discussion (DGD) on the right of persons with disabilities to live independently and be included in the community, to be held on 19 April 2016 in Geneva', fn 5 <<http://www.ohchr.org>> (accessed 6 February 2018).

Interestingly, the Committee expressed concerns over terminology misuse more explicitly in the *draft* General Comment. ‘Independent and community living’ and ‘personal assistance’ were described as ‘frequently used by organizations providing residential or institutional support services [in ways that] that mislead assumptions by the public’.⁶⁸ The paragraph was removed in the final General Comment, but similar sentiments remained elsewhere in the final text.⁶⁹

(b) Mental Health and other Substituted Decision-Making Legislation

The Committee re-states its explicit rejection of mental health legislation and all forms of substituted decision-making.⁷⁰ States must:

[r]epeal all laws that prevent any person with disabilities, regardless of the type of impairment, to choose where and with whom and how to live, including the right not to be confined on the basis of any kind of disability.⁷¹

For the Committee:

[n]either the full or partial deprivation of any “degree” of legal capacity nor the level of support required may be invoked to deny or limit the right to independence and independent living in the community to persons with disabilities.⁷²

The Committee reject ‘forced treatment in all its forms’ as one of the barriers to independent living and community participation,⁷³ making clear that interventions under mental health or mental capacity laws cannot be construed as somehow ‘facilitating’ the right to live independently and be included in the community. This position will frustrate those who see involuntary treatment or deputyship /guardianship as a ‘tincture of coercion’ that can restore a person’s agency and ability to take part in community. An example might be a person in sheer psychosis living on the street who refuses all help but after a short period of forced treatment, willingly seeks support and moves to ‘safer’ living conditions.⁷⁴ Another example might be a temporary intervention under mental capacity law to remove a person with a cognitive disability who faces daily substituted decisions, and even abuse, by an overbearing parent, yet who wishes to remain in the house.⁷⁵

From the Committees view, even if substituted decision-making can serve these functions in *some* circumstances, intervention against the will and preference of a

⁶⁸ CRPD Committee, above n 6, [16].

⁶⁹ Ibid [51].

⁷⁰ See — Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition Before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014); Guidelines on the right to liberty and security of persons with disabilities (A/72/55, annex).

⁷¹ CRPD Committee, above n 6, [97][a].

⁷² Ibid [20].

⁷³ CRPD Committee, above n 6, [15](d).

⁷⁴ L Rosenbaum, ‘Liberty versus Need — Our Struggle to Care for People with Serious Mental Illness’ (2016) 375(15) *New England Journal of Medicine* [1490].

⁷⁵ For an incisive CRPD-oriented examination of precisely this scenario, see — A Arstein-Kerslake, ‘An Empowering Dependency: Exploring Support for the Exercise of Legal Capacity’ (2016) 18(1) *Scandinavian Journal of Disability Research* [77].

person or removal of the person to an institutional environment is an unacceptable cost. Instead, pathways to independent living and community participation must be created for people in various degrees of crisis and disablement. In addition, states are obligated under articles 4(e) and 5.2 to prohibit discrimination by private actors who refuse to respect the autonomy and legal capacity of persons with disabilities and must find ways to do so that do not intrude on the rights of the victims/survivors.

Locked mental health wards clearly activate Art 19 – even as they may more directly concern Art 14 (right to liberty) – and are a logical site for CRPD-based change. Locked wards have been criticised by several commentators in recent years,⁷⁶ including by some empirical quantitative researchers. Christian Huber and colleagues, for example, published the findings from their 2016 analysis of 349,574 admissions to 21 German psychiatric inpatient hospitals, monitored over a 15-year period. They reported that suicide, suicide attempts, and absconding with return and without return (all major justifications for locking wards) were *not* increased in hospitals with an ‘open door policy’; in contrast, treatment on open wards was associated with a decreased probability of suicide attempts, absconding with return, and absconding without return, but not completed suicide (to which the difference was considered insignificant).⁷⁷ Drawing on the same dataset, the researchers later reported that rates of aggression by service users and others subject to mental health law were lower in wards with an open door policy.⁷⁸ Huber and colleagues concluded by recommending; ‘policies targeted at empowering treatment approaches, respecting the patient’s autonomy and promoting reductions of institutional coercion’.⁷⁹ Their research was not without critics,⁸⁰ but the findings offer some empirical and pragmatic support for rights-based claims against locked wards.

In addition to requiring compliance in mental healthcare settings, Art 19 also seems to require non-hospital alternatives for people who may need support, including support for people in acute crises who may wish to stay in their home. The rather arbitrary dichotomy between ‘hospital’ and ‘community’, which took hold in policy discourse in the post-asylum era (at least in high-income countries), surely reflects a lack of political imagination in conceiving a wide range of supports required for people with psychosocial disability across the population. According to the WNUSP, the broader policy framework required should include reasonable accommodation for people with disabilities to use mainstream community services like legal services, hospitals, shelters (and not just disability-specific services), as well as home-based supports for people in

⁷⁶ See — B McSherry, ‘Locked Mental Health Wards: The Answer to Absconding?’ (2014) 22(1) *Journal of Law and Medicine* [17].

⁷⁷ CG Huber, et al. ‘Suicide Risk and Absconding in Psychiatric Hospitals with and without Open Door Policies: A 15 Year, Observational Study’ (2016) 3(9) *The Lancet Psychiatry* [842].

⁷⁸ AR Schneeberger, et al. ‘Aggression and Violence in Psychiatric Hospitals with and without Open Door Policies: A 15-Year Naturalistic Observational Study’ (2017) 95 *Journal of Psychiatric Research* [189].

⁷⁹ *Ibid.*

⁸⁰ T Pollmächer and T Steinert, ‘Arbitrary Classification of Hospital Policy Regarding Open and Locked Doors.’ (2016) 3(12) *The Lancet Psychiatry* 1103. There is also some evidence produced by Nijman and colleagues that door locking is associated with reduced absconding. H Nijman et al. ‘Door locking and exit security measures on acute psychiatric admission wards’ (2011) 18 *Journal of Psychiatric and Mental Health Nursing* [614].

crisis, recognition of support systems for decision making, the linking of hospitals and registered disabled people's organisations, and prohibiting any sort of linkage between eligibility for accessing services and a person's decision to discontinue or modify treatment directives.⁸¹ Arguably this challenge to the hospital/community binary, particularly in the mental health context, calls for a re-casting of current responses to acute crisis resolution, including the provision of respite services, peer-run respite houses, intensive home-based support, and so on.

The Committee draw out links between Art 12 and 19, which may help uncover common ground among those disputing the value of forced interventions and substituted decision-making:

To fully realize the transition to supported decision-making and implement the rights enshrined in article 12, it is imperative that persons with disabilities have the opportunity to develop and express their wishes and preferences in order to exercise their legal capacity on an equal basis with others. To achieve this, they have to be a part of the community. Furthermore, support in the exercise of legal capacity should be provided using a community-based approach which respects the wishes and preferences of individuals with disabilities.⁸²

In other words, independent living and participation in the community can offer 'building blocks' for a person to exercise his or her standing as a person before the law.⁸³ Having a safe home, a valued social role, and a variety of relationships can help create opportunities to exercise one's autonomy. As an example, consider a person who does not even consider the abuse and violence she experienced in an institution or a group home to constitute a crime. In addition, she may have felt so devalued that she did not raise concerns with authorities for fear of being dismissed. After being supported to move into a home of her own, and establishing friends, neighbours and colleagues, she may come to understand her experience as assault and pursue legal redress.⁸⁴

Housing is another area in which 'building blocks' can be laid for achieving equal recognition before the law (bringing together articles 12, 19, 23 and 28). Housing in the mental health context could include housing that is both aligned and non-aligned to mental health services. Some may refuse any housing attached to mental health services, others may embrace it. 'Housing First' policies and programs are an example of how such support can be provided. Under some iterations of the scheme, people with actual or perceived psychosocial disability who are homeless are supported through intensive case management to move into regular housing, with no requirement that they adhere to treatment plans (even as it is offered).⁸⁵

⁸¹ WNUSP, above n 67, [12].

⁸² CRPD Committee, above n 6, [26].

⁸³ G Quinn, 'Rethinking Personhood: New Directions in Legal Capacity Law and Policy' (Paper, New Foundations for Personhood and Legal Capacity in the 21st Century Conference, University of British Columbia, 29 April 2011) 17 <www.nuigalway.ie>.

⁸⁴ For an example of this dynamic for a person with intellectual disability, see e.g. – Jane Rosengrave, 'You Only Live Once', in *19 Stories of Social Inclusion* (website), Belonging Matters & University of Melbourne <<https://www.19stories.org/copy-of-story-14-2>> (accessed 09/03/2018).

⁸⁵ E.g. – Micah Projects, *Housing First: a foundation for recovery Breaking the cycle of Brisbane's housing, homelessness and mental health challenges* (2016) <www.micahprojects.org.au> (accessed 3/4/2018).

The often-cited 'personligt ombud' (PO) scheme in Sweden (PO Skåne) is another example. Under the scheme, a legal mentor or personal ombudsperson is appointed to assist a person to make legal decisions.⁸⁶ Consider the following case described by the Swedish National Board of Health and Welfare:

After a stay in hospital, a client wanted to live in a flat of his own. Since this was the client's wish, he was supported by the personal ombudsperson while many other professional involved with the client advised against it, saying that it would not work out. This in fact turned out to be the case: the client eventually moved into housing with special support and was very happy there. Professionals in the social services and psychiatric services thought that this was an unnecessary failure, while the PO's view was that the reason why the client was so happy in the special housing was that he had been given the chance to live in his own flat.⁸⁷

The emphasis of the personal ombudsperson on respecting the will and preference of the client in this case, rather than prioritising risk-aversion and expert-based paternalism, demonstrates how articles 12 and 19 (and other articles, such as 28 on adequate standard of living and social protection) can work in practice. The example also highlights the importance of having a floor of social protection that allows for multiple choices from among 'good' options about how to live.

One challenging issue for governments and civil society is the type of mistakes and consequences which must be tolerated under a CRPD-based framework, for example; where a person takes a risk and ends up coming to great harm, including suicide or violence against others. In deliberating on any such concerns in domestic law and policy reform, it should be immediately acknowledged that current schemes entail consequences that are effectively seen as an acceptable cost—even if such costs are seen as regrettable with steps taken to try to ameliorate them (for example, traumatic experiences and side-effects from forced psychiatric interventions, increasing rates of hospital-based detention in some countries,⁸⁸ high rates of sexual harassment and assault of women involuntarily placed in psychiatric wards, and so on).

Just as improving social conditions can improve one's chances of exercising legal capacity, the converse is also true. Restoring formal legal capacity under domestic laws can clearly improve one's chances for independent living and participation in the community. The 2011 case of *P J B v Melbourne Health & Anor* (known as "Patrick's Case") in Victoria, Australia, is illustrative. "Patrick" was a 58 year-old man with psychosocial disability who appealed an order by the Victorian Civil and Administrative Tribunal appointing a financial administrator under the *Guardianship and Administration Act 1986* (Vic) (Austl). The appointed administrator made clear his intention to sell

⁸⁶ UN Office of the High Commissioner for Human Rights, 'Chapter Six: From provisions to practice: implementing the Convention, Legal Capacity and Supported Decision-Making', *United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities* (Geneva, 2007) [89] <www.un.org>.

⁸⁷ Swedish National Board of Health and Welfare, 'A New Profession is Born – Personligt ombud, PO' (Västra Aros, Västerås, November 2008) [10] <www.personligtombud.se>.

⁸⁸ Community and Mental Health Team, NHS Digital, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment Uses of the Mental Health Act: Annual Statistics, 2015/16* (30 November 2016) <www.content.digital.nhs.uk>.

Patrick's home against Patrick's wishes. Patrick was detained under the *Mental Health Act 1986* (Vic) (Austli) at the time. His treating psychiatrist had sought the appointment to prevent Patrick from repeatedly seeking to leave hospital and return to his own home. The presiding judge referred to Patrick 'using his home as a medical refuge' in the eyes of the psychiatrist.⁸⁹ The Court held that the order of Tribunal appointing an administrator unjustifiably interfered with Patrick's human rights under the *Victorian Human Rights Charter* and ordered that the appointment of an administrator be set aside. The Judge referred explicitly to articles 12, 19 and 23 (the right to respect for home and family) of the CRPD in framing the decision.⁹⁰

There have been some efforts to integrate the push for positive rights with Art 19 into mental health law. Argentina's *National Mental Health Law 2010* ('*NMHL*'),⁹¹ for example, contains a mechanism in which people in apparent mental health crises are subject to interdisciplinary evaluations which seek to identify the availability of support in a person's life. Where gaps appear, the evaluations can lead to a court ordering that voluntary services are made available to the individual (though the voluntary nature of this support is clearly distorted to some degree by the prospect of forced intervention by the same evaluation team/court).⁹² The evaluation team reportedly use the CRPD as a guide when communicating and reporting to judges, including highlighting a person's communication needs, seeking to discover the person's views on past experiences of involuntary treatment, and possible gaps in informal or formal services that could be remedied with voluntary services marshalled by the court.⁹³

The *NMHL* clearly does not accord with the CRPD and the high standards of the CRPD Committee; it neither questions the legitimacy of forced psychiatric intervention nor removes a rebuttable presumption of mental capacity. Yet, the *NMHL* does show how government agencies working under current laws can to some degree promote Art 19 obligations by placing an order, as it were, on services to assist a person to live independently and participate in community.

As noted, one stated purpose of 'rights-based' mental health and capacity law was to facilitate access to the supports people need in the wake of 'deinstitutionalisation'.⁹⁴ However, this stated goal is generally agreed to be the least successful of the 'new

⁸⁹ E.g. – *P J B v Melbourne Health & Anor (Patrick's case)* [2011] VSC 327 (19 July 2011).

⁹⁰ *P J B v Melbourne Health & Anor (Patrick's case)* [2011] VSC 327 (19 July 2011) [134-137], [337].

⁹¹ Law No 26657, 3 December 2010 [32041] BO 1; 'Mental Health Regime', House of Representatives Res D-276/07 (7 March 2007) Art 1.

⁹² Law No 26657, 3 December 2010 [32041] BO 1; 'Mental Health Regime', House of Representatives Res D-276/07 (7 March 2007) Art 42.

⁹³ FJ Bariffi and MS Smith, 'Same Old Game but with Some New Players Assessing Argentina's National Mental Health Law in Light of the Rights to Liberty and Legal Capacity under the United Nations Convention on the Rights of the Persons with Disabilities' (2013) 31(3) *Nordic Journal of Human Rights* 325, at [339-40].

⁹⁴ Statutory duties introduced under mental health law include those designed to secure individual rights, including rights to accessing services, refusing medical treatment, and having a review process for decisions concerning detention and imposed treatment decisions. L Gostin, 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in P Bean (ed), *Mental Illness: Changes and Trends* (Wiley, 1983) [50].

legalism' framework. Gerard Quinn has argued that this shortcoming draws mental health debates into an imprisoning logic:

Some civil libertarians would hesitate to use an argument for a legal right to treatment (no matter how meritorious) lest the need for treatment might be used to justify an undue encroachment on liberty. Contrariwise, some professionals in the field who have the responsibility to deliver services, would hesitate to embrace liberty-enhancing arguments lest it interfere too much with their capacity to deliver a substantive right to treatment—with their professional prerogatives.⁹⁵

A common critique of 'new legalism' is its struggle to secure substantive rights to persons with mental impairments in the form of facilitating access to voluntary healthcare and support.⁹⁶ The normative content of Art 19 provides an alternative framework for garnering appropriate social provisions and altering the powers of expertise over subjects of mental health law.

Looking beyond mental health and capacity law, examples from domestic violence, drug and alcohol, and homelessness services are worth considering. The previous hypothetical about housing support did not include a situation where someone refuses housing services and government-run shelters *altogether*. The Committee is not explicit about an appropriate response in such cases. Imaginably, good support would include blankets, a tent, food, advocacy, periodic reiteration that housing options are available, and other basic guarantees aimed at harm minimisation.

Similarly, in drug and alcohol services, strategies for basic guarantees and harm minimisation might include needle exchange and safe injecting houses, and the offer for a range of voluntary rehabilitation services — these are all existing practices. In domestic violence service and policies, there are well established harm minimisation strategies in situations where victims/survivors of abuse prefer to live with perpetrators, in which *parens patriae* or police powers are not marshalled against the victim/survivor. Art 19 and the CRPD more broadly, invite a comparison of the liberty rights and social protection promoted in these other service contexts compared to the public policy imperatives of mental health or mental capacity laws. The equality demands of the CRPD counter the view that there is something about mental health conditions that warrants special exceptions to normative rights.

(c) Group Homes, Clustered Living and Involuntary Community Intervention

The Committee call for states to 'ensure that public or private funds are not spent on maintaining, renovating, establishing, building existing and new institutions in any form of institutionalization' including 'private institutions... established in the guise of "community living".⁹⁷ This characterisation would include numerous sites affecting people subject to mental health and capacity laws. Group homes, aged-care settings,

⁹⁵ G Quinn, 'The United Nations Convention on the Rights of Persons with [sic] Disabilities – Towards a Unified Field Theory of Disability' (presentation paper) Indian Law Society, G.V. Pandit Memorial Oration, Pune, India, 10 October 2009, 11 <www.nuigalway.ie/cdlp>.

⁹⁶ See — P Weller, 'Lost in Translation: Human Rights and Mental Health Law' in B McSherry and P Weller (eds), *Rethinking Rights-Based Mental Health Law* (Hart, 2010) [51]; J Peay (ed), *Seminal Issues in Mental Health Law* (Ashgate, 2005) [xvii].

⁹⁷ CRPD Committee, above n 6, [51].

long-stay psychiatric wards, secure facilities, community-based clustered homes will fall under the expansive definition of 'institutional'. Certain forms of compulsory interventions outside of hospitals (e.g. 'community treatment orders' and 'assertive outpatient treatment') may also offend Art 19. '[E]ven individual homes' are implicated where other defining elements of institutionalisation are present, including 'no or limited influence over whom one has to accept assistance from ... a paternalistic approach in service provision [and] supervision of living arrangements'.

Congregate and cluster housing models are used by numerous governments as a "step-down" from institutionalisation or as stable feature of so-called deinstitutionalised systems. Middle and high-income countries often develop such arrangements as cornerstones of 'deinstitutionalisation'. Many congregate and cluster housing models have been criticised in the past for being at odds with the policy aims of 'community care' and 'normalisation'.⁹⁸ However, the Committee do not rule out group-based housing and nor is there anything in Art 19 that prohibits it. Instead, the Committee suggests congregation is typically a defining element of institutional environments. Indeed, a particularly oppressive family home, in which one person with disability lives among many without disability, could contain 'institutional' and exclusionary elements that offend Art 19. The OHCHR's thematic study here provides tests to identify living situations that are not compliant with the CRPD, which include the following:

Living arrangements should be assessed taking into account issues such as the choice of housemates, who decides when residents can enter or exit, who is allowed to enter a person's home, who decides the schedule of daily activities, who decides what food is eaten and what is bought and who pays the expenses.⁹⁹

It is noteworthy that the term 'group homes', which were referred to pejoratively in the Draft version of the General Comment, were removed for the final draft. It is possible that this amendment occurred in response to the submission of the Centre for Disability Studies and Disability Law Hub, University of Leeds, which stated that outright rejection of group settings risked:

(a) overlooking the *de facto* institutionalization that can take place when a disabled person lives alone or isolated in the community and is dependent upon support and services over which they have no choice or control; and (b) overlooking the potential of collective living options in which disabled people (and others) may choose to live and in which they will have full choice and control.¹⁰⁰

WNUSP take up this point and, like the University of Leeds submission, emphasises the importance of deliberative design in compliant group settings. WNUSP made a specific request for the involvement of 'our representative organizations [in the] designing of a range of residential, in-home and community services to ensure inclusion and full participation in the community, and encourage innovation in... research'.¹⁰¹

⁹⁸ I Wiesel and C Bigby, 'Movement on Shifting Sands: Deinstitutionalisation and People with Intellectual Disability in Australia, 1974–2014' (2015) 33(2) *Urban Policy and Research*, [178].

⁹⁹ Office of the United Nations High Commissioner for Human Rights, above n 26, [20-22].

¹⁰⁰ Centre for Disability Studies and Disability Law Hub, University of Leeds, 'Response to Draft General Comment on Article 19', [1] <<http://www.ohchr.org>> (accessed 6 February 2018).

¹⁰¹ WNUSP, above n 67, 12.

(d) Cost

The Committee point to recent global financial crises and warn against the disproportionate impact of fiscal downturns on people with disabilities. So-called austerity measures – whether real or contrived – would require specific safeguards, according to the Committee, to prevent disproportionate effect on persons with disabilities.¹⁰² This directive is timely. Case law is emerging in which austerity measures appear to influence the imposed limits on the provision of state resources for independent living.¹⁰³

Cost will inevitably pose a barrier to achieving Art 19 in policy and practice. It is true that care homes and other sites of congregated living might be a more expensive option. Many group homes, for example, are expensive in both the short and long-term.¹⁰⁴

On the other hand, there will be instances in which congregate care options are ‘cheaper’, at least in financial terms, even as human costs may be great.

The Committee acknowledge financial cost and the implementation challenges but argue that ‘the level of support required’ may not be invoked to deny the right to independent living and community participation.¹⁰⁵ This will be particularly challenging for States Parties and civil society actors wishing to keep services from ‘reading down’ their obligations under Art 19, and it will be important to shine a light on any sectoral interests that may run contrary to Art 19 (for example, private group home providers and some public sector unions that seek to retain institutional environments).

(e) Low and Middle-Income Countries

The General Comment has a strong focus on middle and high-income jurisdictions in Europe, and the broader ‘Anglosphere’.¹⁰⁶ Deinstitutionalisation emerges as a major concern of the General Comment, and understandably so. Yet, there may well be more parts of the world in which institutionalisation has not been, at least historically, the major barrier to independence and community participation; for example, in many parts of Asia, Africa¹⁰⁷ and the Pacific.

¹⁰² CRPD Committee, above n 6, [38],[43],[62].

¹⁰³ See — *Davey v Oxfordshire County Council* (The Equality & Human Rights Commission and Inclusion London intervening) [2017] EWCA Civ 1308, 1 September 2017.

¹⁰⁴ E.g. – C Purcal et al. *Supported Accommodation Evaluation Framework Summary Report (SPRC Report 31/2014) for the NSW Department of Family & Community Services, Ageing Disability and Home Care* (Sydney: Social Policy Research Centre, UNSW Australia, 2014), [37].

¹⁰⁵ CRPD Committee, above n 6, [20].

¹⁰⁶ This point was made quite strongly in a webinar by Inclusion International on preparing a response to the draft General Comment. See — Inclusion International, ‘Video: Preparing Feedback to the CRPD Committee on the Draft General Comment on Article 19’ <<http://inclusion-international.org/video-preparing-feedback-to-the-crpd-committee-on-the-draft-general-comment-on-article-19/>> (accessed 26/03/18).

¹⁰⁷ Elizabeth Kamundia has elaborated on this point with regards to Africa, and a specific focus on Kenya. See — E Kamundia, ‘Choice, Support and Inclusion: Implementing Article 19 of the Convention on the

There are clear exceptions to the above generalisation, as the Users and Survivors of Psychiatry Kenya and the Japan National Assembly of Disabled Peoples' International point out in their submissions to the Committee.¹⁰⁸ Notably, these are two submissions among only four from Asia and Africa, the other two coming from the Government of Mongolia and the India-based organisation, Transforming Communities for Inclusion-Asia (TCI-Asia).¹⁰⁹ TCI-Asia report a troubling development in the recent growth of institutions in Asia, noting that:

[e]ven though mental health legislations do not exist in many [Asian] countries, and some have [only] recently adopted new coercive mental health laws, mental institutions are coming up quite fast, resulting in the escalation of barriers to inclusion.¹¹⁰

Bhargavi Davar (who leads TCI-Asia) has argued elsewhere that CRPD and legal capacity debates are often presented by Anglosphere commentators in universal terms.¹¹¹ The General Comment may leave the Committee open to a similar charge.

The Committee does state that:

Article 19 reflects the diversity of cultural approaches to human living and ensures that its content is not biased towards certain cultural norms and values.¹¹²

Perhaps this point could have been elaborated upon, and may be a fruitful area for future research. Davar again has argued that non-Western, low and middle income countries tend to be more concerned with developing inclusive and community-based support,¹¹³ rather than curtailing coercive state-based interventions.¹¹⁴ Advocates in these countries may be more concerned with family-led or localised forms of segregation, such as 'Pasung' in Indonesia,¹¹⁵ more so than state-based incursions.

Rights of Persons with Disabilities in Kenya' in *African Yearbook on Disability Rights* (Pretoria Law Press, 2013)

<http://www1.chr.up.ac.za/images/files/publications/adry/adry_volume1_2013.pdf>.

¹⁰⁸ Users and Survivors of Psychiatry – Kenya, 'Day of General Discussion on Article 19 of the UN Convention on the Rights of Persons with Disabilities' (2017), paras (5-7). <<http://www.ohchr.org>> (accessed 6 February 2018); Japan National Assembly of Disabled Peoples' International, 'Submission to the Committee on the Rights of Persons with Disabilities on the Day of General Discussion on Article 19, CRPD' (2017), (para) 1. <<http://www.ohchr.org>> (accessed 6 February 2018).

¹⁰⁹ Transforming Communities for Inclusion – Asia, 'Submission to the UNCRPD Monitoring Committee, Day of General Discussion, Article 19' <<http://www.ohchr.org>> (accessed 6 February 2018).

¹¹⁰ Ibid.

¹¹¹ B Davar, 'Legal Capacity and Civil Political Rights for People with Psychosocial Disabilities' in A Hans (ed), *Disability, Gender and the Trajectories of Power* (Sage, 2015) [ch 11].

¹¹² CRPD Committee, above n 6, [8].

¹¹³ Davar, above n 111.

¹¹⁴ Ibid. See e.g. – Transforming communities for Inclusion, Asia, *Summary Report on Transforming Communities for Inclusion - Asia: Working Towards TCI - Asia Strategy Development* (Asia-Pacific Development Centre on Disability, June 2015)

<www.apcdfoundation.org/?q=system/files/TCI%20Asia%20Report_Readable%20PDF.pdf> (accessed 5 May 2016).

¹¹⁵ 'Pasung' refers to the chaining and caging of individuals with psychosocial disability. See; H Minas and H Diatri, 'Pasung: Physical Restraint and Confinement of the Mentally Ill in the Community' (2008) 2 *International Journal of Mental Health Systems* [8].

Consider Davar's comment on recent debates in India around mental health law reform and institutionalisation:

[e]ven these intense debates... are relevant only to the middle and upper classes in urban areas, especially non-resident Indians looking for the ideal mental institutions for ageing parents, sisters or other siblings and dependents. This may constitute around 7% of the Indian population. For the remaining 93% population in rural areas, inner city slums, mountainous terrains, and other far-flung regions of the country, where the social fabric is still intact, and where there is no doctor or asylum, this will have no relevance.¹¹⁶

Elizabeth Kamundia has written from the African context about persons with disabilities typically living with their families against a cultural backdrop of largely communal ways of life without individualised state-funded support services.¹¹⁷ Approaches to securing the right to independent living and participation in the community in these contexts will differ enormously along social, cultural, economic and political lines.

Problem-solving and sharing of solutions between disabled people's organisations between and within low and middle income countries has been taking place for many decades, and show no sign of slowing down. There is scope to foster further collaboration. Some well-known research suggests low income countries tend to enjoy better long-term outcomes for people with severe mental health issues precisely because of higher levels of collectivism and social cohesion.¹¹⁸ This exceptionalism may even apply to socio-economically marginalised groups *within* high income countries. Among Aboriginal and Torres Strait Islander people with disabilities in Australia, for example, some data indicates their participation in cultural activities in their own communities is *on par* with other Aboriginal and Torres Strait Islander people (which is quite unlike non-Indigenous people with disabilities).¹¹⁹

Such solutions and positive trends are relevant to all countries, and their cross-fertilisation surely warrants further research and support. Researchers could also consider how countries without mental health legislation are faring, and how CRPD-based development in those jurisdictions might occur. The World Health Organisation 'QualityRights Framework' may be useful for addressing these intersections,¹²⁰ as are

¹¹⁶ B Davar, 'Legal Frameworks for and against People with Psychosocial Disabilities' (2012) 47(52) *Economic and Political Weekly* [123].

¹¹⁷ Kamundia, above n 107.

¹¹⁸ M Savill, C Banks, H Khanom, and S Priebe, 'Do Negative Symptoms of Schizophrenia Change over Time? A Meta-Analysis of Longitudinal Data' (2015) 45(8) *Psychological Medicine* [1613]. See also – Transforming communities for Inclusion, above n 114.

¹¹⁹ Australian Bureau of Statistics, *Social and Economic Wellbeing of Aboriginal and Torres Strait Islander people with disability. National Aboriginal and Torres Strait Islander Social Survey 2014-2015*. (Feature article) Rel. 4714.0 (2017); S Avery, 'Disability in Aboriginal and Torres Strait Islander communities: The numbers and the narratives' Presentation at the NHMRC-Lowitja Institute Knowledge Translation Conference, Brisbane, Australia (2017).

¹²⁰ See — World Health Organisation, 'WHO QualityRights initiative - improving quality, promoting human rights'—website<http://www.who.int/mental_health/policy/quality_rights/en/>(accessed 27/02/2018). Bernadette McSherry and Yvette Maker have considered the benefits and challenges for mental health practitioners of integrating a human rights perspective into mental health treatment and care. B McSherry and Y Maker, 'International Human Rights and Mental Health: Challenges for law and practice.

the existing regional collaborations between communities in low- and middle-income countries.

(f) Privatisation and Marketisation

To some extent, the Committee brings attention to the increasing privatisation and marketisation of disability and other social services in some countries. The final draft of the General Comment included increased emphasis on 'ensur[ing] that no rights enshrined in article 19 are violated' by '*private entities*' in addition to the state – a point that did not appear in the Draft.¹²¹ However, the scale of social policy change generated by marketisation and privatisation of health and social services in recent decades, particularly in high and middle income countries, may have warranted further attention. Marketisation is linked to efforts to personalise disability supports.¹²² My point is not to query the intrinsic value of 'personalisation' (which involves complex and often context-specific questions about service delivery that have been well-investigated by others)¹²³ but rather to point out that marketisation and personalisation contain potential downsides, such as detracting from social justice agendas and meaningful choices for citizens.¹²⁴ These pitfalls warrant attention by States Parties, civil society organisations and others who are enthusiastically embracing policies of personalisation, often in the name of rights. The General Comment will likely contribute to such enthusiasm, though perhaps without the caution, which (at least I would argue) is required.

The previously noted report of the Special Rapporteur on the Rights of Persons with Disabilities, provides useful insights in on matters of privatised and market-driven services.¹²⁵ In many countries, Art 19 will require effective regulation of market-driven systems aimed at improving choice and control for people with intellectual, cognitive and psychosocial disabilities, and ensuring sufficient feedback loops to guarantee social protection and respond to problems as they arise.

V. CONCLUSION

This review could not cover all issues warranting attention. The Committee does not specifically mention the experience of people with autism, for example. However, the Committee does not focus over-much on any one disability type (the term 'mental health', for example, only appears once, and 'psychosocial' three times). Yet, the absence of specific consideration of autism is noteworthy, including among the submissions.

¹²¹ CRPD Committee, above n 6, [40]. See also – paras (51) and (97(j)).

¹²² See — A Roulstone and H Morgan, 'Neo-liberal Individualism or Self-directed Support: Are We All Speaking the Same Language on Modernising Adult Social Care?' (2009) 8(3) *Social Policy and Society* [333].

¹²³ Ibid. See also – K Rummery, 'A comparative analysis of personalisation: balancing an ethic of care with user empowerment' (2011) 5(2) *Ethics and Social Welfare* 138; J Owens, T Mladenov and A Cribb, 'What Justice, What Autonomy? The Ethical Constraints upon Personalisation' (2017) 11(1) *Ethics & Social Welfare* [3].

¹²⁴ Owens, Mladenov and Cribb, above n 123.

¹²⁵ Human Rights Council, above n 63, [60-62].

Another concern, only touched upon here, is the expansion in some countries of *parens patriae* and police powers beyond mental health law into other policy areas, including drug and alcohol services (for example, forced drug and alcohol 'rehabilitation') and homelessness (for example, services using civil commitment laws to detain homeless people who refuse shelter).¹²⁶

Finally, 'special defences' in criminal law such as unfit to plead rules and the insanity defence are clearly relevant. People subject to such rules are often detained indefinitely. In many cases, increased community-based support will offer alternatives to custodial detention (notwithstanding the major legal challenge of the CRPD to this area of criminal law).¹²⁷

A key next step for those wishing to animate Art 19 is the deliberative development of basic guarantees, a satisfactory floor of social protection, harm minimisation strategies that respect non-interference, and the prioritising of structural changes required to achieve the transformative equality promoted by the CRPD.¹²⁸ Overall, the General Comment brings together both the views of the Committee and a wide range of submission respondents, providing a welcome concentration of global knowledge on this most *sui generis* of CRPD rights. The material highlights points of overlapping consensus among diverse commentators and clear goals for concerted legal change and political action.

¹²⁶ E.g. – K Holland, 'Services 'sectioning' homeless people who refuse shelter' *Irish Times* (3 March 2018).

¹²⁷ E.g. – A Arstein-Kerslake, P Gooding, L Andrews, B McSherry, 'Human Rights and Unfitness to Plead: The Demands of the Convention on the Rights of Persons with Disabilities' (2017) 17(3) *Human Rights Law Review* [399]; T Minkowitz, 'Rethinking Criminal Responsibility from a Critical Disability Perspective: The Abolition of Insanity/Incapacity Acquittals and Unfitness to Plead, and Beyond' (2014) 23 *Griffith Law Review* [434].

¹²⁸ See — T Minkowitz, 'CRPD and Transformative Equality' (2017) 13(1) *International Journal of Law in Context* [77]; T Degener, 'Disability in a Human Rights Context' (2016) 5(3) *Laws* [35].

PSYCHOSOCIAL DISABILITY AND DEPRIVATION OF LIBERTY: REVIEWING THE CASE OF QATAR IN THE LIGHT OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

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I. ABSTRACT

This paper analyses the main implications of the prohibition of deprivation of liberty on the basis of disability in the field on mental health under the Convention on the Rights of Persons with Disabilities and its impact in Qatar's legal system. It shows the contradiction between the specific regimes of deprivation of liberty of persons with psychosocial disabilities and Article 14 of the Convention. The paper also proposes some changes in Qatar's system to ensure that persons with psychosocial disabilities enjoy the right to liberty on equal terms with others.

Key words: CRPD; Convention on the Rights of Persons with Disabilities; Art 14 Qatar; legal system; liberty; security; Law No.16 of 2016 on Rights of Patients with Mental Illness

II. INTRODUCTION

The right to liberty and security is recognised in all major universal and regional instruments for the promotion and protection of human rights.¹ The key content of this right is usually identified as the prohibition of arbitrary deprivation of liberty:² no one

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¹ See — article 3 of the Universal Declaration of Human Rights (United Nations [UN]) UN Doc A/810, 71, UN Doc A/RES/217(III) A, GAOR 3rd Session Part I, 71 (UDHR) [Signed] 10 Dec 1948; article 9 of the International Covenant on Civil and Political Rights (United Nations [UN]) 999 UNTS 171, UN Doc A/6316, UN Doc A/RES/2200(XXI), Annex, UN Reg No I-14668 (ICCPR) [Signed] 16 Dec 1966 [Entered Into Force] 23 May 1976; article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe) 213 UNTS 222, ETS No 5, UN Reg No I-2889 (European Convention) [Opened For Signature] 4 Nov 1950 [Entered Into Force] 3 Sep 1953; para 1 of the American Convention on Human Rights "Pact of San José, Costa Rica" (Organization of American States [OAS]) OASTS No 36, 1144 UNTS 123, B-32, OEA/Ser.L.V/II.82 doc.6 rev.1, 25 (American Convention) [Signed and Opened For Signature] 22 Nov 1969 [Entered Into Force] 18 July 1978; article 14 of the Arab Charter on Human Rights (Revised) (Arab League) (2005) 12 IHRR 893 (Arab Charter) [Adopted] 22 May 2004 [Entered Into Force] 15 May 2008; Article 6 of the African Charter on Human and Peoples' Rights "Banjul Charter" (Organization of African Unity (historical) [OAU]) 1520 UNTS 217, OAU Doc CAB/LEG/67/3 rev.5, UN Reg No I-26363 (African Chapter) [Adopted and Opened For Signature] 27 Jun 1981 [Entered Into Force] 21 Oct 1986.

² These two dimensions are closely connected and are commonly summarised in the concept of protection of liberty, see European Court of Human Rights (ECtHR), *Altun v. Turkey*, no. 24561/94, June 1, 2004 (unreported at the time of writing).

shall be deprived of their liberty save in the cases established by the law, in accordance with proscribed procedures, and not unless several formal safeguards are respected.³ Although persons with disabilities are not explicitly mentioned in the right to liberty provisions within these international instruments,⁴ in theory they are protected by such provisions.

However, this somewhat oblique recognition of the right to liberty has been considered compatible with extended and deeply-rooted practices that introduce restrictions in the enjoyment of this right within the context of disability. These practices, which imply the establishment of specific regimes of deprivation of liberty singularly applicable to persons labelled as having intellectual and psychosocial disabilities (e.g. with a “mental illness or disorder”), are often justified by reference to the need to protect their life or their health and/or to protect public safety and the rights of others.

Actually, most domestic legal systems allow for the involuntary or non-consensual commitment to hospitals, psychiatric institutions and social care homes of persons with intellectual and psychosocial disabilities, in certain circumstances.⁵ Likewise, national laws usually deem such persons *exempt* from *criminal responsibility* and put in place special detention measures based on that consideration. These disability-specific forms of deprivation of liberty have also been legitimised by international human rights protection systems.⁶ Indeed, according to the perspective of assistencialism and the medical model of disability⁷, depriving the liberty of some persons with disabilities is accepted as necessary, in certain circumstances, and is not considered a *de facto* human rights violation.⁸

³ Biel, I. and Smith, R.K.M., *Textbook on International Human Rights*, Oxford University Press, New York, 2007.

⁴ The sad exception is article 5.1(e) of the European Convention (ECHR) that will be commented upon in n 17 below.

⁵ Bariffi, F., *El régimen jurídico internacional de la capacidad jurídica de las personas con discapacidad*, Cinca, Madrid, 2015 – see also; Minkowitz, T., *Why Mental Health Laws Contravene the CRPD – An Application of Article 14 with Implications for the Obligations of States Parties*, 2011. Available at: <http://dx.doi.org/10.2139/ssrn.1928600>.

⁶ Article 5.1(e) of the ECHR explicitly permits the deprivation of the liberty of a person of “unsound of mind.” Although other human rights instruments do not include a similar provision, they also seem to accept disability as a valid ground for deprivation of liberty – re the treatment of psychosocial disability in international systems for protection of rights, see; Perlin, M.L., *International Human Rights and Mental Disability Law. When the Silenced are Heard*, (Oxford University Press - New York, 2012).

⁷ On the medical model and its diferencias vis-à-vis the social model, see; Palacios, A., *El modelo social de discapacidad, orígenes, caracterización y plasmación en la Convención Internacional sobre los derechos de las personas con discapacidad*, Colección CERMI, Cinca, Madrid, 2008; Oliver, M., *Understanding Disability: From Theory to Practice*, (Palgrave - Malaysia, 1996); and Barnes, C. and Mercer, G., *Disability*, (Polity Press, Cambridge, 2003).

⁸ Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches,” *International Journal of Mental Health and Capacity Law*, 2016, 75–101, [79].

The entry into force of the Convention on the Rights of Persons with Disabilities (hereinafter CRPD⁹) changes this scenario. The CRPD marks a fundamental paradigm shift towards the human rights approach and the social model of disability.¹⁰ From this new perspective, the limitations experienced by persons with disabilities in the participation of social life and the enjoyment of human rights are no longer considered a natural consequence caused by the so called deficiencies of those persons, but rather they are the result of a deeply rooted social construct. In other words, such limitations are consequent upon the design of society (including the design of the legal conditions for the exercise of human rights) structured within a “normalcy” parameter that does not take into account the true situation of persons with disabilities and therefore leads to discriminatory practices.¹¹

Assuming this view the CRPD aims to adapt pre-existing general and abstract rights, universally recognised in other international instruments, to the specific necessities of persons with disabilities, thereby ensuring equal recognition, exercise and enjoyment of human rights.¹² Moreover, it also identifies fields where the protection of some human rights must be reinforced for persons with disabilities, taking into account the existence of serious and extended violations in the past.¹³

According to this strategy, Art 14 of the CRPD not only reaffirms the application of the right to liberty and security for persons with disabilities and emphasises the obligation to ensure their protection in equal conditions, but crucially it also reformulates the standard regulation of this right.¹⁴ Indeed, Art 14 specifies the meaning of the right to personal liberty in the context of disability, adding new contents that had not previously been mentioned in general human rights treaties.

The first part of this paper seeks to address the meaning, scope and the main implications of Art 14 of the CRPD regarding the deprivation of liberty of persons with disabilities, especially persons with psychosocial disabilities. The second part will focus on the relevant domestic law regarding the liberty and security of persons with psychosocial disabilities in Qatar and posits recommendations for review.

⁹ (United Nations [UN] 2515 UNTS 3, UN Doc A/Res/61/106, Annex, GAOR 61st Session Supp 49, 65. (Adopted) 13 Dec 2006, (Opened for Signature) 30 May 2007, [Entered Into Force] 3 May 2008.

¹⁰ On the CRPD generally, see — Lawson A., “The United Nations Convention on the Rights of Persons with Disabilities”, *Syracuse Journal of International Law and Commerce*, 34 (2), 2007, 563–619; Mackay, D., “The United Nations Convention on the Rights of Persons with Disabilities,” *Syracuse Journal of International Law and Commerce*, 34 (2), 2007, [323–331]; and Palacios, A., *El modelo social de discapacidad* cited above n 6.

¹¹ Cuenca Gómez, P., *Los derechos fundamentales de las personas con discapacidad. Un análisis a la luz de la Convención de la ONU*, Universidad de Alcalá de Henares, Madrid, 2012, [151].

¹² See — Bartlett, P., “The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law,” *The Modern Law Review*, 75 (5), 2012, [752–778].

¹³ Palacios, A., *El modelo social de discapacidad*, 270 and Lord, J.E. and Stein, M., “The Domestic Incorporation of Humans Rights Law and the United Nations Convention on the Rights of Persons with Disabilities,” *Washington Law Review*; 83, (4), 2008, [449–479, particularly 461].

¹⁴ Article 14 combines the three strategies mentioned by Megret, F., “The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?,” *Human Rights Quarterly*, no. 30, 2008, [494–516].

III. LIBERTY AND SECURITY OF PERSONS WITH PSYCHOSOCIAL DISABILITIES (ARTICLE 14 CRPD)

As explained above, article 14 ensures the effective and equal application of the right to liberty and security for persons with disabilities. It does so by incorporating new standards into international human rights law that have not previously been included in most pieces of domestic legislation. In particular, these relatively new standards challenge the conventional wisdom of mental health practices.

Article 14.1(a) requires States Parties to ensure; “that persons with disabilities, on an equal basis with others, enjoy the right to liberty and security of person.” And article 14.1(b) clarifies that this obligation not only implies guaranteeing (according to the traditional formulation of this right in other international instruments) that persons with disabilities; “are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law,” but also “that the existence of a disability shall in no case justify a deprivation of liberty.” Hence, article 14 must be approached “from a dual perspective.”¹⁵

Firstly, article 14, in connection with article 13 (on the right to access to justice¹⁶) includes the guarantee that no person with a disability can be deprived of her liberty without a legal procedure whereby minimum obligations of due process are respected. At this point, international jurisprudence has made considerable progress in recent years.¹⁷

The second perspective included by article 14 is the guarantee that “the existence of a disability shall in no case justify a deprivation of liberty.” This perspective, where article 14 is in close interrelation with the right to equality and non-discrimination (Art 5 CRPD),¹⁸ implies a revolution from the previous treatment of this issue in national and international law.

¹⁵ Bariffi, F., *El régimen jurídico internacional*, [223].

¹⁶ According to this provision effective access to justice on an equal basis with others includes the provision of procedural and age-appropriate accommodations and appropriate training; “for those working in the field of administration of justice, including police and prison staff”.

¹⁷ E.g. – in the European context (before the entry into force of the CRPD), the case law of the European Court of Human Rights (ECtHR) had already required some formal safeguards to be put into place in order to guarantee that the deprivation of liberty of a person of “unsound of mind,” allowed by Article 5.1(e) of the ECHR, e.g. it must not be arbitrary. The first landmark court decision on Article 5.1(e) of was *Winterwerp v The Netherlands* (A/33) (1979-80) 2 E.H.R.R. 387. After the adoption of the CRPD it is worth mentioning the decision in *Shtukaturov v Russia* (no. 44009/05) (2012) 54 E.H.R.R. 27; (2008) 11 C.C.L. Rep. 440; [2008] M.H.L.R. 238, and after its entry into force the cases *Stanev v Bulgaria* (no. 36760/06) (2012) 55 E.H.R.R. 22; [2012] M.H.L.R. 23, and *DD v Lithuania* (no. 13469/06 [2012] M.H.L.R. 209 that reinforced the procedural safeguards in the application of Article 5.1(e).

¹⁸ Article 5.1 of the CRPD prohibits “all discrimination on the basis of disability” as defined in Article 2 as: “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation”.

Prior to the CRPD coming into force, existence of a psychosocial disability represented a lawful ground for deprivation of liberty and detention under international human rights law.¹⁹ The Convention radically departs from this approach by forbidding deprivation of liberty based on disability, including psychosocial disability.

The new approach means that disability cannot serve in any circumstances as a valid ground for deprivation of liberty. According to the *Guidelines* on Article 14 of the Convention²⁰, (approved by the UN Committee on the Rights of Persons with Disabilities—hereinafter the CRPD Committee), this provision implies “the absolute prohibition of detention on the basis of disability”²¹ and does not permit any exceptions. Thus, national laws that provide instances in which persons may be detained on the grounds of their actual or perceived disability, are incompatible with article 14.²²

Resolutely, the Committee maintains, and recalling the debate on the wording of Art 14 during the negotiation of the CRPD,²³ that this provision prohibits the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria are used to “justify the deprivation of liberty.”²⁴ — for example; risk or danger to self or others, alleged need of care or treatment, or other reasons tied to impairment or health diagnosis. According to this position, already explicated in the CRPD Committee *Concluding Observations* on States initial reports, the existing domestic laws and human rights instruments that permit involuntary commitment of persons with psychosocial disabilities need to be questioned. However, the opinion of the CRPD Committee is not shared by all UN Human Rights Committees or indeed by all the Special Procedures of the Human Rights Council.²⁵

¹⁹ See — Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities, A/HRC/10/48, January 26, 2009, paras (48) and (49). Available at:

<http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf>

²⁰ The right to liberty and security of persons with disabilities (Geneva: Committee on the Rights of Persons with Disabilities, Adopted during the Committee's 14th session, held in September 2015). The *Guidelines* replaces the *Statement* on Article 14 approved in 2014. The *Guidelines* do not have the status of a General Comment, but represent the most recent expression of the Committee's interpretation of Article 14.

²¹ *Ibid*, paras (6–9). As noted by Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms,” [84] – The Committee's guidelines go further than previous interpretations of article 14, for example: “that put forward by the UN High Commissioner for Human Rights, who had suggested in 2009 that it would be in conformity with the CRPD to have disability-neutral laws on preventative detention.”

²² CRPD Committee, *Guidelines on Article 14*, para (6).

²³ *Ibid*, para (7). During the negotiations of article 14 of the CRPD, states and civil society debated in the Ad Hoc Committee whether this provision should be framed to ensure that disability could not be the “sole” or “exclusive” basis for a deprivation of liberty. Ultimately this qualifier was not included.

²⁴ *Ibid*, paras (7) and (13).

²⁵ Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms,” [84]. For an exhaustive explanation on the position of the UN Treaty Bodies and Special Procedures on the deprivation of liberty of persons with disabilities, see — the *Background Note*, paras (24-33); elaborated by the Office of the High Commissioner for Human Rights during the expert meeting on “International standards on the right to liberty and security of persons with disabilities”, on 8-9 September 2015. Available at: <http://www.ohchr.org/Documents/Issues/Disability/DeprivationLiberty/BackgroundNote.doc>

On the one hand; the Human Rights Committee, the Committee against Torture and the current Special Rapporteur on Torture have not fully adopted (or even contradict) the CRPD standard on Art 14.1, developed by the CRPD Committee. These bodies have accepted the possibility of lawful involuntary committal of persons with disabilities as a measure of last resort in qualified situations – in general for the purpose of protecting the individual in question or third parties and with robust and appropriate legal safeguards.²⁶ At the regional level, the European Court of Human Rights have adopted a similar position²⁷.

On the other hand; the Committee on the Elimination of Discrimination against Women²⁸ the Committee on Economic, Social and Cultural Rights²⁹, the UN Working Group on Arbitrary Detention³⁰ and the UN Special Rapporteur on Disability³¹ have

²⁶ See — Human Rights Committee, *General Comment No. 35 – Article 9: Liberty and Security of Person*, CCPR/C/GC/35, December 16, 2014, para (19).

UN Committee Against Torture has already accepted the possibility of lawful involuntary committal and involuntary medical treatment and has recommended ensuring effective supervision and monitoring, appropriate legal safeguards, proper training for medical and non-medical staff, and the use of de-institutionalization strategies and outpatient/community-based services. See e.g. – CAT/C/NLD/CO/5-6, para, (21); CAT/C/LTU/CO/3, para, (23); CAT/C/SWE/CO/6-7, para, (13); and CAT/C/HRV/CO/4-5, para (17). As explained the *Background Note* of the Office of the High Commissioner for Human Rights, para (28), the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment has questioned only forced hospitalization or solitary confinement when not based on medical grounds. See e.g. – CAT/OP/PRY/1, paras (219-224); CAT/OP/ARG/1, paras (94-102); CAT/OP/KGZ/1, paras (111-120); CAT/OP/MLI/1, paras (68-69). While the former Special Rapporteur on Torture, Manfred Novak, supported the absolute ban on deprivation of liberty on the basis of impairments, including in combination with other factors - *Interim Report* of July 28, 2008, A/63/175, para (64) (available at <http://www.un.org/disabilities/images/A.63.175.doc> (last consulted June 3, 2017), - the current Special Rapporteur, Juan Méndez, has accepted involuntary commitment as an exceptional measure in “emergency cases” or “to protect the safety of the person or of others” - *Report* of February 1, 2013, A/HRC/22/53, paras (67–70). Available at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (last accessed August 23, 2017).

²⁷ See — Cuenca Gómez, P. “Revisando el tratamiento de la capacidad jurídica de las personas con discapacidad a la luz de la Convención de la ONU”, *Revista Europea de Derechos Fundamentales*, 20, 2012, 213–246 and Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms”, [76–79].

²⁸ See — CEDAW/C/IND/CO/4-5, para (37), and CEDAW/C/MDA/CO/4-5, para (38)(d).

²⁹ The Committee on Economic, Social and Cultural Rights has recommended the incorporation into the law “the abolition of violent and discriminatory practices against children and adults with disabilities in the medical setting, including deprivation of liberty, the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy”. See — E/C.12/MDA/CO/2, para (24).

³⁰ UN Working Group on Arbitrary Detention, United Nations Basic Principles and Guidelines on the Right of Anyone Deprived of their Liberty to Bring Proceedings before a Court, May 4, 2015, WGAD/CRP.1/2015, para (56).

³¹ See — the opinion of the former UN Special Rapporteur on Disability, Shuaib Chalklen in the *Urgent Request to Amend the Human Rights Committee's Draft Version of General Comment No. 35 (CCPR/C/107/R.3) on Article 9 (Right to Liberty and Security of Person) Bringing it in Line with the UN Convention on the Rights of Persons with Disabilities*, May 27, 2014. Available at: <http://www.ohchr.org/Documents/HRBodies/CCPR/GConArticle9/Submissions/SRDisability.doc> - For her report to the Human Rights Council, 40th session, the current UN Special Rapporteur on Disability, Catalina Devandas, intends to focus on the right to liberty and security for persons with disabilities

endorsed the absolute ban on the deprivation of liberty on the basis of disabilities in line with the interpretation of the CRPD Committee.

Equally, scholars do not have a unified approach about the interpretation of the prohibition on detention on the basis of disability under Art 14 CRPD. As Elionoor Flynn explains³², while some scholars consider that Art 14 must be read to prohibit all deprivations of liberty where the existence of disability is a factor used to justify detention³³, other scholars disagree with this interpretation and some of them argue that an assessment of decision-making capacity can serve as the basis for detention if it is undertaken in a disability-neutral manner³⁴.

Regarding this debate, we consider, in unity with the CRPD Committee's position, that article 14 prohibits any disability-specific form of deprivation of liberty, even when it is purported to be justified by reference to the need to protect the safety of the person with disability and or that of others. In our opinion is not coherent to reject the "dangerousness criteria" for the person or third parties in case of general population³⁵ and instead accepting these criteria in case of people with intellectual and psychosocial disabilities. Indeed the difference between people with and without disabilities regarding the application of these criteria does not have an objective and reasonable justification³⁶ and reflects prejudices and stereotypes attached to the normative design of the law, which in the context of disability (actual or perceived) the Convention seeks to remedy. Moreover, the specific arguments – within the general idea of the protection of the person – that support the deprivation of liberty of persons with disabilities in the need of care or medical treatment contradicts other rights recognised in the CRPD which are closely linked, as we analyse below, with the right to liberty.

In our view, legislation authorising the civil commitment of persons with intellectual and psychosocial disabilities should be replaced by new comprehensive enactments within the health-care system governing all non-consensual treatment.³⁷ According to the CRPD model, this legislation could not be based on a functional test that relies on the assessment of decision-making capacity because, among other reasons, this assessment is not objective and disability neutral.³⁸ In any case – and depending on

³² Flynn, E., "Disability, Deprivation of Liberty and Human Rights Norms", [82].

³³ Particularly some of the scholars who were actively involved in the negotiations as Minkowitz, T., *Why Mental Health Laws Contravene the CRPD – An Application of Article 14 with Implications for the Obligations of States Parties* - already cited above, n 5.

³⁴ See — Szmukler, G. Daw, R. and Callard, F., "Mental health law and the UN Convention on the Rights of Persons with Disabilities", *International Journal of Law and Psychiatry*, 37 (3), 2014, 245–252; and Dawson, J., "A realistic approach to assessing mental health laws' compliance with the UNCRPD", *International Journal of Law and Psychiatry*, 40, 2015, [70–79].

³⁵ Bartlett, P., "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law2", *Modern Law Review*, 75 (5), 2012, [752-778].

³⁶ Nilsson, A., "Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective", *Human Rights Law Review*, 14(3), 2014, [459-485].

³⁷ This view is also maintained by Szmukler, Daw, and Callard and by Dawson in the works previously cited, n 34.

³⁸ *Comment No. 1: Article 12, Equal Recognition before the Law*, CRPD/C/GC/1, April 2014, para (15).
www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx

the way in which national legislation solves the conflicts between liberty and other rights – some non-consensual interventions could be permissible – ie. in cases of life-threatening emergency – but with true parity between persons with and without disabilities. Cases of harm to others should be addressed through the criminal justice system, which should involve the application of robust safeguards and the adoption of procedural accommodations to ensure the effective participation of persons with psychosocial disabilities in the judicial proceedings.³⁹

In the criminal context, the prohibition of deprivation of liberty on the grounds of disability also challenges the detention of persons with disabilities (mainly against persons with intellectual or psychosocial disabilities) who are considered unfit to plead or who are not imputable by domestic legislation. As maintained by the CRPD Committee:

[d]eclarations of unfitness to stand trial or incapacity to be found criminally responsible in criminal justice systems and the detention of persons based on those declarations, are contrary to article 14 of the Convention.⁴⁰

Equally, they also violate Article 13 since:

[i]t deprives the person of his or her right to due process and safeguards that are applicable to every defendant.⁴¹

In line with this approach, the Committee has recommended the elimination of security measures imposed upon persons with disabilities considered *exempt* from *criminal liability*, including those subject to coercive medical and psychiatric treatment in institutions. A special concern about measures involving indefinite deprivation of liberty has been also expressed by the CRPD Committee.⁴² These kinds of provisions deprive individuals of a clear determination of their responsibility and relegate persons with psychosocial disabilities to further segregation and marginalization; “as well as to indefinite detention in psychiatric institutions under the harshest conditions and often for extremely long duration.”⁴³

It is important to clarify that Art 14.1 of the CRPD does not exempt persons with disabilities, including persons with psychosocial disabilities, from general legislation regarding detention or arrest for violations of criminal law or other reasons not linked, directly or indirectly, to the existence of a disability. Paragraph 2 of article 14 requires non-discrimination when persons with disabilities are subjected to lawful deprivation of liberty, setting out the obligation to ensure that they are:

[o]n an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

³⁹ Cuenca Gómez, P., “Discapacidad y privación de la libertad”, *Derechos y libertades*, 32, 2015, [163–203] see – [192]; and Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms”, [85], [100].

⁴⁰ CRPD Committee, *Guidelines on Article 14*, para (16).

⁴¹ *Ibid.*

⁴² *Ibid.*, para (20). See also — UN Special Rapporteur on Disability, *Urgent Request to Amend the Human Rights Committee’s Draft Version of General Comment No. 35*.

⁴³ Minkowitz, T., *Why Mental Health Laws Contravene the CRPD*, cited at above, n 5.

Regarding guarantees of international human rights law, it is important to note the lack of specific attention paid by the general international instruments to the rights of persons deprived of liberty who have psychosocial disabilities. Moreover, disability is not explicitly considered a prohibited ground for discrimination in these general human rights instruments.

The revised Standard Minimum Rules on the Treatment of Prisoners⁴⁴ (adopted by the UN General Assembly in 2015⁴⁵) have recently incorporated the provision of reasonable accommodation for persons with disabilities who are in detention (Rule 5.2). However, in contradiction with the inclusive purpose of the CRPD, the Rules 109 and 110 (former rules 82 and 83) establish that persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, should be transferred to mental health facilities and provided with compulsory psychiatric treatment.⁴⁶

The CRPD Committee has insisted on the right of persons with disabilities deprived of their liberty to be treated according to the objectives and principles of the Convention.⁴⁷ In its jurisprudence under the Optional Protocol to the Convention, the CRPD Committee analysed the scope of the obligation to ensure accessibility and to provide reasonable accommodation in the case of a prisoner with reduced mobility.⁴⁸ In its *Guidelines on Article 14* the Committee also remembered its concerns for the poor living conditions in some places of detention, particularly in prisons, and insisted on the need to promote training mechanisms for justice and prison officials in accordance with the Convention's legal paradigm.⁴⁹

To conclude this section, it is worth mentioning the strong link between Article 14 and other Articles of the CRPD (besides the relationship with Art 5 and 13 highlighted above). As noted by the CRPD Committee, the right to liberty in article 14.1 is closely connected with article 12 (on equal recognition before the law)⁵⁰ which states that persons with disabilities have legal capacity on an equal basis with others in all aspects

⁴⁴ Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules) (United Nations [UN]) UN Doc E/CN.15/2015/L.6, Annex. Available at:

www.penalreform.org/resource/standard-minimum-rules-treatment-prisoners-smr/.

However, this version also does not include disability as a prohibited ground of discrimination in Rule 2.

⁴⁵ [UNGA] UN Doc A/RES/70/175.

⁴⁶ The UN Special Rapporteur on Torture, Interim Report, October 7, 2013, focused on the revision of these Rules, A/68/295, para (72) called for the replacement of rules 82 and 83 with a provision articulating specific guarantees of equality and non-discrimination for all persons with disabilities. Available at:

www.unodc.org/documents/justice-and-prison-reform/SPECIAL_RAPPORTEUR_EN.pdf

⁴⁷ CRPD Committee, *Guidelines on Article 14*, para (18).

⁴⁸ CRPD Committee Communication No. 8/2012, CRPD/C/11/D/8/2012.

Available at: <http://juris.ohchr.org/search/results>

⁴⁹ Ibid, para (17).

⁵⁰ Ibid, para (18).

of life, including in the health domain.⁵¹ According to the CRPD Committee's *General Comment No. 1*:

The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention.⁵²

It is equally important to note that, regarding denial of legal capacity, the CRPD Committee rejects the "status approach" (based on the diagnosis of an impairment), the "outcome approach" (based on the assumption of the negative consequences of a decision), and the "the functional approach" (based on the deficits in decision making skill)⁵³. The refusal of the "status approach" means that legal provisions that allow involuntary hospitalization in cases of "suffering" from a "mental disorder" or a "mental illness" does not meet the requirements of the CRP. Indeed, these are cases in which the "disability itself" justifies involuntary commitment .

As we explained above, the rejection of "functional approach" implies leaving out the positions that ground deprivations of liberty in the assessments of decision-making capacity. Finally, the refusal of the "outcome approach" strengthens the arguments against the "dangerousness criteria", rejecting predictions of future harm or risk "as valid grounds for denying the legal capacity of persons with disabilities to refuse involuntary hospitalization or institutionalization"⁵⁴.

Article 14 of the CRPD also has a strong relationship with both Art 17 (protection of physical and mental integrity) and Art 25 (principle of free and informed consent to their health care of the person concerned) which, again in connection with Art 12, require that every case of deprivation of liberty concerning persons with disabilities, including persons with psychosocial disabilities, should be protected from non-consensual medical treatment.⁵⁵

Furthermore, the CRPD Committee has remarked that some extended practices during the detention of persons with disabilities — including some kinds of forced medical treatment, isolation and methods of restraint in medical facilities, including physical, chemical and mechanic restrains — "are not consistent with the prohibition of torture

⁵¹ Regarding article 12, see — Dhanda, A., "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?," *Syracuse Journal of International Law and Commerce*, 34, 2006–2007, 438–456 and Quinn, G., "An Ideas Paper on Legal Capacity," Consortium on Human Rights and Disability, European Foundation Centre, Brussels, 2009. Available at: <http://www.inclusionireland.ie/sites/default/files/attach/basicpage/846/anideaspaperbygerardquinnjune2009.pdf>

⁵² CRPD Committee, General Comment No. 1: Article 12, para (40).

⁵³ Ibid, para (15).

⁵⁴ *Background Note*, para (94).

⁵⁵ In its General Comment No. 1, Article 12, paras (21) and (42), the CRPD Committee stated that decisions about medical and psychiatric treatment must be based on the free and informed consent of the person concerned and respect the person's autonomy, will and preferences. The CRPD Committee's *Guidelines on Article 14*, para (10), stated that "Involuntary commitment in mental health facilities carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14".

and other cruel, inhumane or degrading treatment or punishment against persons with disabilities”⁵⁶ included within Article 15 of the CRPD. In the opinion of the CRPD Committee:

[I]ack of accessibility and reasonable accommodation places persons with disabilities in sub-standard conditions of detention [which] are incompatible also with article 17 of the Convention and may constitute a breach of article 15(2).⁵⁷

The CRPD Committee has also stressed the necessity of implementing monitoring and review mechanisms in relation to persons with disabilities deprived of their liberty, in connection with Article 16.3 of the CRPD, so as to prevent all forms of exploitation, violence and abuse.⁵⁸

The CRPD Committee has also underlined the link between article 14 and article 19, which recognizes the right to live independently and be included in the community.⁵⁹ In order to realise the full protection of the right to liberty in the context of disability, a policy shift is required – moving away from traditional methods of treating mental health conditions, which legitimise schemes of detention for persons with disabilities, to a public community-based services approach⁶⁰ integrated through the design and implementation of de-institutionalisation strategies.⁶¹

Finally, compliance with the framework of the CRPD requires, according to articles 4.3 and 33.3, the involvement of persons with disabilities and their representative organisations in monitoring the implementation of Art 14.

IV. LIBERTY AND SECURITY OF PERSONS WITH PSYCHOSOCIAL DISABILITIES IN QATAR

Qatar is an independent sovereign Arab State with a legal system based on a mixture of civil law and Shari'a law – the latter being recognised in Article 12 of the Qatari Constitution⁶² as the principal source of legislation. A modernisation strategy, Qatar National Vision 2030, is aimed at renewing and developing the country.⁶³ Qatar's presence in the international system of human rights protection is relatively recent and the State is still awaiting the ratification of very relevant instruments, among them, the

⁵⁶ CRPD Committee's *Guidelines on Article 14*, para (12). The UN Special Rapporteur on Torture in its Reports of 2008 and 2013 also considered that these coercive and non-consensual measures may be deemed torture or ill-treatment.

⁵⁷ CRPD Committee, *Guidelines on Article 14*, para (18).

⁵⁸ *Ibid*, para (19).

⁵⁹ *Ibid*, para (9).

⁶⁰ *Ibid*, UN Special Rapporteur on Disability, *Urgent Request to Amend the Human Rights Committee's Draft Version of General Comment No. 35*.

⁶¹ United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings before a Court by UN Working Group on Arbitrary Detention [UN Doc A/HRC/30/37], principle 20.

⁶² Adopted on June 8, 2004.

⁶³ General Secretariat for Development Planning, Qatar National Vision 2030. Available at: http://www.mdps.gov.qa/en/qnv/Documents/QNV2030_English_v2.pdf

ICCPR.⁶⁴ However, as part of its reform strategy, Qatar signed in 2007, and ratified in 2008, the CRPD without entering any reservations or interpretative declarations.⁶⁵ In virtue of this ratification, the CRPD became part of national law in Qatar⁶⁶. Qatar submitted its initial report regarding the application of the CRPD to the Committee on June 2012 and completed its review in September 2015.⁶⁷

As noted by the CRPD Committee, Qatar still views disability from the *perspective of assistencialism* and the medical model, which is a polarizing contrast to the human rights-based approach and the social model advanced by the CRPD.⁶⁸ This perspective is enshrined in Qatar's legal system as a whole, and particularly in *Law (Act) No. 2 of 2004 in Respect of People with Special Needs*,⁶⁹ and it also inspires the regulation of the right to liberty of persons with disabilities.

The Qatari Constitution in its Article 36 states:

Personal freedom shall be guaranteed and no person may be arrested, detained, searched, neither may his freedom of residence and mobility be restricted save under the provisions of the law; and no person may be subjected to torture, or any degrading treatment; and torture shall be considered a crime punishable by law.

Though this general Article protects all citizens, including persons with disabilities, some disability-specific deprivations of liberty are permitted in Qatar.

(a) Involuntary commitment of persons with psychosocial disabilities in Qatar

The CRPD Committee, in its Concluding Observations on Qatar's initial Report, expressed concern about "involuntary detention of persons in specialised institutions

⁶⁴ Qatar has signaled its intention to ratify this particular covenant and the International Covenant on Economic, Social and Cultural Rights, Report of the Working Group on the Universal Periodic Review: Qatar, June 27, 2014, A/HRC/27/15, para (16). Available at: <http://dag.un.org/handle/11176/307320>

⁶⁵ Qatar also signed the Optional Protocol but it is yet to be ratified.

⁶⁶ Article 6 of the Constitution provides that the State shall respect all international charters and conventions to which it is party and strive to implement them all.

⁶⁷ All documents pertaining to this process are available at: http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/SessionsList.aspx?Treaty=CRPD.

⁶⁸ CRPD Committee, Observations Concluding on the Initial Report of Qatar, September 2015, CRPD/C/QAT/CO/1, para (7). Available at:

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fCO%2fOA%2fCO%2f1&Lang=en For a general analysis on the challenges faced by Qatar in the implementation of the CRPD, see — Rodríguez del Pozo, P. (et. aliii), "The Convention on the Rights of Persons with Disabilities and Qatar's domestic legislation", *The Age of Human Rights Journal*, 9, 2017, [1–17].

⁶⁹ In this law, persons with disabilities are defined as: "any person with a permanent total or partial disability in any of the senses or in his or her physical ability or in his or her psychological or mental ability to such an extent that his or her opportunity to learn or to undergo rehabilitation or to earn a living is limited" (Article 1). The perspective of specialty, according to the medical model, is also present in other definitions, such as "Special education," "Rehabilitation," and "Special Education Institutes."

on the basis of their impairment as well as the deprivation of liberty based on disability, including intellectual and/or psychosocial disabilities.⁷⁰

The Qatari Government reported that the State “does not have specialised institutions for involuntary detention of persons with disabilities.”⁷¹ Despite this comment (although at the time of the CRPD Committee Review Qatar’s authorities had not yet drafted legislation regarding the conditions and the formal proceedings for involuntary admission), persons with psychosocial disabilities were in fact involuntarily hospitalised in mental health facilities, without legal basis.

In 2013, Qatar’s National Mental Health Strategy 2013–2018 was approved.⁷² This Strategy aims to reform the mental health system in order to achieve two main objectives: firstly, to raise public awareness and reduce the stigma associated with mental illness, and secondly to provide the best possible inclusive mental health services for the people.⁷³ The Strategy requires a shift from the model of care “from patient hospitalised in psychiatric departments” to the model of care lived through community services, and includes among its pledges the drafting of a Mental Health Law to safeguard the human rights of persons with a mental illness.

The 2015 Annual Report of the National Human Rights Committee (hereafter NHRC) on the Situation of Human Rights in the State of Qatar and the Committee Activities stated that “mental disability constitutes the main challenge, as this group is facing social exclusion”⁷⁴ and included some specific observations about mental patient conditions. These observations denounced some bad practices with regards to involuntary commitments noting a lack of resources, a scarcity of community services and an absence of a legal framework to address the rights of persons with mental disability. The NHRC’s Report also recommended “promptly issuing a law .. [regulating] .. the mental patient`s rights.”⁷⁵

This new law, which according to Qatar’s National Mental Health Strategy, was to be enacted in December 2015, was finally approved more than a year later. Law No.16 of 2016 on Rights of Patients with Mental Illness⁷⁶ (hereafter the Mental Health Law) gives “psychiatric patients” — defined as persons who “suffer from mental or psychosocial

⁷⁰ CRPD Committee, Concluding Observations on the Initial Report of Qatar, para (27). Available at: <http://www.refworld.org/docid/55eed9fb4.html>

⁷¹ Comments Received from the Competent Authorities of the State of Qatar Regarding the Committee’s Concluding Observations. Available at: <http://disabilitycouncilinternational.org/documents/ConcObv/Qatarcomments.doc>

⁷² General Secretariat, Supreme Council of Health, 2013, *Qatar’s National Mental Health Strategy. Changing Minds, Changing Lives*, 2013–2018. Available at <http://nhsq.info/app/media/1166>

⁷³ Sharkey, T., “Mental Health Strategy and Impact Evaluation in Qatar”, *BJPsych International*, Volume 14, no. 1, February 2017, [18–21].

⁷⁴ *2015 Annual Report of the National Human Rights Committee* (hereafter NHRC) *on the Situation of Human Rights in the State of Qatar and the Committee Activities*, [73].

Available at: <http://www.nhrc-qa.org/wp-content/uploads/2014/01/93621-National-Human-Rights-English.pdf>

⁷⁵ *Ibid*, [58].

⁷⁶ Available at: http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=105416&p_country=QAT

disorders” — specific rights related to being informed about their health condition and their rights;⁷⁷ treatment environment,⁷⁸ medical treatment⁷⁹ and their independence and privacy.⁸⁰ And, for the first time, it regulates “involuntary admission” in a mental health institution.

As we explained above, before this legal regulation – and according to Sharia law and Islamic traditions⁸¹ – the involuntary commitment and the involuntary medical treatment of persons with psychosocial disabilities with the approval of their relatives were accepted practices in Qatar. At this point, it is important to note that Quranic and Islamic practice emphasise the provision of care and protection for persons with disabilities as a collective responsibility that extends to all members of family. This view and the usual collaboration of patients’ families in the commitment of persons with psychosocial – not perceived as involuntary since the consent of the family existed – had obviated the need for elaborate mental health legislation.

The formal regulation in the Mental Health Law, in many aspects similar to other national laws, is an advancement in comparison to the previous lack of legislation. Indeed, the Law represents a first step towards recognising the human rights implications of the detention of persons with disabilities and an attempt to satisfy due process requirements, fixing criteria for deprivation of liberty and providing some safeguards. However, it has serious deficiencies in the light of the CRPD.

The Mental Health Law provides that “involuntary admission” shall only be permissible where a) the patient presents clear symptoms indicative of a psychiatric disease requiring institutional treatment, and its appears that deterioration of health including psychological condition is probable and imminent b) the symptoms of a psychiatric disease represent a serious and imminent danger to the safety and health of the patient or other people.⁸² In both cases, involuntary admission requires the approval of the consultant psychiatrist — a psychiatrist “who is duly licensed by the competent body” to act in this capacity — and notification to be sent to the patient’s guardian, the director of the treatment institution and also to the Ministry of Public Health’s competent administrative body within 24 hours of admission.

⁷⁷ For example, the right to receive an in-depth explanation, in an understandable way, of all rights set out in the Law immediately after being admitted, including the right to file a complaint in accordance with the applicable procedures.

⁷⁸ The law establishes, for example, that the patient’s individual rights shall be observed by way of providing a health and humanitarian setting that preserves his or her dignity and meets his or her medical and personal rights.

⁷⁹ According to the law, the patient shall access the required treatment according to the widely recognized medical standards, shall be provided with the opportunity to be effectively and continuously involved in the treatment process and shall be consulted in all matters related to his or her treatment.

⁸⁰ Including the right to be protected from commercial and sexual exploitation, physical and psychological abuse and humiliating treatment in any way.

⁸¹ On Islamic tradition and people with disabilities, see — GHALY, M., *Islam and Disability. Perspectives in Theory and jurisprudence*, (Routledge, 2010).

⁸² Article 6 of *Law No. 16 of 2016 on Mental Health*.

This Law also lays down the circumstances in which voluntarily admitted patients can be made to remain in the hospital.⁸³ In this situation, the treating psychiatrist — the psychiatrist who is in charge of treating and monitoring a psychiatric patient at the institution — can refuse to discharge a patient if they cannot look after themselves due to the nature or degree of their mental disorder, or if the discharge may involve a “serious possibility of immediate or imminent harm to his/her safety, health, life or the safety, health or lives of others”.

It is worth mentioning that the admission of legally incompetent patients is considered “voluntary admission” if an application for examination and treatment at the institution is submitted by their guardian.⁸⁴ Regarding this issue, Qatar’s Civil Code permits the restriction or deprivation of the legal capacity of persons with psychosocial and intellectual disabilities and it establishes a model of substituted decision-making in order to protect their best interests.⁸⁵

Article 7 of the Law on Mental Health establishes that the period of involuntary admission shall be three months, renewable by another similar period in accordance with the requirements of the treatment. According to article 12, the patient or their guardian may complain about decisions regarding involuntary admission to the competent administrative body who shall then mandate a consultant psychiatrist from outside the institution to examine the patient’s case. The decision made by the competent body on the complaint shall be deemed a “final” decision.

Chapter VI of the Law on Mental Health (Psychiatric Patient Treatment and Care) seems to assume that voluntarily admitted psychiatric patients can be forced to receive medical treatment.⁸⁶ These patients or their guardian, if they are legally incompetent,

⁸³ Ibid, Article 5.

⁸⁴ Ibid, Article 4.

⁸⁵ Article 49 of *Law No. 22 of 2004 Promulgating the Civil Code*. As laid down in Article 52 of the *Civil Code* and in Article 190 of the *Law No. 22 of 2006 on Family Law* “persons of no or defective capacity” shall be governed by the provisions of natural or legal guardianship or curatorship as provided for by special laws. The special legal provision governing this matter is *Law No. 40 of 2004 on the Guardianship over Minors’ Funds*. Article 33 of this Law is worded as follows: “no person above the age of majority who is subject to a habitual state of madness or insanity, or is unconscious, mentally deranged or an imbecile ... shall be allowed to take charge of his own affairs or to administer his estate.” This Law considers “incapacitated” to mean an incompetent minor or an insane, unconscious, or idiotic person. In its general provisions, the Law defines the meaning of “the insane,” “the unconscious,” “the idiotic,” and “the imbecile” and identifies them as persons with psychosocial or intellectual impairments. In Qatar, persons who are incapacitated are subject to a special system of guardianship (Curation or *Qawama*) pursuant to which a third person is appointed to manage the incapacitated person’s property and affairs. On the regulation of legal capacity in Qatar, see — Cuenca Gómez, P. (et aliii), “The impact of Article 12 of the Convention on the Rights of Persons with Disabilities in Qatar-s Private Law”, *The Age of Human Rights Journal*, 9, 2017, [81-104]. All these civil provisions are also inspired in Shari’a law and medieval Islamic thought and practices. For discussion about legal capacity in Islam Law see; Ali Altaf, M., “Mental Disability in Medieval Hanafi Legalism,” *Islamic Studies*, vol. 51(3), 2012, [247-262].

⁸⁶ According to Article 19 of *Law No. 16 of 2016 on Mental Health*, in cases of voluntarily admitted psychiatric patients, to administer treatment without the approval of the patient shall be permissible if it is necessary “to prevent an imminent deterioration of the physical or psychological condition of the patient, or to prevent a significant danger threatening the life or health of the psychiatric patient or others.” The period within which that treatment is taken should not exceed seventy-two hours.

must receive information on any treatment “in terms of medical, psychological, behavioral or electroconvulsive therapy.” But if they refrain from taking the prescribed treatment, “the treatment psychiatrist shall be entitled to oblige him/her to take the treatment.” In this case, the law provides some safeguards: the revision of treatment once per thirty days at least; the reconsideration of such treatment when the attending psychiatrist makes a fundamental change in the authorised treatment plan; and the necessity of an independent medical assessment if the treatment period exceeds ninety days.⁸⁷

The Law allows the placement of a “psychiatric patient” in an isolation room when it is determined necessary by the attending psychiatrist.⁸⁸ It also establishes that the patient may be subject to scientific research, with his or her written approval; or the approval of the guardian, or the competent bodies of the State (if the patient does not have a guardian).⁸⁹ Electroconvulsive therapy is permitted, “under general anesthesia” and using a muscle relaxant. Written consent must be obtained from the patients or their guardians, if they are legally incompetent, after providing information about the nature of the treatment, its purpose and its negative effects. The law adds that in cases where an involuntarily admitted “psychiatric patient” or their guardian refuses this treatment, even though it is deemed necessary for their condition, he/she can be forced to receive it after an independent medical evaluation.⁹⁰

The regulation of involuntary admission in the Mental Health Law is contrary to the CRPD Committee’s interpretation of the Art 14 since it implies a special regime of deprivation of liberty based on psychosocial disability linked to additional factors (such as the need for treatment or care; protection of the safety, the right to life or the right to health of the patient or of other persons; or the risk of harm to self or others⁹¹). These justifications for special detention of persons with psychosocial disabilities should be questioned.

In cases where protection of the individual’s life or health is required (danger to the person), treatment and support should be provided through less restrictive and more effective means than deprivation of liberty in psychiatric facilities, within the framework of community-based mental health services in line with the requirements of Article 19 of the CRPD.⁹² At this point, it is important to note that in Qatar, Hamad Medical Corporation (HMC) has recently launched services to implement the National Strategy

⁸⁷ Article 20 of *Law No. 16 of 2016 on Mental Health*.

⁸⁸ Article 3 *Law No. 16 of 2016 on Mental Health*.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*, Article 21.

⁹¹ *Ibid.*, Articles 5 and 6.

⁹² Although in Qatar there are several services and programs for persons with disabilities, they are designed from the point of view of assistencialism rather than the perspective of independent living, and they are not enough to ensure that persons with disabilities can choose where and with whom they wish to live. The CRPD Committee in its *Concluding Observations on the Initial Report of Qatar*, para (37) expressed its concern “about the absence of a strategy to promote the rights of persons with disabilities to live independently and be included in the community and the lack of systematic provision of information by the State party to persons with disabilities and their families on how to claim support services and assistance to which they are entitled”.

on Mental Health,⁹³ focused on in-home, residential and community support. The next stage, involving the creation of a network of community-based specialised mental health centers and the implementation of a new policy of mental health home care, also aims to improve community mental health care facilities.

As we explained above, cases involving potential danger to others should be addressed through the criminal justice system which implies the application of stronger safeguards. Moreover, according to the CRPD procedural accommodations should be adopted in order to ensure the effective participation of persons with psychosocial disabilities during judicial proceedings. Obviously, if the standard of “danger to others” is accepted as a valid ground for imposing preemptive detention — something problematic from the point of view of the principles of the rule of law — it should be applied to all persons with and without disabilities in equal measure.

From our exposition of the Mental Health Law it is quite clear that some of its provisions violate Articles 12 (equal legal capacity), 17 (protection of physical and mental integrity) and 25 (principle of free and informed consent of the person concerned for health care) as they allow substituted decision-making and do not adequately protect the interests of persons with psychosocial disabilities surrounding non-consensual medical treatment. Qatar should also review this regulation in order to ensure that persons with psychosocial disabilities can make their own decisions — with whatever support they may require — concerning their health and care. With respect to this issue, some current policies of the Hamad Medical Corporation, such as the Policy on Informed Consent (CL 7226) and the Policy on the Care of the Vulnerable Patient Population (Policy CL 7221), that refer explicitly to “patients with emotional or mental illness,” may be interpreted in the light of the CRPD, incorporating assistance mechanisms in mental health decision-making until the necessary (and complex) legal reform — that requires the modification of the general framework on legal capacity — has been undertaken.

The coercive measures included in the Mental Health Law regarding involuntary admission are incompatible with Art 17 of the CRPD. Nonconsensual electroconvulsive therapy and scientific research represent a breach of article 15 which prohibits torture and inhuman or degrading treatments. These practices should be prohibited in order to respect the dignity of persons with psychosocial disabilities.

As discussed above, the Mental Health Law imposes procedural safeguards on involuntary commitment and forced medical treatment, eg the authorisation and supervision of the competent administrative body and compulsory expert medical assessment. However, judicial control and independent monitoring are not mentioned. Regarding the first issue, it is fundamentally important to stress that should decisions on involuntary admission be judicially appealed, persons with psychosocial disabilities would face barriers to accessing the justice system given the requirement of possessing

⁹³ Available at:

<https://www.hamad.qa/EN/hospitals-and-services/Rumailah-Hospital/Hospital-Services/Clinical%20Departments/Pages/Department-of-Psychiatry.aspx>.

legal capacity to take part in judicial proceedings⁹⁴ and the lack of accessibility measures and reasonable accommodations.⁹⁵

With regard to independent monitoring, according to Law No. 10 of 2002 on the Public Prosecution, in theory in Qatar prosecutors have competence to monitor mental health facilities by conducting periodic and random visits as well as receiving complaints. The NHRC also conducts field visits to mental health facilities to monitor human rights compliance. However, these mechanisms seem insufficient, as found by the Committee against Torture who has expressed its concern about the lack of systematic and effective monitoring of all places of deprivation of liberty in Qatar by national and international bodies. Thus, it has recommended: ensuring that fully independent monitoring of all places used for deprivation of liberty, including psychiatric facilities, as well as unannounced visits, takes place on a regular basis; enabling effective follow-up on the outcome of such systematic monitoring in order to prevent torture and other cruel, inhuman or degrading treatment or punishment; strengthening the mandate and resources of the NHRC and other national monitoring mechanisms; accepting monitoring of places of detention by non-governmental organizations and relevant international mechanisms; and the ratification of the Optional Protocol to the Convention against Torture as soon as possible.⁹⁶

The implementation of these observations is crucial to complying with the requirements of Article 16.3 of the CRPD. On a positive note, with regards to the content of Article 16 of the CRPD, the Mental Health Law introduces some penalties surrounding abuse or neglect by medical staff and establishing four separate new crimes prohibiting the mistreatment of patients with "mental illness."⁹⁷

Another deficiency of the Qatari framework regarding the right to liberty and security of persons with disabilities, including persons with psychosocial disabilities, is the lack of sectorial legislation regulating psychiatric care institutions and residential facilities (conditions to admission, rights of the users and monitoring, among other issues).⁹⁸

(b) Deprivation of liberty of persons with psychosocial disabilities in Qatar's criminal justice system

In the criminal context, the Qatari justice system, as in the case of other frameworks, deems psychosocial and intellectual disabilities to be justification for total or partial

⁹⁴ Law No. 13 of 1990 Civil and Commercial Procedure Law.

⁹⁵ The CRPD Committee in its *Concluding Observations on the Initial Report of Qatar*, para (25) expressed its concern "about the lack of accessibility to the Qatari justice system, including legal aid and assistance, sign language interpreters in court rooms, as well as procedural accommodations and programmes specifically designed to provide assistance to persons with disabilities in the justice sector".

⁹⁶ Committee against Torture, *Concluding Observations on Second Periodical Report of Qatar*, 2012, CAT/C/QAT/CO/2, para (15). Available at: <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6OkG1d%2FPPrICAqhKb7yhsvozOgiFOpniYolYH2kyd5sA%2FJDRmUyncxHFfiqcb0XKKsBfp00i3ELvJS%2FsU%2B%2FYgjLv5EaHG9GZZH%2F87V0y4OpEzVDIvMT8Xs9mqErmWIM1> (last accessed June 3, 2017).

⁹⁷ Articles 27 and 28 of Law No. 16 of 2016 on Mental Health.

⁹⁸ Just recently, Qatar has approved a Law regulating childcare services (*Law No. 1 of 2014 on regulating nurseries, day care centers, play schools and similar facilities*).

exemption from criminal liability. Article 54 of Law No. 11 of 2004 Issuing the Penal Code states that:

Nothing is an offence which is done by a person who, at the time of committing the offence, in a state of unconsciousness or loss of reason or volition due to insanity or infirmity of mind or because he is in a state of intoxication or under the influence of drugs resulting from the consumption of intoxicating or narcotic substances given to him against his will or without his knowledge or due to any other reason which leads one to believe that he has lost his reason or volition is not criminally liable.

According to this law, if "madness" or "mental defect" leads to "only deficiency or weakness in consciousness or in capacity when the offence is committed, it shall be considered an extenuating excuse."

This regulation should be reviewed to define in general, neutral and contemporary terms, in relation to disability and impairments, the circumstances in which a person cannot understand the unlawfulness of his or her actions and act according this understanding.

Section 7 of Law No. 23 of 2004 Regarding Promulgating Criminal Procedure Code refers to "Mentally Disabled Suspects" and the Law on Mental Health also includes some provisions referring to this categorization of suspects.

Article 209 of the Criminal Procedure Code sets out that if it is necessary to examine the condition of the suspect who is suffering from "mental disability or serious mental illness," the public prosecution, or the court considering the case, "may order to place" the accused under observation "in a specialized therapeutic facility, for successive periods."⁹⁹ Article 16 of the Mental Health Law provides that the institution shall examine the person's mental and psychological condition and should draft a report including the following points: the mental and psychological state of the person at the time of the crime in terms of awareness and choice; the mental and psychological state of the person at the time of examination; the proposed treatment plan and any other elements the institution considers important.

If it is proved that the "suspect is unable to defend himself/herself because of mental disability, or serious mental illness" occurring after the crime, Article 210 of the Criminal Procedure Code establishes that the case against him/her or the continuation of the trial "shall be suspended until the reason no longer exists, and the suspect shall, in this case, be placed in a specialised therapeutic facility". Article 211 states that the time spent by the suspect in the therapeutic facility, in accordance with Articles 209 and 210, "shall be deducted from the term of penalty or measures of which he may be adjudged."

These articles permit involuntary transfer to mental health facilities of accused individuals with intellectual and psychological disabilities without determining their participation in the offence and without the requirements that Qatari legislation establishes in case of precautionary detention. Therefore, they represent discrimination on the basis of disability in the context of arrest and detention.

⁹⁹ According to the Law, each of these periods must not exceed fifteen days and the total number of days of all periods combined must not exceed forty-five days.

Finally, Article 212 of the Criminal Procedure Code regulates the application of security measures in the Qatari criminal justice system. It provides that, “if an order that there is insufficient evidence to proceed in the criminal case or an acquittal of the suspect is issued” because of “a mental disability or serious mental illness”, the authority that issued the order or the judgment “shall order to place the suspect in a therapeutic facility” until it decides to release him on the basis of medical reports. As a result of this article, in the case of suspects with psychosocial and intellectual disabilities, their deprivation of liberty through incarceration in a “therapeutic facility” can be ordered, without proving the participation of the suspect, regardless of the seriousness of the crime or offence and the kind of penalty that would be applicable in the case of criminally responsible suspects. The decision can be made by the judge or by the public prosecution before the trial and the duration of detention in a mental institution is not fixed. The Mental Health Law states that in these cases termination of the placement and home leave shall not be permissible prior to the approval of the judicial body that ordered the measure, and that the placement shall be reconsidered at least once a year.¹⁰⁰ The “psychiatric patients” placed in a mental institution by virtue of a judicial decision shall have all the rights ascribed to other patients in the Mental Health Law.

The Initial Report submitted by Qatar to the CRPD Committee considered that the section of the Criminal Procedure Code on “Mental Suspects” put in place “special guarantees for persons with mental and intellectual disabilities, [stating that] such persons may not be subjected to criminal proceedings or trial.”¹⁰¹ However, and in fact, these provisions provide fewer safeguards and are in breach of Articles 5, 13 and 14 of the CRPD. As noted by the CRPD Committee, they imply disability-specific forms of deprivation of liberty in unequal conditions since persons with intellectual and/or psychosocial disabilities “accused of an offence are declared unfit to stand trial and not given due process.”¹⁰² Hence, Qatar should review and amend this regulation in line with the CRPD Committee recommendation:

[t]hat persons with disabilities accused of an offence are entitled to the provision of procedural accommodations and a fair trial and due process guarantees on an equal basis with others, including the presumption of innocence.¹⁰³

Moreover, the primary response to persons with psychosocial disabilities suspected of committing a crime should not involve deprivation of liberty in therapeutic facilities, but rather the provision of social and community mechanisms and services to promote their inclusion into the community in accordance with Article 19 of the CRPD.

¹⁰⁰ Article 17 of the *Criminal Procedure Code*. In the cases of minor offenses and infractions—that despite their lack of seriousness also imply the deprivation of liberty of the accused—the court or the public prosecution may authorize the competent body to terminate the placement or give home leave without consulting the judicial body.

¹⁰¹ *Qatar’s Initial Report*, CRPD/QAT/1, July 9, 2014, paras (138), (139) and (140). Available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FOAT%2F1&Lang=en

¹⁰² CRPD Committee, *Concluding Observations on the Initial Report of Qatar*, para (27).

¹⁰³ *Ibid*, para (28).

Qatari criminal law also provides for the deprivation of liberty of victims of crime with intellectual and psychosocial disabilities in some cases. According to the section of the Criminal Procedure Code (Protection of Minor and Mentally Disabled Victims), public prosecution or the court considering the case, may order that the victims of crime “with mental disabilities” be put in a therapeutic facility while their case is being resolved. Although, again, Qatar’s initial Report considered this provision to be a special guarantee for persons with disabilities,¹⁰⁴ the CRPD Committee also expressed its concern about it.¹⁰⁵ Indeed, though this measure has a protective aim, it is not compliant with the CRPD, given that it may imply a disproportionate response that deprives persons of their liberty on the basis of disability. In cases of risk of harm to the victim, the response should focus on the perpetrator ¹⁰⁶ and, within the CRPD framework when special measures of protection are needed, the will of the victim should be taken into account and support for the expression of their preferences should be provided. Official assistance should be available for these victims and, if in some circumstances the placement in an institution is necessary, the approval of the person concerned must be required. The institution should not have a therapeutic nature, but a protection purpose, in the same way as Qatari Law provides such protection for minors who are victims of crime.

The CRPD does not exempt persons with psychosocial disabilities from the generally applicable powers of the state to arrest and detain persons for violations of criminal law.¹⁰⁷ In these situations, the requirements of paragraph 2 of Article 14 of the CRPD must be followed. According to Law No. 3 of 2009 on the Regulation of Penal and Correctional Institutions, in Qatar all prisons have a health unit that provides special healthcare for inmates with disabilities and attends to various needs in certain circumstances.¹⁰⁸

Although in Qatar prisoners with disabilities have the same rights as other prisoners, there are no legal measures or binding protocols to ensure the accessibility of facilities, educational programs and services, or the provision of reasonable accommodation and support. It is worth noting that, according to the CRPD, prisoners with psychosocial disabilities retain the right not be medicated against their will. This right is not ensured in Qatar’s criminal justice system.¹⁰⁹ As in the case of psychiatric facilities, the monitoring and review of prison conditions must be improved according to the observations of the Committee against Torture, as discussed earlier.

The CRPD Committee in its Concluding Observations on Qatar did not express concerns regarding the detention conditions for persons with disabilities in prisons, however it

¹⁰⁴ *Qatar’s Initial Report*, para (109).

¹⁰⁵ CRPD Committee, *Concluding Observations on the Initial Report of Qatar*, para (27).

¹⁰⁶ Flynn, E., “Disability, Deprivation of Liberty and Human Rights Norms”, [85].

¹⁰⁷ Minkowitz, T., *Why Mental Health Laws Contravene the CRPD*.

¹⁰⁸ *Qatar’s Initial Report*, para (117).

¹⁰⁹ For example, Article 355 of the *Criminal Procedure Code* considers the situation of a person serving a custodial sentence who is later affected by a mental disability. In this case, the enforcement of the penalty shall be postponed until recovery, and persons shall be admitted to a hospital, provided that the period they spend in the hospital be deducted from the adjudged penalty term.

focused on the conditions surrounding the deprivation of liberty in deportation and detention centers.¹¹⁰

V. CONCLUSIONS

Article 14 of the CRPD and in particular its requirement that; “the existence of a disability shall in no case justify a deprivation of liberty” represents a big challenge that demands profound changes not only in law and policies, but also in professional practices and in social perceptions.

In Qatar, as with most of the States Parties of the CRPD, persons with psychosocial disabilities are subject to specific instances of deprivation of liberty — in worse conditions and with fewer safeguards in comparison with the general regime applicable to all citizens — which constitute disability-based discrimination prohibited by the CRPD.

As in other States, Qatari regulation of involuntary commitment and security measures reflects the traditional medical model of psychosocial disability that — with beneficial intent — seeks to justify segregation, confinement and compulsion of those labeled as “mentally ill”¹¹¹ and promotes prejudice and stereotypes. Indeed, in this approach, persons with psychosocial disabilities are deemed to be either, individuals in need of special protection – largely because of a presumption that they are unable to make informed decisions as to matters regarding their life and health; or dangerous persons who represent such a threat to society, and to the rights of others, that they must be controlled, at time in the extreme – as being the case of detention.

This approach should be replaced by a new and holistic view based on the social model of disability and a human-rights perspective that accords with the CRPD’s paradigm. This paradigm requires a shift towards public community-based mental health services. In line with this shift, laws and policies should guarantee that all mental health services provided are based on the free and informed consent of the person concerned; they should ensure access to the necessary support in decision-making; and they should not condone coercive practices and compulsory detention in the field of mental health.

While Qatar’s National Mental Health Strategy is fully in accordance with this new approach, the Mental Health Law, the Criminal Procedural Code and other pieces of legislation — in particular laws on legal capacity — need to be reviewed. This review and the full implementation of the paradigm shift in the mental health domain need to be tackled taking into account Qatar’s context and culture and with broad public engagement and collaboration.¹¹² Specifically, the participation of persons with

¹¹⁰ *Concluding Observations on the Initial Report of Qatar*, paras (35) and (36). The NHRC also denounced the fact that deportation centers are extremely crowded, which affects hygiene and safety standards. See; National Human Rights Committee, *Report of the National Human Rights Committee on the Situation of Human Rights in the State of Qatar and the Committee’s Activities during the Year 2014*, [17]. Available at: http://www.nhrc-qa.org/wp-content/uploads/2014/01/en_2014-NHRC-report_finalss2.pdf

¹¹¹ Minkowitz, T., *Why Mental Health Laws Contravene the CRPD*, cited at n 5 above.

¹¹² As promoted by *Qatar’s National Mental Health Strategy*.

disabilities should be ensured in coherence with the framework of the CRPD. In order to comply with this obligation, Qatar should, and is invited to, promote, strengthen and empower associations representing the interests of persons with disabilities, including organizations of persons with psychosocial disabilities.¹¹³

This policy shift will contribute to a culture of change, overcoming the stigma associated with psychosocial disability, as desired by Qatar's National Mental Health Strategy. In any case, raising awareness among key professionals within the mental health domain, and the awareness of society as a whole, is essential to ensure that persons with psychosocial disabilities enjoy their human rights, including their right to liberty, on equal terms.

¹¹³ The CRPD Committee, *Concluding Observations*, para (9), pointed out that in the past there was a lack of consultation both with individuals with disabilities and with independent organizations regarding disability-related policies and the process of implementation of the CRPD. The NHRC has remarked on the lack of a sufficient number of civil society organizations that are concerned with disability issues and the non-existence of specialized associations for certain types of mental disabilities. In particular, it has expressed its concern about the absence of civil society organisations in the mental health field, see — the 2015 NHRC *Report on the Situation of Human Rights in the State of Qatar*, [75] and [57].