

International Journal of Mental Health and Capacity Law

Articles

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Adult Incapacity Law: Visions for the future drawn from the unfinished story of a new subject with a long history

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Book Review

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The Editors are keen to receive academic articles, both shorter ones of around 5000 words and longer ones of up to 12,000 words; and practice points, case notes and reports of research of around 5000 words. Submissions should be made via the Journal's website - <http://journals.northumbria.ac.uk/index.php/IJMHMCL/index> - and comply with the directions given there as to process. Manuscripts should comply either with the Oxford University Standard for Citation of Legal Authorities (<http://www.law.ox.ac.uk/publications/oscola.php>) or the APA Referencing Style Guide. If you use footnotes, we encourage short footnotes.

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*Articles and pieces in this issue have been edited by:
Carole Burrell, Kris Gledhill, Catherine Penny, Alex Ruck Keene*

EDITORIAL

This issue of the International Journal of Mental Health and Capacity Law may be relatively slim, but it contains multitudes. First, there is a concise overview by Giles Newton-Howes, Leah Kininmouth and Sarah Gordon of the debates about coercive practices in psychiatry prompted by the UN Convention on the Rights of Persons with Disabilities ('UNCRPD'). The authors are all based at the University of Otago, New Zealand, and two are part of the World of Difference service user research group at Otago's Department of Psychological Medicine. The overview provides a sure-footed guide to those new to the area.

Building on these foundations, the next two contributions reflect – we can say without disrespect – the cumulative wisdom of well over a century of hard thinking about how to reform the law relating to those with cognitive impairments.

The first of these contributions is a lecture delivered by Adrian D Ward MBE, a retired Scottish solicitor, at an event entitled "Adrian Ward at 75" at the Centre for Mental Health and Capacity Law, Edinburgh Napier University, on 13th November 2019. In it, he reflects upon nearly half a century of working to reform the law in Scotland – and further afield – in the context of those with cognitive impairments. The lecture serves as a history lesson on the course of reform in Scotland, reform in which he has been instrumental, and an agenda for further action. It also sets out a sustained critical engagement with the UNCRPD, an engagement all the more valuable for the fact that, in many cases, the work that Ward was doing can be seen as implementation of the UNCRPD *avant la lettre*.

George Szmukler, Emeritus Professor of Psychiatry and Society, Institute of Psychiatry, Psychology and Neuroscience, King's College London, United Kingdom, has been at the forefront of proposals to develop a fusion law to replace standalone mental health legislation. In this paper, he tackles an aspect of fusion law that has long posed apparent conceptual and practical problems – i.e. how to address the position of offenders with a mental impairment. The difficulties of addressing their position is tellingly illustrated by the extremely complex way in which the Mental Capacity Act (Northern Ireland) 2016 seeks to deal with the position of such offenders within what is otherwise intended to be a fully-fused system. In his paper, Szmukler argues that within the parameters of a fusion law, unfair discrimination towards those with a mental impairment placed on treatment orders by a court - as exists presently in nearly all jurisdictions - can be avoided while at the same time providing satisfactory public protection. Szmukler's proposals pose their own challenges, which he frankly accepts, but, as with his previous work, they represent a sustained and rigorous attempt to produce a legal system which does not discriminate against those with a mental impairment.

Read together, the papers by Ward and Szmukler stand as an important corrective to the impression that is sometimes given that serious thinking about

reform in relation to those with mental impairments was non-existent prior to the conclusion of the UNCRPD. They also provide detailed and 'operational' attempts to answer some of the difficult questions that that the Convention poses, answers of relevance far beyond the two jurisdictions (Scotland and England) within which the two authors work. In the specific context of psychiatric practice, this then brings us helpfully full circle to the overview in Newton-Howes et al of some of the approaches that may start to help us to unlock the dilemmas.

As usual, we wish to thank our peer reviewers, whose input assured better quality outputs, and the authors for using the Journal as a way to contribute to the debate on these important topics.

Alex Ruck Keene

(for the editorial team for this issue, Carole Burrell, Kris Gledhill, Catherine Penny and Alex Ruck Keene)

SUBSTITUTED DECISION MAKING AND COERCION: THE SOCIALLY ACCEPTED PROBLEM IN PSYCHIATRIC PRACTICE AND A CRPD-BASED RESPONSE TO THEM

GILES NEWTON-HOWES, LEAH KININMONTH, SARAH GORDON*

ABSTRACT

Psychiatry has a long tradition of enforcing 'care' within mental health settings, through formal and informal coercion, often with little regard to decision-making capacity. Despite scant evidence for the effectiveness of coercive interventions and the wide variation in their application, indicating structural as opposed to health-driven reasons for use, coercive practices continue to be routinely used internationally. This is notwithstanding the recovery model of care that is endorsed on a national public policy level in many countries. Further, the Convention on the Rights of Persons with Disabilities (CRPD) and its Committee make plain that the use of practices of coercion for those who experience disability, including people who experience psychosocial disability, are unacceptable and in breach of their and other international conventions. The CRPD is interpreted as demanding an end to coercion, primarily through substitute decision-making being replaced with supported decision-making. This critical analysis examines the development of coercive practices in psychiatry, how they have become embedded as both common and socially acceptable, and approaches that may help to reduce their use in light of the CRPD. Models of care where changes have been successful in reducing substitute decision-making and promoting supported decision-making are highlighted to challenge some of the inertia to change.

I. INTRODUCTION

The World Health Organisation defines health as, "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (1) Health in this context stretches beyond the correction of a physiologically abnormal marker, the anatomical correction of a physical abnormality or the support of a person to the point of temporary happiness. Health includes and is reliant on the support of resilient psychological well-being. Despite this, medicine continues to be increasingly specialised (2) with the focus being biological and narrow (3). In the area of psychiatry, change over time has not led to a similar degree of subspecialisation (4) and there have been some attempts to introduce a more holistic stance, such as through adoption of the biopsychosocial model of care (5, 6).

Despite this, many problems faced by people who experience psychosocial disabilities create challenges in relation to the delivery of effective support. Endemic poverty, substandard housing, disparities as victims of violence, exploitation and abuse (7),

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discrimination in employment and economic opportunities (8), coercive and discriminatory legal and medical treatment (9) and disparities in physical health care provided to those who experience mental distress continue. Arguably some of these problems occur at the interface of psychiatry, public policy and society, constraining psychiatric practice within a context where systemic injustice exists (10). The normative societal position, and that of psychiatric practice, minimises the value of the voice of those who experience mental distress (11), adding barriers to even recognising the extent of problems, including those at the socio-political level, that impact negatively on individuals and the support they receive (12).

These problems result in reduced quality and effectiveness of support. The consequence of this are inequities and disparities in terms of patient outcomes, physical illness, and premature mortality (12, 13). The deprivation of usual legal freedoms, such as presumed capacity, violate fundamental human rights, and act to deepen these inequities and disparities and make challenging them difficult (14). The long-standing power imbalances in psychiatry (15), facilitated through coercive practices (16), create a globally established psychiatric normative practise, which is critiqued in this paper.

II. THE CALL TO REDRESS THE PROBLEM OF COERCIVE PRACTICE

Both the evidence that coercion is of limited effectiveness and human rights imperatives are coalescing to challenge coercive practice. The variation in compulsory treatment within the same jurisdiction, between regions and individual psychiatrists (9, 17, 18) suggests non-clinical factors drive decision making in relation to the use of coercion (18, 19). The evidence for many coercive treatments are weak. Community treatment orders, a form of coercive treatment, are an example of this (20). Furthermore, the use of coercive treatments are increasingly becoming less accepted and more often challenged from the perspective of international human rights conventions and bodies (21). This raises the question of how mental health services could be configured without elements of legal coercion (17).

A. The CRPD

The CRPD (22) was adopted by the United Nations in 2006 and came into force in 2008. Importantly, the CRPD does not create any new rights for people with disability (including people who experience psychosocial disability) but rather it clarifies the application of rights and seeks to protect the rights of persons with disabilities that exist in other international treaties (23). These have been described as including: dignity, equality, non-discrimination, individual autonomy, fair access to resources and support, and full social participation and inclusion (24). Interestingly the CRPD, developed with considerable input from those with experience of disability, recognises that disability occurs when society does not sufficiently accommodate an impairment or, in other words, where 'various barriers may hinder the full and effective participation of persons with impairments in society...' (14). As Article 1 states:

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

This contrasts with the current biomedical model of disability (25) that sees deficits as being within the individual. One of the most contentious provisions of the CRPD is Article 12, equal recognition before the law, which entails the right to legal capacity (25, 26). Legal capacity involves two strands – legal standing (to hold rights) and legal agency (to act on those rights and have them recognised), including specifically in relation to fundamental decisions regarding health.

The premise of the CRPD is the contention is that despite a perceived or actual impairment in decision-making ability (often referred to as mental capacity), people experiencing psychosocial disability maintain the right to legal capacity. No matter how impaired a person's decision-making capability might be, this must not be used as justification for denying legal capacity. As an example, consent or rejection of medical intervention involves an exercise of legal capacity (27), and this is free of the normative value of the decision itself (28).

B. Supported decision making as opposed to substituted decision making in light of the CRPD

In 2014, the Committee (29) issued a general comment making it clear that Article 12 and the right to legal capacity should be interpreted to ban any form of substituted decision making (where people make a decision on behalf of another person). This radical stand was considered necessary as: "there are ongoing violations found in mental health laws across the globe, despite empirical evidence indicating its [forced treatment's] lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment" (29).

To support coercion within the most commonly based 'best interests' framework is an example of substitute decision-making and remains non-compliant with the CRPD. The act of substituting a decision in the patient's presumed interest requires an outcome that is 'the good' in the substituter's perspective, and this approach by its very nature is a tautology.

The CRPD Committee identify that support in the exercise of the right to legal capacity requires a paradigm shift in the practice of services - from the approach of substitute decision-making that involves the determination and delivery of supports considered by others to be in the best interests of individuals to the approach of supported decision-making that involves the determination and delivery of supports in accord with the will and preferences of individuals.

The interpretation of the CRPD Committee has caused significant debate in the literature, with the response by some scholars and clinicians being critical, defending the need for coercion (30, 31). Concern has been raised that potentially serious adverse consequences could arise from a 'supported decision-making' only stance (25, 32). These consequences are identified as including possible legal (33, 34), social (33),

and societal impacts. Unintended consequences, such as increased criminalisation (24, 25), is given as an example of this. It has been argued that to leave persons with mental disorder, "...free to destroy their own lives and ruin the lives of their loved ones" (35) severely endangers the interests of that person, or others, by blocking necessary preventive action, and preventing extra, positive entitlements being conferred (24). Others go so far as to say that failure to provide (involuntary) treatment in response to the impact of a person's disability is in conflict with Article 25 of the CRPD (the right to the highest attainable standard of health (23, 24, 36)) and is therefore itself discriminatory (24). Taken as a whole, this view considers that the Committee fails to offer adequate guidance on how to resolve situations where rights are in conflict (e.g. autonomy versus protection of interests of vulnerable persons (14)), where there are conflicts between will and preferences in different moments (37), when there is a radical change in a person's preferences (potentially related to psychopathology) (14) or what to do in emergency situations (25). The fundamentally 'supported only' view is considered by these critics to ignore the realities of imminent threats to the safety of a person who is experiencing mental distress, or threats to the safety of others around them (24).

As such, there is additional concern that the duty of countries to protect the vulnerable is in conflict with the Committee's interpretation of the CRPD (24, 35, 36).

These rights are, however, automatically granted to every other adult. People are allowed to make many poor choices, which may lead to harm to themselves or others. This is true of other medical decisions, such as the decision to smoke or refuse a cancer curing operation but these choices are not removed from those individuals just because of the obvious harm that will occur.

Although the CRPD reflects a rights-based ethic, the underlying basis is deontological. This perspective is radically different from a utilitarian position that is focused on providing 'the good'. Such a view necessarily examines the 'ends', to support a 'good'. The practice of psychiatry involves some of the most challenging ethical questions in medicine and the CRPD highlights key tensions inherent in much clinical practice. As a result of the potential issues considered by critics to be a consequence of implementing change in accord with the position of the CRPD Committee, there is a consistent call for exceptions to the "absolutist" position of the Committee which is in "stark contrast" with the reality of current mental health care (30) and is "dramatically at odds" with centuries of legal acceptance of involuntary detention and treatment (14) where prevailing concepts have been widely considered as reflecting a human rights perspective (33). It is thought that the CRPD provisions threaten to "disrupt" long-standing approaches to mental health law which negates traditional approaches to protection of those without capacity (23) and is contrary to the fundamental principles of virtually any sophisticated legal system (24).

Despite the fact that there is no jurisdiction in the world that has legislated the 'absolutist' recommendation of the CRPD, any suggestion that the status quo is the best or most appropriate system for the support of those who experience mental distress no longer holds up to scrutiny. The current psychiatric system in many parts of the world causes harm, at least from some patient's perspectives, and includes

powers that do not respect the means of people to make choices for themselves, even if they are not considered to be the 'right' choice by others (38).

Zinkler (30), a leading psychiatrist and academic who has led a coercion-free psychiatric support system, states that changes in mental health practice toward a system based only on support, without any resort to the use of coercion, are possible and can be operationalised. Under this approach, psychiatric diagnosis and/or any other manner of rendering a determination of psychosocial disability, would not lead to restrictions of liberty. Rather the task of healthcare professionals would be to change the nature of the support provided, to encompass both informal and formal support arrangements that enable individuals to make decisions in accord with their will and preferences (14). The type and intensity of support required will vary based on need in relation to decision-making abilities. For example, those in crisis situations may require more support. In such a system, the abolishment of coercive practice should not equate to the abandonment of support. So, if a person declines the assistance of mental health and social services, it would then be incumbent upon those services to be creative in identifying various options that may be more or less acceptable to the individual, plus identify and implement effective forms of engagement to determine wills and preferences, and develop further individualisation of support. One of the keys to supported decision-making will be the provision of options in terms of the where, how, when, what, and who of service delivery. For example, in terms of where, services could be provided in an environment of the individual's preference such as at home, in a crisis centre or at a friend's home.

Engendering change by amending the law is, however, difficult and may ultimately prove impossible to do in a way that adequately addresses the problems with the psychiatric system that exist, at least from the perspective of the CRPD and its committee. The CRPD was widely ratified over a decade ago, and every legal amendment to mental health law globally since that time falls short of the standard of supported decision making as recommended by the Committee. Critique of efforts to legislate with the CRPD in mind suggest they are superficial (8), and it is difficult to conceptualise what law reform would actually involve to meet the standards of the CRPD. Greater effort than simply those of policy makers or government is required. A concerted and multisystem international change program is needed to support systems and services to convert to more human rights-based models of practice.

C. Alternative models of care: CRPD compliant mental health practice

Successful alternative models of psychiatric practice, involving conceptual changes on the meso-level, have been developed. In their systematic review, Lloyd-Evans and Johnson (39) note that mental health wards may be "harmful, frightening, stigmatising, and socially dislocating". They suggest that community-based residential crisis services can provide a feasible and acceptable alternative to hospital admission for some people experiencing acute mental distress. For these to succeed Lloyd-Evans and Johnson identify a rapid response to distress and the management of acuity as key principles. Specific models, as detailed below provide real-world evidence that support can be delivered in a fashion that would be considered CPRD compliant. Notably, none of these models arose in response to the CRPD. However, they do act

as examples of how change, even at this level, can be implemented to work in practice and result in dramatic changes to the individual experience of mental health care. They also provide a practical counter-argument to those who suggest implementing the CRPD as understood by the committee is impossible. Obviously these examples exist within a social framework where coercion still exists, as no jurisdiction has yet provided for a fully CRPD-compliant system. However, this should not be seen as a reason to dismiss them. They are models that provide alternatives, and do not require the broader coercive system to enable them to exist. As such they provide a direction of travel for jurisdictions to consider more widely.

The Heidenheim Mental Health Service in Germany is an example of a new coercion-free environment. Since 1995, they have operated an open-door system with no seclusion. The use of antipsychotic medication has reduced by more than 40% without coercive use (19). A critical element of this service is well trained staff.

Another example is reported by Mezzina (40). Trieste is a sustainable, community-based system that provides a 24/7 network of walk-in community mental health services, where service users are considered guests. The shift of focus is from hospitalisation to hospitality. The no-coercion system of support for recovery involves the health and welfare systems working together based on a whole-of-life vision. This service has led to decreased acute presentations and crises. There are low rates of hospitalisation and compulsory treatment rates are less than 10 per 100,000 of population, which is internationally admirable (17, 18). Again, they have a strong focus on training, motivation, and professional development of staff that facilitates a high standard of positive attitudes and skills.

The Soteria project (41) is a third example of innovation in service delivery that is aimed at minimising coercion and facilitating supported decision-making, in line with the requirements of the CRPD. Designed for those early in the course of psychosis, 58% of Soteria subjects received antipsychotic medication during the follow-up period, and only 19% were continuously maintained on antipsychotic medications. This suggests significant recovery for those participants.

One notable reflection from these services is that the lack of coercion and the facilitation of supported decision-making appears to result in reductions in medication use. Contrary to assumptions in this area and clinical guidelines, the published data is inadequate to conclusively evaluate whether long-term antipsychotic medication treatment results in better outcomes (42). The fact that coercion is then used to compel people to adhere to such treatment regimens provides further support for CRPD-compliant models of service delivery.

As these projects show, a CRPD-compliant, recovery-oriented and sustainable coercion-free psychiatric environment can be conceptualised and implemented without the resultant adverse consequences predicted by some. Whilst all these are currently smaller scale projects, they do serve to provide some challenge to the inertia in response to recommended legal reforms; and some guidance around operationalisation. The CRPD and these exemplar projects provide a fulcrum around which social opinion can be levered to support such changes on a national level. It is

multi-system changes, including shifting social perspectives, psychiatric developments in practice as well as legislative reform that will support more extensive reform of services in accord with the CRPD recommendations. Further, this approach to change does not place the burden for insisting on foundational human rights on those who experience psychosocial disability.

III. CONCLUDING REMARKS

Changing any national and international systems to improve health is a challenging task. International human rights instruments and bodies act to articulate basic rights and freedoms that every person in the world should have and monitor countries in relation to the protection of those rights. In this case it is the CRPD, clarifying that the application of existing human rights requires coercive practices (substitute decision-making) in psychiatry to be abolished and replaced with supported decision making. Progressing such change is proving slow, despite over a decade of work from the direction set by the CRPD. In examining the international landscape, examples can be found of CRPD-compliant services, albeit within jurisdictions that still enable coercion. Nonetheless these examples appear to flourish from the development of thoughtful training, care systems design and founding principles in line with those of the CRPD. These not only function but are also reported to be engendering good outcomes, which appear to be sustained over prolonged periods, for people who experience psychosocial disability. As such there is both the international legal convention and practical examples of how supported decision making and non-coercive practice can occur. It is not for individual clinicians, or patients, to enact change alone. As this paper identifies, ever increasing travel towards a socio-political climate enabling non-coercive psychiatric practice is imperative and needs to be supported.

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“ADULT INCAPACITY LAW: VISIONS FOR THE FUTURE DRAWN FROM THE UNFINISHED STORY OF A NEW SUBJECT WITH A LONG HISTORY”

Adrian D Ward* MBE LLB

ABSTRACT

In 1961 Adrian Ward was one of the first intake for the first full-time law degree in Scotland. He was enrolled as a solicitor in 1967 and practised for approximately 50 years. From 1976 he was gradually drawn into the subject of what is now known (in Scotland) as adult incapacity law, in which he became a national and then international expert. As his interest and involvement developed, so did the subject. However, although it is still a new subject, its history in law goes back to Roman law, and concepts from Roman law were central to leading cases in the development of the subject in which Adrian was involved. Attempts to protect the human rights of defined groups go back in Scotland to the 7th century, but there is fundamental conflict between the concept of universality of human rights, and according particular rights to defined groups. Violations of human rights often start with putting people into categories seen as “other”. A deliberately personalised lecture confronted the audience with personally witnessed human rights violations. Of the concepts defined in the UN Convention on the Rights of Persons with Disabilities, “reasonable accommodation”, though it attracts more attention, is always second-best to non-discriminatory solutions offered by “universal design”. Human rights must be translated into law, and law into practice. Existing law should be understood, used to maximum effect, and then if necessary improved. Measures for the exercise of legal capacity can be categorised as voluntary, involuntary, and third party, but need to recognise the reality that “capability” and “incapability” are the extreme ends of a wide spectrum. Such variations, and individual progressions through them, must be accommodated in general provision and in individual measures. Fundamental concepts of human rights and their progressive developments have driven progress to date, and enabled probable future trends to be identified.

Keywords: capacity; law reform; human rights; legal history.

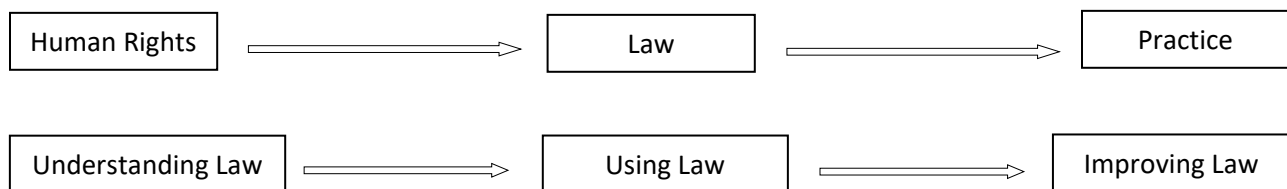
My subject today is “Adult incapacity law: visions for the future drawn from the unfinished story of a new subject with a long history”.

In over 43 years since I first lectured on this subject, this will be different. It will be personalised, and not sanitised. I shall try to encapsulate where we are, and where we are going, from the intersections of long perspectives over time, and broad perspectives geographically.

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It is a great honour that those intersections bring me right now to Edinburgh Napier University, at an event created and hosted by the Centre for Mental Health and Capacity Law. In my first significant conversation with Jill Stavert, I said that Scotland needed such a Centre, and Jill replied by telling me of her aim to establish one. I pay tribute to her huge achievement in creating and continuing to develop this Centre. And I thank her for providing the opportunity for this lecture.

I start with these two themes. First, the converging sequence of human rights translating into law, and law translating into practice, towards making theoretical rights real for individual people who need them most. Lauterpacht wrote that “the basic unit of all law is the individual human being”¹. Second, for us lawyers, is the sequence of understanding the law, using the law, and improving the law, towards that same objective.



Starting with fundamental human rights, a former synagogue in Prague has an exhibition of drawings made by children in Treblinka Concentration Camp, with personal details of each child artist, including their dates of death – mostly in October 1944, and some on the very day on which I was born. Those times produced the first formulations of fundamental human rights which continue to apply. Article 1 of the United Nations Universal Declaration of Human Rights of 1948 reads as follows:

“All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and **SHOULD** act towards one another in a spirit of brotherhood.” (Emphasis added.)

That word “should” identifies a tension between what as a species we may do, and what “reason and conscience” tell us we should do. We are a contradictory species, capable both of great compassion, and of great cruelty. While we are comfortably together here, extreme violations of human rights are happening somewhere in the world, right now.

A psychiatrist, recently returned from counselling victims of such atrocities, had terrible stories to tell. He was asked: “What sort of people can behave like that?”. He told me: “The worst thing of all is that they are people just like you and me”.

Both the UN Declaration of 1948 and the European Convention for the Protection of Human Rights and Fundamental Freedoms, drafted two years later, point to another long-standing theme, that of discrimination within anti-discrimination. The anti-discrimination Articles of

¹ “The individual human being”: Hersch Lauterpacht, “The Law of Nations, the Law of Nature, and the Rights of Man” (1943), in *Problems of Peace and War*, ed. British Institute of International and Comparative Law, Transactions of the Grotius Society 29 (Oceana Publications, 1962) 31.

both Conventions give a list of common grounds of discrimination, but neither mentions disability, in both cases relegated to the words “or other status” at the end². The same trend towards discrimination within non-discrimination can be seen in the UN Convention on the Rights of Persons with Disabilities. The key definition in Article 1 of that Convention reads as follows:

“Persons with disabilities **INCLUDE**³ those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (Emphasis added.)

This strangely non-exclusive definition, and renderings of it limited to the description after the word “include”, has the effect of prioritising people who fit that part of the definition, and thus marginalising those who do not. People with short-term mental and intellectual impairments may well need the protections of the Convention. Also marginalised are people whose cognitive impairments are disabling even when all barriers are removed. They are the very people who most need the protections of the Convention. They should be at the centre of its requirements, not marginalised. Any interpretation of the Convention that has to squeeze them in as “hard cases” is flawed and unacceptable, supporting “discrimination within anti-discrimination”.

Scotland’s world-leading record in our subject includes recognition and protection of fundamental human rights going far further back than my lifetime. Over 14 centuries ago Adamnan’s “Law of the Innocents” protected children and others in time of war, with specified penalties and enforcement mechanism⁴. Sadly, breaches of that principle continue to this day, as do wider breaches of the fundamental rights of children, including in particular children with disabilities. As a boy in the 1950s, in the village where I still live, we were aware of the large house in the woods full of such children. It was several years later as a member of the Local Health Council that I first saw inside it. What I saw was shocking. When such establishments became subject to educational inspection for the first time, an experienced and hard-bitten Inspector of Schools told me how – after his first visit – he sat in his car, and wept.

We may have moved on, but efforts to place children more appropriately have led to other issues, such as children with disabilities placed far away from home areas and families, often cross-border. Such a case is currently before the Court of Session. In the case of young people aged over 16, this focuses a particular aspect of the more general scandal that Scotland was the first country in the world in which the Hague Convention 35 on the

² United Nations Universal Declaration of Human Rights 1948, Article 2: “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. ...”

³ My emphasis.

⁴ Cain Adamnan, 697 AD, a “perpetual law on behalf of clerics and women and children” protecting them in time of war, acceded to by over 50 “kings”, enforced through judges appointed specifically for the purpose. A heavy fine was imposed upon “whoever wounds or slays an innocent child under the ordinance of Adamnan’s law”, with the same fine “for him who commits the deed and for him who sees it and does not save to the best of his ability”; and “if there is negligence or ignorance, half the fine for it”.

International Protection of Adults was ratified, but it has still not been ratified in respect of England & Wales.

More serious breaches of the human rights of children persisted longer in other parts of our own continent. On my very first visit to the former Soviet Union following its breakup, I learned how in a low wage, high employment economy parents of children with disabilities were under huge pressure to surrender them into institutional care. The alternative, which some bravely adopted, was to conceal such children within their own homes. On that very first visit I stayed in such houses. I also met two young doctors whose dream was to create a school and day centre for such children, enabling them to continue to live with their own families. Cutting a long story short, we worked together, converting the dream to reality, a reality which became an example for the region, and which continues to thrive⁵.

But what of children already in institutional care? Eventually that project began to take them out, but in one of those early visits one of those doctors took me to such a place. The most disabled children were accommodated not on the ground floor, with easiest access to the grounds, but on the top floor, furthest from human view. They were held in cage-like cots. They were so starved of human contact that, if you went close, they hurled themselves at you – if they could. Some soft toys gifted from the west were pinned high on the wall as ornaments. At mealtimes they were lifted out of their cots and placed around a large bowl of food for which they sometimes fought. Annual mortality rate was 8%. My guide looked me straight in the eye and said: “the cause of death is usually certified as pneumonia”.

Of course, violations of the basic human rights of adults as well as children also continued long after the fundamental Conventions. One of those young doctors shuddered as we walked down the street. “Are you alright?” “It’s that building.” It was the former KGB headquarters. Her father was a quiet and decent man. I had been a guest in their house. She told me that he had been held here and continuously tortured for 18 months, before he and his parents were deported to Siberia. Similarly, with other hosts in another country, I was shown the yard behind a building where a lorry was parked with its engine running all night – to try to drown out the screams of people being tortured.

A first-hand example, one among many, was the “social institution” seen during one of my WHO visits, where the director entertained our team lavishly to lunch. When he escorted us around, I noticed female residents visibly shrinking from his presence. I also noticed that he steered us away from one particular building. We persisted in wanting to see inside. After a pantomime that no-one could find the key, we gained admission to what I can only call a hellhole, crammed with men with no activity or stimulation of any nature, dominated by the stink of the malfunctioning toilet.

I tell you these personalised examples to dispel any feeling that serious human rights violations can be depersonalised as distant in time or space. We slide towards them whenever people become defined by characteristics and put into categories. They become “other”,

⁵ Tartu Maarja Kool, Tartu, Estonia, see www.maarja.tartu.ee.

depersonalised, in perception if not in language “Untermenschen”, be they people defined by colour, gender, status as immigrants or refugees, or people with disabilities. They are placed outside the scope of normal human compassion.

Such depersonalisation is constantly to be found, in some degree or other; and generally in gradually increasing degrees when politics move further to the right or to the left or in both directions, as is happening in the United Kingdom currently. We have seen the consequences of such slides in other places and in other times. We enjoy no automatic immunity. The situations that keep our Equality and Human Rights Commission busy are worrying both in themselves and in their implications. To characterise as perpetrators hard-pressed front-line staff doing their best with hopelessly restricted resources is often unfair. We have to look to those who impose constraints and create cultures.

On 18th July 2019 the Supreme Court finally determined the case of *MM*⁶ about personal independence payments. For *MM*, the difference between requiring “prompting” or “social support” was the difference between qualifying for PIP and not. He was successful all the way from the Upper Tribunal through the Court of Session to the Supreme Court. The Secretary of State for Work and Pensions not only challenged his entitlement in successive appeals, but even although the case was said to be concerned with a general point of statutory interpretation, *MM* was deprived of the payments which he ought to have received for some four years from when he first applied for them. I would say quite firmly that no adequately civilised regime would have deprived a disabled person of such prospective entitlement while battling on a point of law, for that length of time. But we live in a society where – according to the press last week – a person who admits to having said of benefits claimants that “these people need putting down” is deemed to be a suitable parliamentary candidate for one of our major parties⁷.

However, attempts to respond to such categorisation and depersonalisation lead to a contradiction. The essence of human rights is universality: they apply to every human being on our planet by virtue of being a human being. They have been created to counteract risks of denial of those rights to people categorised as “other”. But if we try to define particular categories, giving them enhanced protection, do we not strengthen that concept of otherness? By putting definitional boundaries around those categories, do we exclude some people who need those protections? Do we risk treating included people as units within a special category, rather than as individuals in all their variety, risking discrimination within anti-discrimination?

Protection of special categories is as old as the concept of human rights, as my example of the law of Adamnan shows. But many key provisions of the Universal Declaration begin “Everyone ...” or “No-one ...”. Do we need more than emphasise that everyone means everyone and no-one means no-one? Do we need a Disability Convention or other special Conventions?

⁶ *Secretary of State for Work and Pensions v MM* [2019] UKSC 34. *MM* claimed PIP on 25th February 2015. The Supreme Court decision was issued on 18th July 2019.

⁷ The Times, November 5th 2019, page 8.

Accepting that we do have that Convention, that concern is exemplified by the definition of disability that I have already quoted. It also leads to a further contradiction, exemplified by the definition of discrimination on the basis of disability in Article 2 of the Disability Convention 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.”

To apply a “reasonable accommodation” to some people with some disabilities in some circumstances, albeit with the best of intentions, is discriminatory. I much prefer the concept of “universal design”, which is inclusive. Its use in the law and legal processes is seriously under-developed. To take simple examples, if some witnesses are permitted to sit while giving evidence while others stand, the feeling of differentiation can cause them to be less confident, and for that to be communicated as less certainty about what they are saying. Why doesn’t everyone sit down, including those questioning them? Even at the beginning of their evidence, does the formulation “raise your right hand and repeat after me” add veracity to the following evidence, and accordingly do people who cannot raise their right hand, or do not have one, automatically contribute less veracity?

Just a week ago the press reported a relaxation in the Court of Session, allowing judges and counsel to appear without the customary court dress – but only in hearings not involving giving evidence⁸. One would prefer to have seen evidence-based assessment of the advantages and disadvantages of wearing, or not wearing, court dress when litigants and witnesses are present, including persons with disabilities or other vulnerabilities.

More generally, as demonstrated in the paper “Access to justice for people with disabilities”⁹ by Dr Polona Curk, a psychologist with Essex Autonomy Project, and me of August 2018, the Equal Treatment Bench Books both sides of the border are valuable resources, but essentially contradict their titles. Rather than promote equal treatment of people with disabilities, they attempt to mitigate unequal treatment.

Of course, discrimination in the administration of justice takes more serious forms. A major culprit is Scottish Legal Aid Board, refusing to sanction minimum necessary periods of time for solicitors to take instructions and advise when dealing with people with mental health and other issues. To refuse to sanction Legal Aid for clients whose ability to instruct cannot be confirmed on the basis of a maximum of ten minutes on the telephone, even for those with severe difficulties in communicating at all by telephone, is a clearly discriminatory violation of the right to legal advice and representation. I have heard it suggested that this particular practice has stopped, but I am reliably informed by practising solicitors that it has not.

⁸ See Court of Session Practice Note (No. 1 of 2019) “Court dress in Outer House”, dated 31st October 2019, taking effect on 1st December 2019.

⁹ <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2018/08/Article-132-paper-.pdf>

Let us move from rights to law and practice, and some long-term trends identifiable from the development of Scots law.

Nowadays we talk about voluntary measures where formerly we called them anticipatory measures; involuntary measures where formerly we called them responsive measures; and third party measures. Let us run through the history of principal measures in the involuntary and voluntary categories taking us to where we now are.

In relation to involuntary measures, please look at Diagram A¹⁰. One theme is shifting terminology, to which I shall return. Another more seriously problematical one is the importation of child law to be applied to adults with disabilities. This takes us to a long-running and fundamental tension between doing what is "easy and certain" and what is "more difficult and less certain".

What is easy and certain? It is easy and certain to divide adult humanity into people deemed to be fully capable and responsible, and those deemed to be completely incapable and incapacitated. All juridical acts by the former are valid and binding. All juridical acts by the latter are void. Once this simple categorisation has been established, it is easy and certain to put people into the incapable category upon medical diagnosis of a defined relevant disability, without further enquiry into the effects of that disability. And once that category has been created, the easy option is to apply to people within that category the existing ready-made and well understood law applicable to young children.

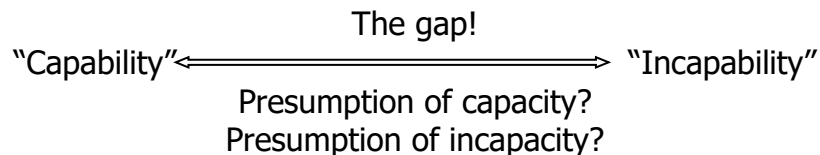
Thus, as we can see from Diagram A, a statute of 1585 imported the Roman law of children and applied it to adults with cognitive impairments. In 1913 the existing law of children was used to create a form of statutory guardianship for adults.

What is wrong with the easy and certain option? It is fundamentally discriminatory to place any adults, however disabled or frail and elderly, into a category of quasi-children and to deprive them of some of the basic rights held by all other adults¹¹. That violates the primary concept that human rights attach to every human being on our planet. Adults, however disabled or elderly, are not "big children". It is inappropriate to apply to any adults traditional concepts of child law, such as "best interests" tests and plenary, incapacitating guardianship. Relevant disabilities do not eliminate the rights of every adult to exercise autonomy and self-determination. Indeed, if capabilities are limited, the exercise of autonomy and self-determination as far as possible, if necessary with appropriate support, becomes even more important.

¹⁰ Appended to this paper.

¹¹ Scottish Law Commission Report No 151 on Incapable Adults, September 1995, Paragraph 2.50: "*Our general principles do not rely on the concept of best interests of the incapable adult ... 'best interests' does not give due weight to the views of the adult, particularly to wishes and feelings which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law ... We think it is wrong to equate such adults with children, and for that reason would avoid extending child law concepts to them. ...*"

This leads to an even more basic objection to the “easy and certain” option. It has never coincided with reality. Concepts of total capability and total incapability are the extremes, probably fictional extremes, bracketing a huge range of variable capabilities in between. At one extreme, it is doubtful whether anyone is so robust that they could never need any form of support or protection. At the other extreme, complete incapability, and with it the connotation of lack of any individuality as a person, is most certainly a fiction. I call the space between those extremes “the gap”. Where in theory “the gap” should be filled by a presumption of capacity, in practice it is often filled by a presumption of incapacity.



Let us now follow the history of voluntary measures, leading us to confront that same gap. Nowadays the most common voluntary measure is the power of attorney, but until 1990 it was believed in many quarters that the authority of the attorney automatically ceased if the granter lost relevant capacity. My clients complained “you give us an umbrella, then take it away when it starts to rain”. In 1990 we went by statute to the opposite extreme¹². All powers of attorney were assumed to continue in force following impairment of relevant capacity, unless the document explicitly stated otherwise: with no controls or safeguards either at time of granting or during operation. Hence the elderly gentleman who was admitted to hospital and in quick succession granted three powers of attorney in favour of three different relatives. Since 2nd April 2001 we have had the safeguards at time of granting, and during operation, contained in the Adults with Incapacity (Scotland) Act 2000¹³. However, at first sight the language of that Act inhabits the binary world of capability or incapability, ignoring the gap between. Thus, both sections 15 and 16 refer to “the event of the granter’s becoming incapable in relation to decisions about the matter to which the power of attorney relates”, with a similar formulation in section 18. The same binary approach appears in the definition of a continuing power of attorney in Principle 2.1 of Council of Europe Recommendation (2009)¹¹ on principles concerning continuing powers of attorney and advance directives for incapacity, as:

“a mandate given by a capable adult with the purpose that it shall remain in force, or enter into force, in the event of the granter’s incapacity.”

We should note at this point the long-running commitment of Council of Europe to preferring voluntary measures over involuntary measures, and generally supporting the principles of autonomy and self-determination. Principle 7 of Recommendation (1999)⁴ on principles concerning the legal protection of incapable adults reads:

“Consideration should be given to the need to provide for, and regulate, legal arrangements which a person who is still capable can take to provide for any subsequent incapacity.”

¹² Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, s71.

¹³ See Part 2 of the 2000 Act, which entered into force on 2nd April 2001.

Principle 1 of the 2009 Recommendation reads:

- “1. States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives.
2. In accordance with the principles of self-determination and subsidiarity, states should consider giving those methods priority over other methods of protection.”

Principle 14 of Recommendation 2014(2) on the promotion of human rights of older persons reads:

“Member States should provide for legislation which allows older persons to regulate their affairs in the event that they are unable to express their instructions at a later stage.”

Unlike the earlier Recommendations, Recommendation 2014(2) also introduces the right to support.

Principle 13 declares that:

“Older persons have the right to receive appropriate support in taking their decisions and exercising their legal capacity when they feel the need for it, including by appointing a trusted third party of their own choice to help with their decisions. This appointed party should support the older person on his or her request and in conformity with his or her will and preferences.”

Having approached the gap from various angles, let us rewind and follow another thread of my remit today, which is to trace briefly some aspects of my own experience, and the developments in which I have been involved, through to date, before concluding with my thoughts as to where all of these trends have taken us, and where I believe they will take us out into the future.

In 1961 I was part of the intake for Scotland’s first ever full-time law degrees, offered as first degrees. At that time no coherent subject of incapacity law, under any title, existed. That was still the case in 1976 when a friend who was an educational psychologist asked me to address a group of parents of children with learning disabilities who wanted to know about their children’s status in law then, and once they became adults. I said that I knew nothing about that subject. My friend said that they could not find any lawyer who did, so could I try to put together a talk for those parents. As a favour to a friend, I did so, thinking no more about it until a second group asked me to do the same. The vacuum quickly sucked me in. By 1984, Enable (then the Scottish Society for the Mentally Handicapped) asked me to write a book¹⁴ encapsulating the topic, so I did, thinking that they could sell the book and I could regain my evenings.

Demand doubled, particularly because at that time Scots law was in some respects beginning to progress beyond black and white concepts of total incapacity derived from a diagnosis. That had started with the abolition in the Education (Scotland) Acts 1980 and 1981 of the concept that some children were ineducable, replacing that with the concept of special

¹⁴ Ward “Scots Law and the Mentally Handicapped”, SSMH, 1984.

educational needs and the requirement for a record of needs setting out an individualised assessment and package of provision. Next, anticipating by several years the Disability Convention and published views of the UN Committee on the Rights of Persons with Disabilities, came the abolition of plenary disqualifying guardianship in personal welfare matters, which applied in all cases where any guardianship was required. Abolition came in the Mental Health (Scotland) (Amendment) Act of 1983, consolidated into the Mental Health (Scotland) Act 1984. The preceding regime, dating from 1913¹⁵, was linked to the process of institutionalisation under the Lunacy Acts, starting in 1857. It was directed at remedying the perceived “lasting injury to the community” resulting from the presence of people with learning disabilities “at large in the population”. It was a regime under which they should be “placed” in institutions or in guardianship.

The statutory guardianship introduced in 1984 conferred fixed and limited powers designed “as a means of ensuring that some mentally disordered people living in the community received the protection and support they require”. There were already trends internationally towards creating limited guardianship along the same lines as the reforms to our education law, assessing individual need and creating an individual package of provision. That was the context in which I also researched the history of the subject, encapsulated in the diagram that I have shown you, based on a diagram down to 1990 included in my book of that year “The Power to Act”¹⁶.

I was in the midst of these researches when along came the parents of Simon Morris¹⁷. Simon had recently attained majority. He still needed the support of his parents in many matters, including encouragement towards independence and making his own decisions. His parents were hampered by lack of recognition of their role, and also felt that they should not be playing such a role without some legal authority. They had studied my 1984 book, including the “comments and suggestions” in the last chapter. My researches told me that although procedure to appoint tutors-dative to adults had fallen into disuse, they had never been abolished, and indeed in 1923 there had been an isolated case of appointment with powers limited to personal welfare matters. So in 1986 we petitioned the Court of Session to revive the procedure, to do so in accordance with modern perceptions and principles, and to meet what was expressly observed as Simon’s needs for support with an appointment with powers limited to those shown by medical certificates to be necessary, and time-limited to ensure review. The petition was granted¹⁸. The concept was increasingly used, and increasingly refined and developed, throughout the period from then until Part 6 of the Incapacity Act came into force on 1st April 2002. Some appointments covered specific self-contained decision-making, for example in medical matters, foreshadowing intervention orders.

¹⁵ Mental Deficiency and Lunacy (Scotland) Act 1913.

¹⁶ Ward “The Power to Act”, SSMH, 1990.

¹⁷ Where I use real names in this paper, they are already in the public domain and/or I have permission to use them.

¹⁸ *Morris, Petitioner* (unreported) 1986 – see Ward, “Revival of Tutors-Dative”, 1987 SLT (News) 69: Revival of tutors-dative to adults.

However, tutors-dative were appointed only in personal welfare matters. Until 2002 we still had curators bonis acting in property and financial matters, again under a regime which completely disqualified the adult if such an appointment were made. The human rights violations (as we would now describe them) of that regime were multiple, and I sought to describe them in my 1990 book. Then along came Eileen Britton with her parents. As a youngster, Eileen had been brain-injured by a hit and run driver. Substantial damages had been awarded. By the time that I met the family, they were administered by a curator bonis. The family had been advised by a welfare rights officer to see a lawyer because the income allowed to Eileen by her curator was less than if she had never received the damages, and had been dependent upon state benefits. In the memorable words of her father: "Mr Ward, we are just ordinary working class people, but this does not seem right. Can you help us?" In my efforts to persuade the curator bonis to change his policies, I was a complete failure. When I went to see him, before my bottom even touched the chair, he had pronounced: "The family know that Eileen has money. They want to get their hands on it. It's as simple as that." To try to get the conversation going, I mentioned Eileen's desire to try typing. She might never be the world's best typist, but she wanted to try, and could easily afford a typewriter. Had she never said this to the curator? I then learned that he had never met her. He would neither budge nor resign.

However, curator bonis procedure was not devised by the legislature. It was invented by the courts, and thereafter regulated, initially by an Act of Sederunt of 1730¹⁹. Curators bonis had in practice replaced appointment of tutors-at-law, because that procedure came to be regarded as "very absurd, very cumbrous, and very expensive". Such words would never apply to any modern procedure, would they? Curators bonis were originally introduced as a temporary measure pending service of a tutor-at-law. Tutors-at-law trumped curators bonis. Back we went to the Court of Session. The curator bonis opposed. The family won²⁰. Eileen's father became her tutor-at-law. He always felt that it was unfair that this ancient procedure did not recognise the role of Eileen's mother. After he had become a guardian under the transitional provisions of the Incapacity Act, she was appointed as additional joint guardian. They applied their role inventively. Eileen deserved greater independence, but still required support. The family lived in the ground floor of a four-in-a-block building. The house above theirs became vacant. Through her guardians, Eileen bought it. It was marvelous for me to experience the pride with which she admitted me after I had rung the bell, invited me in, and showed me round. Unfortunately, her life was bracketed at both ends with tragedy. She succumbed to breast cancer at a very young age. Sitting quietly at the back of the church at her funeral, I reflected on how the true heroes of the development of our law were these and many other families, motivated by a basic sense of injustice and challenging our profession to deliver justice.

That case, unlike *Morris*, is in the law reports. It was decided in 1992. Back in 1986 I had proposed to Scottish Law Commission a coordinated review and reform of both mental health and incapacity law. Their response was that such a task would be too large, but they could

¹⁹ Act of Sederunt 1730, see also Judicial Factors Acts 1849, 1880 and 1889.

²⁰ *Britton v Britton's Curator Bonis*, 1992 SCLR 947.

take on incapacity law. I was recruited on a temporary, part-time basis to the Commission as an external expert. What is now essentially our Incapacity Act appeared as a draft Bill annexed to the Commission's 1995 Report on Incapable Adults. That same collective sense of injustice carried through to the campaign for enactment. I had the great honour to be recruited as principal spokesperson for the campaign. In the run-up to the first elections for the Scottish Parliament, I went to all the party conferences and secured the commitment of every party to support the legislation. I then had the unique experience for any lawyer of accompanying the first major legislation through a brand-new Parliament.

The Incapacity Act completed the shift from what I term old law to new law. Old law was characterised by fixed provision, often complete incapacitation, based on diagnosis. New law sought to provide an individualised package of provision based on assessment. I prepared Diagram B²¹ twenty years ago to encapsulate the basic structure of the Act. It speaks for itself.

Before that, other things had happened. As to service provision, various involvements included the founder chairmanship in 1978 of Renfrew District Association for Mental Health, subsequently renamed RAMH – "Recovery Across Mental Health". From 1992 to 1997 I chaired successive NHS Trusts with an expanding remit covering learning disability, mental health and community services, and services for the elderly, in what was then the central region of Scotland. That included responsibility for the Royal Scottish National Hospital, which only shortly beforehand had been severely criticised by the Mental Welfare Commission for overcrowding to the extent that some residents could only reach their own beds by climbing over others, personal clothing got mixed up and redistributed in the laundry, and there was a lack of general stimulation and appropriate activity. The population was reducing as, in the language of the time, residents were "repatriated" to areas all over Scotland and the north of England. But those considered most difficult were left behind. So, as I can now admit, we broke the rules. We did what an NHS body should not do. We started buying ordinary houses in surrounding communities, registering them voluntarily with the local authority to ensure independent supervision and monitoring of standards, and started moving our residents out into them. I learned much else, beyond the scope of this talk, in those years.

Another development began in an improbable way in 1991. The former Soviet Union had broken up. Many of the constituent nations wanted to enhance their human rights standards with a view to joining the Council of Europe, in many cases as a stepping-stone to membership of the European Union. In their search for accessible material, they had somehow come across my 1984 and 1990 books, written in straightforward language for non-lawyers. My involvement in that whole region thus began, with echoes of the development of my involvement in Scotland. Yet again, I was asked to write a book, this time "A New View", published in 1993 and rapidly translated into five other languages²². That was

²¹ Appended to this paper.

²² Ward "A New View", International League of Societies for the Mentally Handicapped (subsequently "Inclusion International"), 1993 (English-language edition); also published in Czech (1994), Estonian (1995), Russian (1995), Polish (1996) and Lithuanian (1999).

a year after Gordon Ashton and I jointly produced "Mental Handicap and the Law"²³, which we were told was the first textbook to cover the law on a topic for both Scotland and England & Wales. That is certainly what Lord Mackay of Clashfern thought, and he kindly wrote a most generous Foreword.

Across Europe and the former Soviet Union, my travels were generated partly by individual countries, partly by projects funded by the European Union, and also in the mental health sphere by World Health Organisation. Yet again, I myself was on a huge learning curve. Scotland was seen as a world leader in the subject, and also as helpfully straddling both common law and civil law jurisdictions. Later involvements included joint authorship of "The International Protection of Adults"²⁴, contributions to various English and other textbooks, and a particular line of work in relation to voluntary measures – a series of seminars here in Scotland in the 1990s, advising the Nordic nations on the introduction of powers of attorney in 2007, joining the working party to draft Recommendation (2009)11, then more recently reviewing implementation of that Recommendation throughout Europe for Council of Europe.

Let me now pick up some more themes from all of that. Terminology continues to shift, and also to trip us up as soon as we cross borders. Back in 1980, World Health Organisation introduced the International Classification of Impairments, Disabilities and Handicaps²⁵, but we now use "impairment" where that document used "disabilities", and we use "disabilities" in place of "handicaps" to mean the disadvantages encountered in society, including physical structures and the ways in which society is organised.



"Capacity" and "incapacity" have unfortunate dual meanings. In the Disability Convention and associated literature, "capacity" means the holding of rights and status, and exercising these is referred to as "the exercise of legal capacity". Our Incapacity Act defines incapability, meaning factual incapability, and provides that "incapacity shall be construed accordingly"²⁶.

²³ Ashton and Ward "Mental Handicap and the Law", Sweet & Maxwell, 1992.

²⁴ Frimston, Ruck Keene, van Overdijk and Ward "The International Protection of Adults", Oxford University Press, 2015.

²⁵ Geneva, 1980.

²⁶ Adults with Incapacity (Scotland) Act 2000, definition of capacity:

"1. – (6) For the purposes of this Act, and unless the context otherwise requires –
'adult' means a person who has attained the age of 16 years;

'incapable' means incapable of –

- a) acting; or
- b) making decisions; or
- c) communicating decisions; or
- d) understanding decisions; or

As a general piece of advice, where another jurisdiction uses what appears – often in translation – to be terminology with which we are familiar, to a greater or lesser extent it will mean something different.

Such caution may also be necessary in interpreting international instruments. I have three general comments on the interpretation of such instruments, sometimes relevant also to statutory interpretation. Firstly, often overlooked is the difference between principles, whether in human rights instruments or in our own Incapacity Act, and rules of law. Principles, in the famous words of Douglas Bader as once quoted to me by one of our most highly respected sheriffs, “are for the guidance of wise men and the obedience of fools”. Applying them blindly in isolation can produce daft results. If they conflict in particular circumstances, that is not a disaster – they have to be balanced to meet those particular circumstances. Secondly, documents such as the Disability Convention are not targeted exclusively at the laws, practices and experience of any one country. They are drawn from worldwide experience, and often the least satisfactory worldwide experience, of which I have given you a few snippets. Thirdly, documents such as the Disability Convention and comments on it tend to be weighted, even in the disability sphere, in favour of those able to articulate personal experience most loudly, creating hierarchies, so that particular care is needed in relation to the people with whom we as lawyers need to be most greatly concerned, namely those towards the bottom of such hierarchies.

The phrase “rights, will and preferences” features prominently in the Disability Convention and surrounding discussion²⁷. These elements are often at odds with each other. It is often people with relevant disabilities themselves who lead calls for careful balancing of these elements, with no one element automatically overriding the other two. Thus, a group of people with lived experience of compulsory psychiatric intervention agreed with the statement of one of them that “I am glad that when I was ill my right to life was considered more important than my right to autonomy”. A group of people with learning disabilities articulated the need, when will and preferences seemed to be at odds, for someone else to determine what was the overriding will; and even for predictable future will to override currently expressed will. Where there is some confusion between will and preferences, in a recently published article Dr Curk and I argued that there can only be one expression of will in a particular matter at any one time, derived from preferences, sometimes a bundle of preferences which may conflict with each other, and including preferences which reflect the in-built character and background of the individual. We quoted an analysis by Viscount Stair of the stages of will through to commitment, and equated this with the example of online

e) *retaining the memory of decisions,*

.....

'incapacity' shall be construed accordingly."

²⁷ Disability Convention Article 12.4: *"States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."*

shopping: selecting an item, putting it in the basket, but only committing to purchase upon review of the basket and total cost, and perhaps rejecting some items at that stage²⁸.

A key element of the Scottish Law Commission's 1995 report²⁹, carried forward into the Incapacity Act, was the rejection of a best interests test, appropriate as I have already said to the law of children, and inappropriate for adults. I frankly disagree with precedents which suggest that our benefit principle is the primary principle³⁰. That seems to amount to adopting a best interests test. It is not supported either by our legislation or by the intentions behind it, which give no priority to any principle. If in the modern human rights era any principle should have priority, it is the requirement to take account of the present and past wishes and feelings of the adult³¹, including – in the language of the UN Committee – the best interpretation thereof where necessary³². Prior to the Convention, I had already suggested a methodology for achieving that in the last chapter of my 2003 book "Adult Incapacity", entitled "Constructing Decisions"³³.

It is not my intention to speak in detail about the Three Jurisdictions Report, published well over three years ago by Essex Autonomy Project³⁴. My very first meeting with Wayne Martin of Essex University echoed that first conversation with Jill. We quickly agreed that the Three Jurisdictions Report was needed. So we recruited a core research group, of which the Scottish half included Jill and Alison Hempsey – both here today – and pressed ahead. The main recommendations of our Report remain highly relevant at this point. The rights, will and preferences of the individual must lie at the heart of every regime. There should be attributable duties to ascertain the individual's will and preferences, which should only be overridden if stringent criteria are met. Independent advocacy services should be

²⁸ "Respecting 'will': Viscount Stair and Online Shopping", Ward and Curk (with contributions by People First (Scotland)), 2018 SLT News 123; also published in German translation in *Betreuungsrechtliche Praxis*, 2019 p54.

²⁹ Scottish Law Commission Report No 151 on "Incapable Adults", September 1995. See paragraph 2.50 quoted in footnote 12.

³⁰ Sheriff Principal Stephen on 26th August 2014 in Appeal by *BG in the Application by West Lothian Council*, noted at 2014 GWD 40-730: "This is indeed the core principle namely that it is the welfare of the adult and the benefit to the adult which is the overarching principle. ..."

³¹ Lady Hale in *Aintree University Hospital NHS Foundation Trust v James* ([2013] 3 WLR 1299, [2013] COPLR 492) (Supreme Court): "Insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

³² UN Committee on the Rights of Persons with Disabilities ("the UN Committee"), General Comment No 1 (2014) entitled "Article 12: Equal Recognition before the Law", paragraph 21: "Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the 'best interpretation of will and preferences' must replace the 'best interests' determinations. This respects the rights, will and preferences of the individual, in accordance with article 12, paragraph 4. The 'best interests' principle is not a safeguard which complies with article 12 in relation to adults. The 'will and preferences' paradigm must replace the 'best interests' paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others."

³³ Ward "Adult Incapacity", W Green/Sweet & Maxwell, 2003, Chapter 15: "Constructing Decisions", pp331 *et seq.*

³⁴ "Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK", Martin *et al*, 6th June 2016, at <http://autonomy.essex.ac.uk/eap-three-jurisdictions-report>.

strengthened and adequately funded, and should be focused on enabling people to overcome obstacles³⁵. Obligations to provide support should also be attributable and should encompass support for exercise of legal capacity, not simply for communication.

Let me now conclude by returning to that gap, and looking into the future.

Firstly, far too often the concept of tailored provision is abandoned in practice. If we look at powers of attorney documents or guardianship orders, it is easier to recognise the standard forms of particular firms, than to recognise the characteristics, circumstances and needs of the individual. I have picked up general international evidence of much greater use of fixed and plenary powers than intended in modern legislation. The reasons are to an extent understandable. Let's be sure that power of attorney documents cover every eventuality that may arise. Let's do the same with guardianship orders, to avoid having to go back to court for additional powers.

In the case of guardianship orders, I would suggest that this can best be remedied by a two-step procedure. Let the order include all the powers that might foreseeably be required, though still personalised to the particular person and circumstances. But at time of granting of the order, let the sheriff identify those immediately operable, with a simple procedure to bring other powers into operation when needed – perhaps a form of declaration by the guardian, lodged with the Public Guardian, explaining why a particular power needs to be brought into operation, that the guardian has used reasonable endeavours – specified – to support the adult in dealing with the matters without exercise of formal powers, and that the guardian has duly considered and applied the Act's principles in determining that the power should be exercised. Sheriffs can do this without waiting for amending legislation, using their broad discretionary powers under sections 3(1) and (2) of the 2000 Act. Perhaps in some cases the section 1 principles require them to do so.

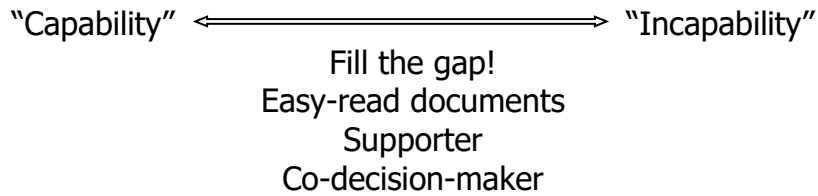
In relation to powers of attorney, the gap is already being addressed. First of all, it is absolutely acceptable for powers of attorney to be granted with appropriate support, and the techniques such as using brief and simple language, and where appropriate large print, provided that the safeguards in Article 12.4 of the Disability Convention are applied. Such a style was proposed in my 2003 book³⁶. Adequate provision of legal services must certainly include offering this where appropriate, as a form of support for the exercise of legal capacity.

Addressing the gap in the period following granting involves including provisions for support and for co-decision-making in power of attorney documents.

³⁵ That is to say, obstacles to comprehension or communication, so as to enable exercise of capacity.

³⁶ Ward "Adult Incapacity", W Green/Sweet & Maxwell, 2003, pp 101-102.

Proposal 5³⁷



Typically in such documents, the attorney is appointed also to be supporter³⁸, with a general supporting role, and particular functions to determine and communicate:

- (a) what is the granter’s competent acts or decisions, and/or
- (b) the best interpretation of the granter’s will and preferences, and/or
- (c) whether or not the granter has been subjected to undue influence.

Usually such documents will declare that the supporter’s opinion is definitive, except if and to the extent that it is shown to be manifestly incorrect.

The most common complaint by persons trying to act as supporters is that they experience difficulty in obtaining information. Such documents accordingly instruct and authorise that the supporter shall be provided on request with all or any data or information relevant to the granter, whether confidential or not, including unredacted copies of any writings, documents or similar.

As to co-decision-making, that appointment will declare that any act or decision by the granter and the attorney jointly shall be valid and binding, and shall be recognised by all parties as such, on the basis that to the extent that the granter does have relevant capacity, it is the granter’s valid and effective act or decision; and to the extent that the granter does not, it is the valid act or decision of the attorney acting with the authority conferred by the power of attorney document³⁹. Thus in practice there need be no enquiry into the granter’s capabilities, because by one route or the other, the act or decision under the co-decision-making provisions will always be valid.

³⁷ “Enabling citizens to plan for incapacity: Report on a review of follow-up action taken by member states of the Council of Europe to Recommendation CM/Rec(2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity; Report prepared by Mr Adrian D Ward on behalf of the European Committee on Legal Co-operation (CDCJ)”, June 2018, published in English and French at: <https://www.coe.int/en/web/cdcj/activities/powers-attorney-advance-directives-incapacity>

³⁸ “I appoint my # to be my supporter and co-decision-maker. In relation to the whole or any part(s) of any act or decision by or for me, his/her opinion shall be definitive as to what are (a) my competent acts or decisions, and/or (b) the best interpretation of my will and preferences, and/or (c) whether or not I have been subjected to undue influence; except if and to the extent that his/her opinion is shown to be manifestly incorrect. I instruct and authorise that he/she shall, if and to the extent that he/she so requests, be provided with all or any data or information relevant to me, whether confidential or not, including unredacted copies of any writings, documents or similar.”

³⁹ “Any act or decision by me and him/her jointly shall be valid and binding, and shall be recognised by all parties as such, on the basis that it is my valid and effective act or decision to the extent that I have relevant capability and his/hers, acting as my attorney on my behalf, to the extent that I do not.”

Such documents typically contain further provisions. They place an obligation on the person who is supporter, co-decision-maker and attorney to provide the granter with all reasonable support in acting, deciding, formulating the granter's will and preferences, and communicating them⁴⁰. There will often be further express provisions that the overriding purpose of the document as a whole is to facilitate the exercise by the granter of the granter's legal capacity, as far as possible by the granter personally, if necessary with the attorney's support, and failing that – or in the event of doubt – using the co-decision-making arrangements; or, failing all of those alternatives, by the attorney playing the classic role under the 2009 definition of acting and deciding on the granter's behalf, but doing that on the basis of what the attorney reasonably believes the granter would do if capable, and in accordance with all other relevant human rights principles.

In the modern world, and in the context of modern human rights developments⁴¹, in my view it would be a failure to provide adequate legal services not to offer the possibility of including such provisions when advising and taking instructions on preparation of powers of attorney.

As with my previous suggestions, there is no reason why such provisions should not be included in guardianship orders, and they may be necessary to ensure full compliance with the section 1 principles. However, I must acknowledge the uncomfortable presence in the room of a massive mastodon still surviving from ancient times, in terms of development of human rights. That is the procedure for appointment of DWP appointees, conscientiously operated by many, but violating almost all relevant human rights requirements as to both appointment process and effective lack of accountability and supervision, giving rise to constant examples of misuse⁴². Among my failures is a complete failure over very many years to date to have these obvious deficiencies mitigated.

Four final thoughts are these.

Firstly, my work for Council of Europe identified that everywhere the concept of advance directives as a unilateral instrument complementary to powers of attorney, is undeveloped. Provision was included in the Draft Incapable Adults Bill of 1995, but disappeared from our Incapacity Act. It requires to be reinstated.

Secondly, twenty years after the Incapacity Act went through its parliamentary passage, we are in a process of comprehensive reform that is likely to take some time yet to result in updated law. Such updated law will require to be future-proofed. In my view it will require, for example, to take account of likely development of Fintech to enable creation of individual packages for financial management. If they become sufficiently sophisticated, with sufficient

⁴⁰ "The provisions of this paragraph are subject to the proviso that he/she shall have provided all reasonable support to me in acting, in deciding, and in formulating my will and preferences, and in communicating all of these."

⁴¹ Essex Autonomy Project – Three Jurisdictions Report (June 2016): Full potential as instruments of support and for exercise of legal agency of powers of attorney and advance directives should be recognised (Rec. 7).

⁴² Essex Autonomy Project – Three Jurisdictions Report (June 2016): "Legislation should ensure CRPD compliance for all measures relating to the exercise of legal capacity".

input as to a person's priorities, preferences, wishes and circumstances, is there any reason in principle why such a package should not have the same status as a continuing power of attorney? Could it be put in place upon granting of a guardianship order? If sufficiently sophisticated and accurately reflective of the individual, could it be a tool to guide the operation of welfare guardianship?

Thirdly, in my old overhead slides in the 1970s I pointed out that special provision equals discrimination, and protection equals disqualification⁴³. The dilemmas identified then still need much work in the era of the Disability Convention to achieve in practice maximum implementation of the prohibition in Article 5 against discrimination on the basis of disability and of the requirement of Article 12 for recognition of legal capacity in all matters on an equal basis with others, by finding least restrictive and disqualifying ways of providing the protection against exploitation and abuse required by Article 16.

Finally, I return to that contradictory creation of special categories. Currently, every month sees one or more consultations on proposals to address the needs of vulnerable clients or vulnerable consumers⁴⁴. There are as many definitions of vulnerability as there are consultations. All carry the risks that I have described of inappropriate inclusion or exclusion, and of categorisation. To a large extent, it would be better to develop techniques of universal design to ensure general inclusivity.

The same applies even more to legal systems. I have argued the point many times, ever since "A New View" in 1993. Put simply, the individual human being, characterised by Lauterpacht as the basic unit of all law, is depicted in law as the fully capable, fully able and well-resourced person – until recently male person. Laws seek to accommodate everyone else by special exceptions and special provisions. I have argued, and shall continue to argue, for what I now describe as the principle of reversed jurisprudence⁴⁵. All laws should be rigorously tested for maximum possible inclusivity. If some people do not need some of the resulting provisions and protections, that is not a problem. Failure to deliver true equality before the law, in all of our law, is a fundamental problem.

We can take particular pride in the recognition of Scotland's leading role in this subject by the award to us of the World Congress on Adult Capacity from 7th – 9th June 2022⁴⁶. We are by far the smallest country ever to host that event, and shall be only the second European

⁴³ From overhead slides in the 1970s:

- "minimum necessary special provision, accurately related to need"
- "no unnecessary imposition of special provision"
- "special provision = discrimination"
- "protection = disqualification"

⁴⁴ At time of writing, the Mental Health and Disability Committee of the Law Society of Scotland had received thirty such consultation documents since 1st January 2019.

⁴⁵ Lohnig *et al* "Kindesrecht und Elternkonflikt", Giesecking, 2013: see "Children's Rights and Parental Conflict in Great Britain", Ward, pp264-265; see also Ward "A New View", ILSMH, 1993 "Postscript: A Contradiction and a Vision", page 198.

⁴⁶ World Congress on Adult Capacity, WCAC 2022, Edinburgh International Conference Centre, 7th – 9th June 2022.

country to do so after – by then – it will have been held in every inhabited continent except Africa.

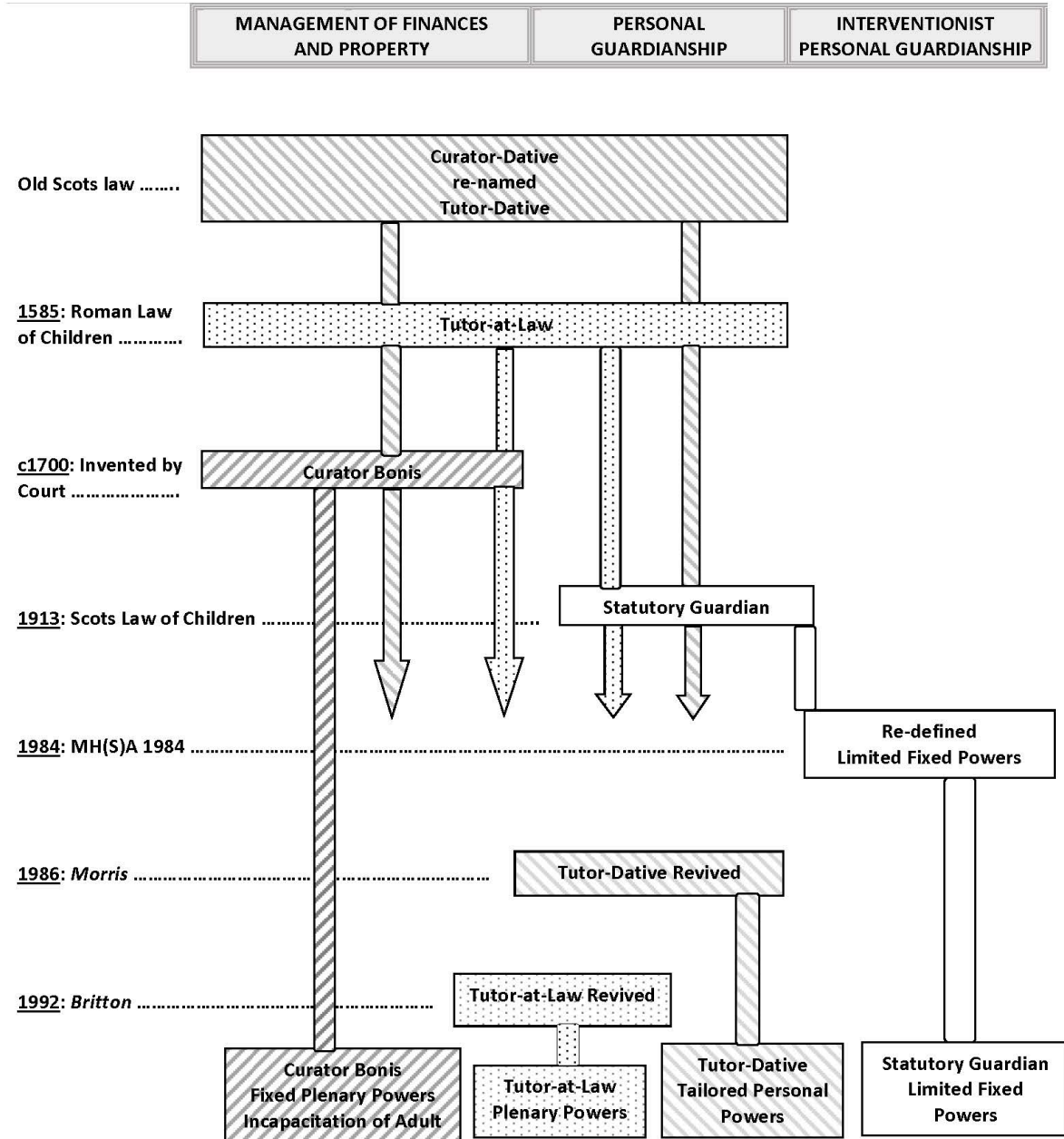
WCAG 2010	Japan
WCAG 2012	Australia
WCAG 2014	USA
WCAG 2016	Germany
WCAG 2018	South Korea
WCAG 2020	Argentina
WCAC 2022	Scotland

Those of you with sharp eyes, if they are still open, will note the shift from “WCAG” to “WCAC”. Hitherto, the title of these Congresses has been “World Congress on Adult Guardianship”. A subsidiary success for Scotland has been to obtain the necessary international board approval to change this, in 2022, to “World Congress on Adult Capacity”. For the people upon whom all such regimes should be centred, the implications have the potential for practical, not merely symbolic, refocusing.

In our whole subject we are in challenging times, with huge potential for better delivery in practice of basic human rights. Despite my rather long personal involvement, I have to say that in many ways we are only beginning.

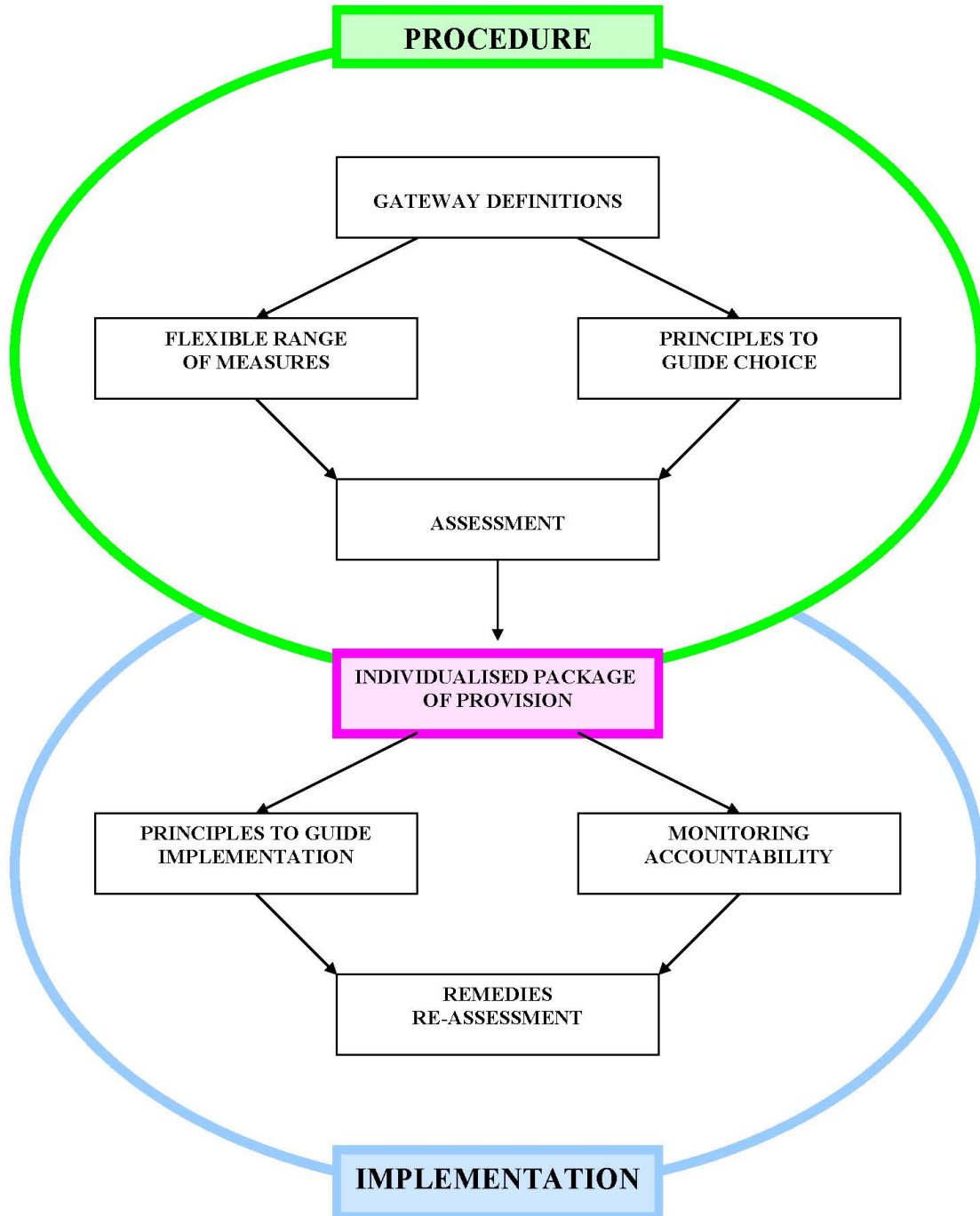
DIAGRAM A

HISTORICAL SUMMARY – GUARDIANSHIP IN SCOTS LAW TO 2002



From "The Power to Act" (1990) adapted and extended

DIAGRAM B



OFFENDERS WITH A MENTAL IMPAIRMENT UNDER A 'FUSION LAW': NON-DISCRIMINATION, TREATMENT, PUBLIC PROTECTION

GEORGE SZMUKLER*

ABSTRACT

A common criticism of a 'fusion law' - a generic law covering all instances where a person's ability to make a treatment decision is impaired, regardless of the cause, and furthermore which only allows non-consensual treatment if it is in the person's 'best interests' - is that it fails to deal adequately with the protection of the public. This paper examines the implications of a 'fusion law' where a person with an 'impairment or disturbance of mental functioning' has committed an offence or where the person has been found 'unfit to plead' or 'not guilty by reason of insanity'. It is argued that within the parameters of a fusion law, unfair discrimination towards those with a mental impairment placed on treatment orders by a court - as exists presently in nearly all jurisdictions - can be avoided while at the same time providing satisfactory public protection. This can be achieved through hospital treatment, voluntary or involuntary depending on the person's decision-making ability and best interests (or best interpretation of 'will and preferences'), and a form of supervision order in the community that is supportively structured, but includes special conditions to ensure compliance.

I. INTRODUCTION

The aim of this paper is to examine the implications of a 'fusion law'¹ for the management of offenders with an 'impairment or disturbance of mental functioning', regardless of its cause. As the fusion law, a generic law applicable to all patients in all medical specialties, is based on a 'decision-making capacity' model, most of the discussion would apply also to a separate 'capacity'-based 'mental health' law.²

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¹ Dawson J, Szmukler G. Fusion of mental health and incapacity legislation. *Br J Psychiatry*. 2006;188:504-509; Szmukler G, Daw R, Dawson J. A model law fusing incapacity and mental health legislation & outline of the Model Law. *Journal of Mental Health Law*. 2010;Special Issue Ed 20:11-24; 101-128; Szmukler G, Kelly B. Debate: We should replace conventional mental health law with capacity-based law. *Br J Psychiatry*. 2016;209:449-453.

² The meanings of 'capacity' (and the related concept of 'best interests') have been contested and are still developing. I have argued for a concept of capacity or decision-making ability based on an analysis of the terms, 'will' and 'preferences', used in the UN Convention on the Rights of Persons with Disabilities (UN CRPD), but not further defined therein. [Szmukler G. The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities. *Int J Law Psychiatry* 2017;54:90-97]. According to this account, decision-making may be undermined when there is a disjunction between a person's 'will' - that is, their, by and large stable, deeply held beliefs, values, commitments or conception

The arguments for a fusion law are readily available elsewhere. In essence, the fusion law aims to eliminate discrimination in the law against people with a diagnosis of a 'mental disorder' when it comes to non-consensual treatment. Under current legal arrangements, the autonomy or right to self-determination of those with a mental disorder is not accorded the same respect as it is for all other patients, when those with a mental disorder who retain the ability, or capacity, to make treatment decisions can nevertheless be treated involuntarily, while those with a physical disorder cannot. A second form of discrimination against persons with a mental disorder is their liability to preventive detention and treatment (albeit usually in a hospital) based solely on their purported risk of harm to others, and not, like the rest of the population, to their having committed an offence (or being strongly suspected of having done so). A fusion law, by applying the same justifications for involuntary treatment to all persons, regardless of medical specialty, eliminates these forms of discrimination.

A number of criticisms of the fusion law proposal have been raised, but the one probably generating most apprehension concerns the implications for the management of people with a mental disorder who present a significant risk of violence to others. Daw, for example, provides a good account of the prominence in the UK of public protection concerns during debates on reform of the Mental Health Act 1983 (MHA 1983) in response to proposals that some form of capacity-based criterion should be included in the justification for involuntary treatment.³ Inclusion of such a criterion was supported by the Richardson Expert Committee⁴ set up by the government to review the MHA 1983, by a number of stakeholders' (including the Royal College of Psychiatrists, the British Psychological Society, Mind) as well as in parliamentary recommendations from the Joint Scrutiny Committee, the House of Lords, and the Joint Committee on Human Rights.⁵

Governmental responses were strongly against this proposal. Rosie Winterton, Minister of State for Health Services stated: "every restriction was a patient not treated" and warned:

of the good – and a 'preference' – a wish, desire or intention expressed in the present. The greater the risk to the person's 'will' from acting on a 'preference' that contradicts that 'will' the stronger is the justification for an intervention. The object of the intervention is to support the person in giving effect to their 'will'. Such an intervention may, if all reasonable efforts at supported decision-making prove unsuccessful, lead to 'involuntary' treatment – in fact, supporting the 'will' (*voluntas*) rather against the 'will'. 'Best interests' in this sense is giving effect to the person's 'will'. The making of an advance directive is a good model – it asks that the 'will' of the maker should be respected if a situation should arise in the future where the person becomes unable to express that 'will' and instead may express a 'preference' inconsistent with that 'will'. The person asks that 'preference' not be respected. I will use the terms 'decision-making capacity' and 'best interests' in this paper but ask the reader to bear in mind how their interpretation may change. Alternative terms might be 'treatment decision-making ability' and 'will and preferences'.

³ Daw R. The Mental Health Act 2007: the defeat of an ideal. *J Mental Health Law*. Nov 2007;131-148.

⁴ Expert Committee (1999) Review of the Mental Health Act 1983, Dept of Health, Nov. 1999.

⁵ *Supra* Note 3

"... if it cannot be shown that a patient's judgment is impaired, they cannot be detained – regardless of how much the patient needs treatment and however much they, and others, are at risk without it."⁶

In the Government's response to the Joint Scrutiny Committee it stated:

"... In the Government's opinion, it is not safe to assume that there is a link between the severity of a condition – and therefore the need for treatment – and the person's ability to make decisions. It is possible that people who are at very great risk to themselves or others would nonetheless retain the ability to make unimpaired decisions about their treatment."⁷

An echo of the same concerns is repeated in the 2018 Final Report of the Independent Review of the Mental Health Act 1983.⁸ Despite suggesting that a fusion law is currently the most promising direction of travel for the future, a number of 'tests' are proposed that such a law would need to pass. One is a 'public interest' test:

"The final confidence test is whether fusion law can take proper account of what is in the public interest, particularly when it comes to the risk of harm to others. We have considerable reservations as to whether the concept of 'best interests' can work in this respect. We think at this stage that necessity and proportionality are likely to be more appropriate assessments."⁹

II. ANOTHER FORM OF DISCRIMINATION

The discrimination against people with a mental disorder noted above concerns the failure to accord to them the same respect for autonomy as is accorded all other categories of patient. I propose there is a second form of discrimination, one that is evident in the forensic domain. Offenders with a diagnosis of a mental disorder may be subject to deprivations and restrictions of liberty for periods far in excess of those imposed on 'normal' (or 'non-disordered') offenders who have committed a similar offence with a similar level of seriousness.

In England and Wales, for example, under the Mental Health Act an offender with a mental disorder, following conviction, may be placed by the court on a hospital order (s.37) that, with renewals, is potentially indeterminate (though subject to appeal to a Mental Health Tribunal after 6 months, and once per year thereafter). In cases where it is deemed to be necessary for the protection of the public from serious harm, the hospital order may have a *restriction* order attached (s.37/41). This requires an authorisation by the Ministry of Justice for absolute discharge from hospital, which occurs rarely, or for a conditional

⁶ Rt. Hon Rosie Winterton MP Local Government Association Conference, Mental Health Bill, 1 March 2007.

⁷ Government response to the report of the Joint Committee on the draft Mental Health Bill 2004. Presented to Parliament by the Secretary of State for Health, July 2005.

⁸ Modernising the Mental Health Act. Final report of the Independent Review of the Mental Health Act 1983. GOV.UK, 2018

⁹ Ibid, page 227.

discharge to the community where the person is liable to recall if the person is thought again to pose a risk to themselves or others as a result of their mental disorder. An absolute discharge from conditional discharge again requires Ministry of Justice authorisation. Alternatively, discharge may occur via a Mental Health Tribunal. Again such a discharge is nearly always conditional; a later appeal may result in an absolute discharge.

III. VIOLENCE AND MENTAL DISORDER

Behind the concerns about whether a fusion law would fall short in protecting the public lies a stereotype that people with a mental disorder are intrinsically dangerous, especially those with a psychosis and thus apparently wildly irrational. This is presumably why mental health laws in the vast majority of jurisdictions couple the risk to others with the risk to the person themselves in the risk criterion supporting involuntary detention.

To what extent is that stereotype justified? Population studies show that people with a severe mental illness – a psychotic illness or an affective disorder, in the absence of drug or alcohol abuse or an antisocial personality disorder – are modestly, if at all, more likely to be violent than the rest of the population.¹⁰ Drugs or alcohol are especially associated with violent offences, whether with or without a mental illness. A meta-analysis of studies examining violence in schizophrenia found that those with this diagnosis were no more likely to commit a violent offence when abusing substances than those without a mental disorder who abused substances.¹¹

In England and Wales in 2004 1.6% of serious violent offences were perpetrated by persons known to have had contact with mental health services within the previous 12 months and who had a diagnosis of schizophrenia (or other delusional disorder) or an affective disorder. Eighty-five percent of those in this category, with schizophrenia, had also misused or were dependent on drugs or alcohol at the time.¹² The frequency of persons with such a mental illness among those who carried out a homicide was found to be higher, 3.5%. In 54% of these, drug or alcohol misuse was also present.

¹⁰ The risk of violence for those with a mental illness, in the absence of drug or alcohol misuse or antisocial personality, is only modestly, if at all higher than for the rest of the population. [Coid J, et al. Violence and psychiatric morbidity in a national household population--a report from the British Household Survey. *Am J Epidemiology*. 2006;164:1199-1208; Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives Gen Psychiat*. 2009;66:152-161; Fazel S, Lichtenstein P, Grann, et al. Bipolar disorder and violent crime: New evidence from population-based longitudinal studies and systematic review. *JAMA Psychiatry* 2010;67:931-938].

¹¹ Fazel S, Gulati G, Linsell L, et al. Schizophrenia and violence: systematic review and meta-analysis. *Plos Medicine*. 2009; <https://doi.org/10.1371/journal.pmed.1000120>

¹² Flynn S, Rodway C, Appleby L, Shaw J. Serious violence by people with mental illness: national clinical survey. *J Interpersonal Violence* 2014;29:1438-1458

A report on mental illness and homicide in England covering 2005 to 2015 found 6% of perpetrators (an average of 32 per year) had a diagnosis of schizophrenia. Of these, 61% were known to mental health services, while 88% also had a history of alcohol or drug misuse. Thirty-six percent with this diagnosis had an abnormal mental state at the time of the offence; 34% were convicted of murder; and 41% received a custodial sentence.¹³

A rarely cited Home Office Statistical Bulletin in 2006 reported on the experiences of victims of violent crime who were interviewed as part of the British Crime Survey. Three years, between 2002 and 2005, were covered. Victims who had experienced a violent incident were asked why they thought the incident happened. 'The offender was suffering from a mental illness' was given as the reason in 1%, 2% and 1%, of all violent incidents, per respective year.¹⁴

These data indicate that fears of violence caused by people with a severe mental illness are grossly unrealistic and are underlined by a seductive prejudicial stereotype of dangerousness.

IV. FORENSIC IMPLICATIONS OF A FUSION LAW - PRINCIPLES

Central to a fusion law is the principle that involuntary detention or treatment is only justified when a person with an impairment or disturbance in the functioning of mind lacks treatment decision-making capacity *and* the intervention is in the person's best interests.¹⁵ I am using the terms 'impairment or disturbance in the functioning of mind' and not 'mental disorder' to make it

¹³ National Confidential Inquiry into Suicide and Homicide. Annual Report 2017. <https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-homicide-annual-report-2017/>

¹⁴ Coleman K, Hird C, Povey D. Violent crime overview, Homicide and Gun Crime 2004/2005. 2nd Edition (Supplementary Volume to Crime in England and Wales 2004/2005), Home Office Statistical Bulletin 2006

¹⁵ An assessment of the 'best interests' of a person does not mean that the well-being of third parties is necessarily excluded. For example, if violence against another person is threatened by a person who is currently mentally ill and lacking decision-making capacity, this might be inconsistent with the best interests of the ill person. An example would be where the ill person, when well, deeply values their relationship with the threatened person (for example, a close relative or friend). Causing serious physical or psychological harm would be contrary to the ill person's normal commitments to the victim. Following recovery, such harms are likely to be regretted by the ill person and seen by that person as having been caused when not 'really being himself or herself', or as being opposed to the person's deeply held values. Acting to prevent a risk of violence to unspecified persons, if inconsistent with the person's deeply held beliefs and values, such as the unacceptability of violence, would again be in the subjective 'best interests' of the person. (A consistency of values, on the other hand, would in these terms suggest antisocial behaviour without an impairment of decision-making capacity). Another example would be a person admitted to hospital involuntarily for treatment in their best interests who becomes violent to other patients. Proportionate measures taken to prevent such violence would be justified as cessation of treatment would not be in the person's best interests. In a similar vein, violent acts that are radically contrary to a person's deep beliefs, values or commitments are proposed by Tadros to best define an attribution of 'not guilty by reason of insanity' (Tadros V. *Criminal Responsibility* Oxford, Oxford University Press. 2005)

clear that in a fusion law the impairment is not restricted to those who have a diagnosis of a psychiatric or 'mental disorder'; it can result from any disease or disorder. As a shorthand I will use the term 'impairment of mind'. The interpretations of decision-making capacity and best interests are evolving, with a growing regard, at least in some jurisdictions, being given to a respect for the person's beliefs and values (or 'will and preferences'). Details will not be discussed here; they are readily available elsewhere.¹⁶ The essential principle I am advocating is that a hospital order made by a court should not authorise involuntary treatment if an offender retains decision-making capacity. Voluntary treatment would be the only option for such a person.

A second principle follows from the need to eliminate discrimination against offenders with an impairment of mind when compared to non-disordered offenders convicted of a similar offence with a similar level of seriousness (based, for example, on the degrees of harm and culpability). The management of those with a mental impairment should be, as far as possible, on an equal basis with other offenders. Most importantly, the total duration of a deprivation of liberty (in hospital or prison) or a restriction of liberty (following discharge to the community) imposed by a sentence or court order for an offender with an impairment of mind should be no longer than that imposed on a non-disordered offender. Depending on the response to treatment, where provided, it may indeed be shorter.

Northern Ireland is the first country to pass a form of fusion law (Mental Capacity Act, 2016).¹⁷ It accords with the first principle cited above in that involuntary treatment is restricted to offenders who lack decision-making capacity and it must be in the person's best interests. The second principle, however, is not fully recognised. An offender (or person found 'unfit to plead' or 'not guilty by reason of insanity') may be detained in a hospital or care home against their capacitous wishes, even though they cannot be treated if they have decision-making capacity and refuse the treatment. Detention may occur for an indeterminate period. For example, under a *Public Protection Order* (PPO) (s. 168) the person can be detained in an 'appropriate establishment' (a hospital or care home) if they have committed an imprisonable offence (other than those for which the sentence is fixed by law, i.e. murder) and if: they have an impairment of, or a disturbance in, the functioning of the mind or brain; appropriate care and treatment is available; releasing the person would create a risk, linked to the impairment of mind, of serious physical or psychological harm to others; and, depriving the person of their liberty is proportionate to the likelihood and seriousness of the risk. A 'restriction condition' may also be imposed with the PPO if the court is satisfied, having regard to all of the

¹⁶ Szmukler G. The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities. *Int J Law Psychiatry* 2017;54:90-97; Szmukler G. "Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities. *World Psychiatry* 2019;18:34-41

¹⁷ Mental Capacity Act (Northern Ireland) 2016
<http://www.legislation.gov.uk/niu/2016/18/contents/enacted>

circumstances, and particularly the nature of the offence, the history of the offender and the risk of physical or psychological harm to the public, that restrictions are necessary for the protection of the public from serious physical or psychological harm. A PPO is of indeterminate duration; a restriction condition may be for a specified or unlimited period (until terminated when considered no longer necessary by the Department of Justice).¹⁸

There are three countries that limit the length of a hospital order to no longer than a prison sentence for a similar offence – Italy, Croatia and Portugal, though in the case of the first, a conditional discharge may continue long beyond the custodial phase, and in the case of the last, the order may be extended by 2 years on multiple occasions. However, decision-making capacity is not a pre-requisite for involuntary treatment in any of those jurisdictions.

What would be the implications for forensic practice if both anti-discrimination principles – first, equal respect for the autonomy of persons with a mental disorder compared to other patients, and second, management of offenders with a mental disorder on an equal basis with non-disordered offenders – were to be implemented?

I shall restrict the discussion mainly to people who have committed a serious offence (or if not convicted because of a 'mental condition' defence, have nevertheless done an act or omission that would normally constitute a serious offence). Of greatest concern are serious violent or sexual offences.

I shall first consider offenders with an impairment of mind who lack decision-making capacity and those who retain decision-making capacity. I will then consider persons who are judged to be 'unfit to plead' (or to stand trial) and those judged 'not guilty by reason of insanity'; in most jurisdictions imprisonment is ruled out in these situations since the person has not received a conviction.

A further option that should be available for the court in all cases involving a person with a mental impairment is diversion to mental health services, under a civil involuntary treatment order. In such cases, the patient would fall outside the criminal justice system, with treatment and discharge decisions resting entirely with the clinician (or a civil mental health tribunal). This would be an option under a fusion law, but the criteria for an involuntary treatment order would now be based on decision-making capacity and best interests. Where a serious offence has been committed, however, the court is unlikely to adopt such a civil law disposal.

¹⁸ Campbell P, Rix K. Fusion legislation and forensic psychiatry: the criminal justice provisions of the Mental Capacity Act (Northern Ireland) 2016. *Br J Psychiatry Advances* 2018;24:195-203.

V. OFFENDERS WITH AN IMPAIRMENT OF MIND WHO LACK DECISION-MAKING CAPACITY

Consider the case where a court has found the person guilty of the offence. It accepts further the evidence that the offender has an impairment or disturbance in the functioning of mind, that he or she lacks treatment decision-making capacity, and that treatment would be in the person's best interests. Under a fusion law the person would thus meet the criteria for *involuntary treatment*. Transfer to a psychiatric hospital would thus be appropriate.

However, I suggest that a number of other conditions should also apply to such a disposition. An order by the court could not impose a deprivation of liberty (or post-release restriction of liberty) that would last longer than that imposed by a sentence on a non-disordered offender convicted of a similar offence with a similar level of seriousness. An indeterminate hospital order would not be possible (unless, of course, the usual sentence was life imprisonment).

Furthermore, if or when the person on an involuntary hospital order recovers decision-making capacity with an adequate degree of stability following treatment, the person would now be able to choose to continue with, or reject, further treatment. Continuing with treatment in hospital – if this were recommended by the clinician – would be as a *voluntary* patient. Treatment on this basis could be terminated by the patient at any time as long as they had decision-making capacity. If the patient, now with decision-making capacity, were to refuse treatment on a voluntary basis, there would be two management options. The first would be transfer to *prison* (this person having been convicted of the offence) until release was determined to be appropriate. The second would be *discharge* directly to the community under a form of *supervision order*. The decision to discharge the person to the community, whether from hospital or prison, would fall to a parole board (or other form of review board) that would have the necessary expert psychiatric membership. The aim would be, wherever possible, for the total duration of incarceration to be no longer than the usual custodial part of the sentence imposed on the non-disordered offender.

What if the offender were to remain ill and still meet the criteria – decision-making incapacity and best interests – for involuntary hospitalisation (or for a community treatment order) at the end of the court order related to their offence? At this point, the person would be managed under a *civil* order, and would now be outside the criminal justice system.

Thus the total duration of the court order related to the offence - including the hospital, custodial and community supervision components - would be no longer than that imposed by the usual sentence on the non-disordered offender for a similar offence. For the person with a mental impairment who might make a rapid recovery in hospital, the deprivation of liberty element (in hospital or prison) might be substantially less than the usual custodial element in the case of the normal offender. The duration of the supervision order might also be

shorter. The parole board or tribunal would decide, having taken into account the risk of further violence.

The nature of the *supervision order* that would apply following the person's release from confinement under this proposed regime needs particular attention if it is to satisfy concerns about public protection. It must have adequate 'teeth'. I propose that the supervision order will mandate *regular reviews* (probably with a social worker or probation officer with special expertise in mental health matters) and mandate a *mental health assessment* from an expert if the reviewing officer detects signs of relapse or indicators of a significant risk of reoffending. Other conditions may be imposed as occurs for non-disordered offenders on parole (e.g. prohibiting the individual from attending at a specified place; a restraining order where the necessary criteria are met). Supervision, however, should involve more than monitoring; it should be constructive, offering support, and help for engaging in health care, rehabilitation, education, training or employment programmes. Where appropriate, assistance could be offered with access to specialised supported accommodation (particularly helpful for some offenders with intellectual disabilities). Involuntary treatment would not be possible unless the person were to relapse, and again lose decision-making capacity, and treatment would be in their best interests. Otherwise treatment could only occur on a voluntary basis.

A *breach of the conditions* of the supervision order in the absence of reasonable mitigation could result in recall to the court. If the person retains decision-making capacity and refuses voluntary treatment, the court could impose a range of penalties, including a curfew, with or without an electronic tag, and up to a custodial disposal. The processes would be similar to those for a breach of parole conditions or could mirror existing penalties for breaches of protective orders, as exist, for example, with regard to breach of a restraining order under the Protection from Harassment Act 1997 or a Sexual Harm Prevention Order under the Sexual Offences Act 2003. A supervision order could not extend in the context considered here beyond the period stipulated in the court order made at sentencing (or longer than the sentence for a comparator non-disordered offender).

It would be necessary that the offender have the capacity to understand the terms of the supervision order for it to be an option. The proposal has much in common with the Law Commission's proposed supervision orders for those found 'unfit to plead' and supported by Justice in its report 'Mental health and fair trial'.¹⁹

¹⁹ Law Commission. Unfitness to Plead. Volume 1: Report. 2016 Law Com No 364. <http://www.lawcom.gov.uk>; Mental health and fair trial: A report by JUSTICE. 2017. www.justice.org.uk

What if the offender were assessed by the court to present a serious risk to others that would be likely to outlast the usual term of a sentence for the offence? A restriction order of indeterminate duration specifically for offenders with a mental disorder would be discriminatory and thus no longer available. However, a non-discriminatory solution exists. In England, for example, '*extended sentences*' are available for non-disordered offenders who are assessed as presenting a risk to others that is likely to persist beyond the term of a usual sentence. Depending on the nature of the index offence and specified previous offences as set out in a schedule to the Criminal Justice Act 2003, the extension may be for up to 5 years or 8 years depending on the index offence. A *discretionary life sentence* may also be imposed by the court where the offender is assessed as dangerous and the offence itself justifies a life sentence, or where the defendant is convicted of a serious specified offence and has a previous conviction for such an offence. An extended court order could be imposed on an offender with an impairment of mind based on the same criteria. This form of preventive detention is established at the sentencing stage. Attention would need to be given to the possible intrusion here of a form of *indirect discrimination*. Persons with a mental illness may be more likely judged to pose an ongoing risk, simply because they have such an illness. Evidence would thus be required concerning the precise nature of the risk, its relationship to the mental illness, how exactly the risk might unfold and how the sentence is proportionate to the risk.

VI. OFFENDERS WITH AN IMPAIRMENT OF MIND WHO RETAIN DECISION-MAKING CAPACITY

What if the court has found the person guilty of the offence, it accepts the evidence that the offender has an impairment or disturbance in the functioning of mind but finds that he or she *retains* treatment decision-making capacity? Under a fusion law the person would not meet the criteria for involuntary treatment. Transfer to a psychiatric hospital would then only be possible if the offender accepted treatment on a *voluntary* basis. If such treatment were refused, or having commenced the patient decided no longer to continue, then the person would go to prison. If there is a treatment that would benefit the person, the option of treatment should be retained so that the person could be transferred to a hospital as a voluntary patient if they were to change their mind.

Discharge from voluntary hospitalisation to the community or release from prison to the community would be with the authorisation of the parole or review board as for offenders who have a period of involuntary treatment in hospital. *Supervision orders* would involve the same range of conditions as described above. Again, the total duration of the deprivation of liberty (in custody or hospital or both) plus restriction of liberty in the community (on a supervision order) must be no longer than the sentence incurred by a non-disordered offender who has committed a similar offence with a similar degree of seriousness. *Extended sentences* would be available as described above.

Engagement in treatment on a voluntary basis may increase the likelihood of an earlier release or discharge into the community. If this were being cynically used by an offender with the aim of obtaining earlier release from detention, one hopes that this would become evident in the way the person engages, or fails to engage, in the treatment. In any case the person would still be under a supervision order in the community for the remainder of the sentence and be required to have a mental health assessment if there were indications of increasing risk.

VII. THE 'MENTAL CONDITION' OR 'SPECIAL' DEFENCES

A. The problem

Persons judged to be 'unfit to plead' (or unfit to stand trial) or 'not guilty by reason of insanity' (or another form of insanity defence) may present special problems in respect of their disposal by the court. As culpability is absent in the case of the person not guilty by reason of insanity, or not able to be fully established in the case of unfitness to plead, a conviction is excluded, and a custodial sentence is ruled out. Currently, the usual disposal when the options of a discharge or supervision order are regarded as inadequate is a hospital order that may be of indeterminate duration. The purpose of the hospital order is to provide treatment, but equally, though arguably less explicitly, to protect the public. The two elements are somewhat obscured in the hospital order. Whether the person has or does not have treatment decision-making capacity at the time of the court hearing is immaterial as to whether a hospital order can be made.

Under a fusion law, involuntary treatment would only be possible for a person with a mental impairment if the decision-making capacity and best interests criteria were met. While this would be the case in many - perhaps the majority of cases - where a mental condition defence were accepted, it is likely there will be cases where the person has decision-making capacity at the time of the hearing and would thus not be eligible for an involuntary treatment order. For example, sufficient time may have elapsed between the act or omission and the court hearing for a defendant judged not guilty by reason of insanity to have regained decision-making capacity, perhaps following treatment during the period on remand. Or in the case of unfitness to plead, the criteria for unfitness may not map well on to those determining an impaired decision-making capacity for treatment. Colleagues suggest that such cases are likely to be rare; there is a commonly held view that the threshold for unfitness to plead is higher than the civil threshold for decision-making incapacity

Thus, where the defendant is judged to be unfit to plead or not guilty by reason of insanity and i. has been found to have done the act or omission, and ii. he or she lacks decision-making capacity and treatment for a mental impairment is in the person's best interests, an involuntary treatment order would be justified under a fusion law. Such treatment would need to be continued on a voluntary basis following a recovery of decision-making capacity, or if refused,

treatment would end. But what would be the options available to the court when the defendant is judged to be unfit to plead or not guilty by reason of insanity, *has* decision-making capacity but *rejects* the offer of treatment, yet is assessed as presenting a substantial *risk* to others? Or what if on a stable recovery of decision-making capacity, when involuntary treatment must cease, the person subject to such an order rejects further treatment on a voluntary basis yet is assessed as presenting a continuing substantial risk to others?

If there were some form of *generic dangerousness legislation* that allowed the preventive detention of any person - irrespective of whether they had a 'mental disorder' or not - assessed by a court as presenting an unacceptable risk to others, even if not convicted of an offence, the problem could be solved. (As would the discrimination against persons with a mental disorder who are singularly liable under current mental health laws to be detained if deemed to present a risk to others, even if they have not committed an offence). Such legislation is unlikely to be adopted. It would also probably be in breach of the European Convention on Human Rights.

Another argument might be founded on the *exceptional position* of those judged to be unfit to plead or not guilty by reason of insanity. Despite having perhaps done an act of great seriousness, such as a homicide, they are not held culpable, and thus cannot be detained even if assessed as presenting a substantial risk to others (unless, for a period at least, they meet the criteria for involuntary treatment). One could claim that this exceptional group of persons merits exceptional measures. In the absence of any acceptable alternative, it could be argued that they might be detained on a hospital order on the basis of the risk they are deemed to pose. Further conditions might be attached: that the risk to others is serious, there is a causal nexus with an impairment of mind, and that there is a treatment for the condition that will significantly reduce the likelihood of future violence. The question of a time limit on the order would need to be addressed.

Or one might *do away with* the 'mental condition' defences altogether. Zero culpability on the basis of a mental impairment, as in the case of a person deemed 'not guilty by reason of insanity', might be regarded as a fiction. After all, the vast majority of persons with a serious mental illness, especially in the absence of drug or alcohol misuse, do not commit serious acts of violence. If there always remained an element of culpability, even if low, a conviction would then be possible, especially if another element in determining the seriousness of an offence - the harm caused - were high. Detention in an appropriate establishment - not necessarily a prison but a place more supportive for a person with a mental impairment - would then be possible. Treatment would need to be on a voluntary basis for the person with decision-making capacity. The maximum duration of the detention would be commensurate with the sentence imposed on a non-disordered offender who has committed a similar offence of a similar degree of seriousness. The low culpability might be taken to mean that the major contribution to the level of seriousness would be the harm entailed in the index offence.

There are indeed a few jurisdictions where the insanity defence has been abolished. Sweden is a notable example. However, the court can sentence the offender with a 'severe mental disorder' to indefinite detention in a forensic facility and allow compulsory treatment. The deprivation of liberty of the person detained in a forensic unit may, as elsewhere, far exceed in its duration the sentence that would be imposed on a non-disordered offender for the same offence. There is at present a strong movement for reform; criticisms surround the way in which various interests are blurred: the need for treatment, principles of criminal responsibility and public protection.²⁰ A recent governmental committee has proposed the reintroduction of a criminal responsibility element with an acquittal if the person is found unaccountable. However, it is proposed that a form of declaratory judgment would be made, and this could entail a number of 'public protection measures', including incarceration, involuntary treatment, restraint orders, residency requirements, or prohibitions on drug or alcohol use. These measures would be reviewed six-monthly and with no fixed term overall. While the criminal responsibility element has received support, the 'protective measures' have been the subject of criticism. Proportionality is again an issue here: those with a mental impairment may suffer longer restrictions on their liberty than other offenders.

The abolition of the mental state defences is also claimed to be necessary for compliance with the UN Convention on the Rights of Persons with Disabilities (UN CRPD).²¹ Such defences are deemed to be discriminatory as they limit persons with disabilities' legal capacity on the basis of their having a disability. Instead it is claimed that support measures or special accommodations are required to make the normal procedures of law accessible to those with disabilities on an equal basis with others. It is further argued by the UN CRPD Committee that an impairment of 'mental capacity' is not a justification for an interference with legal capacity. Despite statements such as the following from the Office of the High Commissioner for Human Rights:²² '... disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant' - a detailed account of how accommodations to legal procedures would operate were these changes to be introduced has yet to be provided, certainly one that has attracted a reasonable degree of wider support.²³

²⁰ Gooding P, Bennet T. The Abolition of the Insanity Defence in Sweden and the United Nations Convention on the Rights of Persons with Disabilities: Human Rights Brinkmanship or Evidence It Won't Work? *New Criminal Law Rev* 2018;21:141-169

²¹ Committee on the Rights of Persons with Disabilities. Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. Adopted during the Committee's 14th session, held in September 2015. <https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc>

²² Annual report of the High Commissioner for Human Rights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para 48-9.

²³ Peay J. Mental incapacity and criminal liability: redrawing the fault lines? *Int J Law Psychiatry* 2015;40:25-35; Gooding P, O'Mahoney C. Laws on unfitness to stand trial and the UN Convention on the Rights of Persons with Disabilities: Comparing reform in England, Wales, Northern Ireland and Australia. *Int J Law, Crime and Justice* 2016;44:122-145

The fullest schema thus far is probably that suggested by Slobogin.²⁴ He proposes that the mental condition defences be dropped, and that culpability on conviction be determined by the court on the basis of the *subjective mental state* of the mentally ill defendant, in the same way as it is for other defendants. The degree of mitigation would depend, for example, on whether the person believed circumstances existed, that if true, would have justified the offending act, for example, by amounting to duress. However, he also supports a *preventive detention* measure, though strictly limited to persons who pose a significant risk of unjustifiable serious bodily harm to another, but who are presently, like those not guilty by reason of insanity, not subject to criminal jurisdiction. This would require proof, he proposes, that such a person: (a) believes such harm is not criminal (for some with serious mental illness or enemy combatants); or (b) is powerless to prevent the harm (as with 'automatisms' or with contagious diseases) or (c) is willing to cause such harm even if punishment, death or serious bodily injury to the actor is highly likely (as with some terrorists). So far, the schema, if applied generically to all in a 'disability-neutral' fashion, might be seen as compliant with the CRPD. However, the third element in the schema, 'protective' of the person's *competence* to make decisions or autonomous choices, might be seen as not. Competence is to be determined by a 'basic rationality and basic self-regard' test. This would require the person to have a 'minimal' understanding of the risks and benefits of the choice to be made, an ability to give reasons not based on demonstrably erroneous facts, and an effort to consider these and other reasons for self-preservation. Peay²⁵ discusses the 'esoteric' questions that may arise in attempts to apply the 'subjective element' in a criminal act to people with a serious mental illness, such as one involving delusional ideas. For example, what is to be the definition of, or weight to be attached to, a perpetrator's 'reasonable' or 'honest' belief concerning the circumstances of an offending act if the act is based on an 'irrational' delusional belief?

However, a powerful argument against an abolition of the not guilty by reason of insanity verdict is the centuries-old moral principle in the law that a person who is not criminally responsible for an act should not be punished for it.

B. Management under a fusion law

Returning to, and accepting the conventional current situation where a verdict of not guilty by reason of insanity or unfit to plead is adopted, how would a fusion law, strictly observed, play out?

Let us first consider a *not guilty by reason of insanity* verdict. A trial has shown that the act or omission was done. A prison sentence is not possible as there is

²⁴ Slobogin C. Eliminating mental disability as a legal criterion in deprivation of liberty cases: the impact of the Convention on the Rights of Persons with Disability on the insanity defense, civil commitment, and competency law. *Int J Law Psychiatry* 2015;40:36-42.

²⁵ *Supra* Note 20

no conviction. The options would be: i. acquittal and discharge; ii. a supervision order; iii. treatment on a voluntary basis if the person has decision-making capacity; iv. involuntary treatment on a hospital order if the person lacks decision-making capacity and treatment is in his or her best interests. When decision-making capacity is regained, treatment could only be continued on a voluntary basis, otherwise the person would be discharged from hospital. Some options may be combined sequentially, for example, voluntary treatment and a supervision order.

As noted earlier for those with a mental impairment who have been convicted, the *supervision order* must have 'teeth'. Such an order would only be imposed where the person was assessed on the best available evidence as presenting a substantial risk of serious harm to others. Mandatory reviews would be required, as well as a mandatory mental health assessment if there were evidence of relapse of an illness that has been associated previously with serious harm to others. Other conditions could also be imposed as described earlier for supervision orders (e.g. a restraining order). Again, supervision should be constructive, offering support, and help for accessing suitable programmes, and where it might be helpful, specialised supported accommodation. Involuntary treatment would not be possible unless the person were to relapse, again associated with a loss of decision-making capacity and with the treatment being in the person's best interests. Otherwise treatment could only occur on a voluntary basis. A breach of the supervision order would be reported to the court and might, depending on the circumstances, constitute a separate *offence*. If so, punishment would include a possible custodial sentence. As noted above, a breach of a supervision order under the *Protection from Harassment Act 1997*, an order that can be made even if the person is not convicted, carries a range of penalties up to a custodial sentence of 5 years. The Law Commission examined the arguments concerning the moral case for and against creating a related offence for persons found not guilty of the index offence.²⁶ It concluded that where a person poses a significant risk of harm, having no sanction to ensure compliance with a supervision order would undermine public confidence in the court system. As stated earlier, the assessment of risk would need to be as transparent and objective as possible.

The total duration of an order could be no longer than the sentence passed on a non-disordered offender who had committed a similar offence, of a similar degree of seriousness. At the end of this period, if the criteria for involuntary treatment were still met, only a civil order could be imposed. As in the case of convicted mentally impaired persons, an *extended order* could be imposed by the court according to the same criteria as apply to non-disordered offenders. The only difference would be the absence of a conviction for the index act or omission, but commission of the act has nevertheless been established by trial. The history of prior offences (including acts or omissions where the person was found not guilty by reason of insanity) would parallel those of the non-

²⁶ Law Commission. Unfitness to Plead. Volume 1: Report. 2016 Law Com No 364. <http://www.lawcom.gov.uk>

disordered offender subject to an extended sentence. The key issue here is one of risk, not culpability.

In the case of a ruling that the person is '*unfit to plead*', the same options as for not guilty by reason of insanity would apply. The court, however, could stipulate a period within which a restoration of the capacity to stand trial would result in a full trial.

VIII. CONCLUSIONS

Concerns about the adequacy of measures to protect the public from offenders with a mental disorder have been frequently raised as an argument against the feasibility of a fusion law (and in key respects, of a 'capacity-based' mental health law). I have sketched out the possible implications of such law for forensic provisions. Two key forms of discrimination against persons with a mental impairment (including, but not restricted to, so-called 'mentally disordered' offenders) need to be avoided. The first is that arising from the treatment of persons with a mental illness when compared to all other patient groups; the second is that arising from the treatment of an offender with a mental impairment when compared with non-disordered offenders. Eliminating the first form requires that patients' autonomy is equally respected. Eliminating the second form of discrimination requires that the total period of a deprivation of liberty and restriction of liberty must not exceed in duration that entailed in the sentence imposed on a non-disordered offender convicted of a similar crime having a similar level of seriousness.

The management of convicted offenders with a mental impairment or disturbance in the functioning of mind would in some respects parallel that imposed on non-disordered offenders, especially in terms of comparable periods of deprivation and restriction of liberty. The differences would be in periods of inpatient treatment, voluntary or involuntary, and a form of post-discharge supervision which, despite resembling probation, would however have a stronger therapeutic and supportive emphasis. Extended sentences would be available on the same basis as for non-disordered offenders.

Some colleagues voice concerns about the unsuitability of a prison environment for people with a mental disorder, even if they have decision-making capacity yet refuse hospital treatment. This view should be taken seriously and presents a strong argument for making 'reasonable accommodations' in prison for people with disabilities, including mental health disabilities, especially as their numbers would likely increase with a concomitant decrease of those in secure hospitals.

The 'mental condition' defences, the insanity defence and unfitness to plead, present a special problem in terms of management. Imprisonment is ruled out since the person is not convicted. The difficulty arises when the person has done an act - and perhaps previous acts - that suggest the person poses a substantial risk to others. Under a fusion law, the conventional recourse to a hospital order would only be available if the person lacked decision-making

capacity and treatment was in their best interests. For the person with decision-making capacity, treatment if considered appropriate, could only occur on a voluntary basis.

One possible solution to the problem posed by a person who presents a serious risk, retains decision-making capacity, and refuses treatment is to see the position of such a person - in a kind of 'no-man's land' between the criminal justice system and the healthcare system - as exceptional. One might then argue that a hospital treatment order might be made even if capacity is preserved. The avoidance of discrimination would require at least that the maximum term of such an order should be no longer than the sentence normally imposed for a similar offence with a similar level of seriousness. However, satisfactory public protection may be achieved in a non-discriminatory manner within the parameters of a fusion law by making use of hospital treatment, voluntary or involuntary depending on the person's decision-making capacity, and a form of supervision order in the community that is supportively structured, but includes conditions to ensure compliance.

BOOK REVIEW: 1. THE LEGACIES OF INSTITUTIONALISATION: DISABILITY, LAW AND POLICY IN THE 'DEINSTITUTIONALISED' COMMUNITY, EDITED BY CLAIRE SPIVAKOVSKY, LINDA STEELE AND PENELOPE WELLER (OXFORD: HART, 2020) AND 2. RECOGNISING HUMAN RIGHTS IN DIFFERENT CULTURAL CONTEXT: THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD), EDITED BY EMILY JULIA KAKOULLIS AND KELLEY JOHNSON (LONDON: PALGRAVE MACMILLAN, 2020)

ALEX RUCK KEENE*

INTRODUCTION

These two edited multi-author books landed on my desk for review nearly simultaneously, and I read them side by side, because, in different ways, many of the essays are chewing over the same essential questions: why, and how, it is so difficult to change cultures, whether they be social work cultures, medical cultures, legal cultures or wider societal cultural attitudes? And both are doing so as part of the second wave of studies relating to and engaging with the UN Convention on the Rights of Persons with Disabilities, now that the initial wide-eyed and possibly naïve¹ enthusiasm for the Convention and its promise has passed, and the hard work of operationalising in different jurisdictions has not only begun but also run into considerable resistance in many quarters. Much of that resistance could be characterised negatively; some of that resistance less obviously so, especially where the resistance consists of seeking the answers to the hard questions that the drafters of the UNCRPD had to avoid in order to secure the compromises required for consensus. Whilst, almost without exception, all the authors in the two volumes under review would, I think, characterise themselves as supporters of the UNCRPD, many of the essays not only offer explanations as to why progress towards implementation has been so slow in many jurisdictions, but also raise yet further hard questions.

LEGACIES OF INSTITUTIONALISATION

The first book, *Legacies of Institutionalisation*, brings together 20 contributors from the UK, Canada, Australia, Spain and Indonesia, and reflects the fruits of a workshop (coordinated by the editors) held in June 2018 at the Oñati International Institute for the Sociology of Law in the Basque Country, Spain. The workshop, and the essays, grapple with (as the editors put it in the

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¹ A word that the former Chair of the CRPD Committee, Theresa Degener, said could perhaps be used about the Committee itself in relation to its decision to devote its first General Comment to the issue of legal capacity against a deeply unpromising set of background circumstances. Degener T. Editor's foreword. *International Journal of Law in Context*. 2017 Mar;13(1):1-5.

thoughtful and wide-ranging introduction, p.3) “the extent to which contemporary laws, policies, practices and practices in the post-deinstitutionalisation agenda continue or legitimate historical practices associated with [...] the institutionalisation” of people with disabilities.” The book is then divided into three parts. Part 1 (6 chapters) address power dynamics that shape the conditions and possibilities of people with disabilities within and beyond sites of physical containment. The chapters vary significantly both in scope (from episodic disability within the context of the academy to a historical review of the biopolitics of disability in Spain between 1959 and 1981) and relevance to the direct theme of the book. However, within this part, the stand-out chapter is the first, by Liz Brosnan, a Research Associate at the EURIHKA Project based at the Service User Research Enterprise at the Institute of Psychiatry, Psychology and Neuroscience, King’s College London. In the chapter, entitled “Navigating Mental Health Tribunals as a Mad-identified Layperson: An Autoethnographical Account of Liminality,” Brosnan reflects upon and poses difficult questions arising out of her experience of sitting as a lay member of approximately 40 Mental Health Tribunals in Ireland between 2006-2013. Her experiences lead her to question the value of such Tribunals, and to ask the simple question “is this best that can be done”? In the context of reforms (such as those proposed by the recent Wessely Review of the Mental Health Act²) which place faith in the power of such tribunals to serve as champions of those who are detained, the chapter make challenging – but necessary – reading.

Part 2 (5 chapters) is entitled “Complicated Alliances: the Confluence of Ableist, Sanist, Gendered, Classed and Racialised Logics in Law, Policy and Practice.” However, those looking to that Part for wide-ranging discussions of these hugely important issues may find themselves disappointed, because with the exception of an interesting but (frankly) slightly off-topic chapter on responses to immigration, the remaining chapters are all, in fact, detailed micro-studies of particular situations within Australasia. Wider themes can certainly be drawn from them, and the introduction to the Part seeks to do so (in particular the ease with which dissenting responses to marginalisation and structural injustice can be silenced and subverted). However, this Part, sadly, to this reader at least, promised more than it ultimately offered.

In Part 3 (6 chapters), the contributors tackle institutionalisation and human rights: the role of the CRPD in the emancipation of people with disabilities. For me, this is the richest section of the book, not least because the contributors ask some of the hard questions posed at the outset of this review. Elivra Pértega Andía, for example, seeks to examine in some detail how the CRPD plays out in the context of whether or not physical restraints should be used in paediatric psychiatric healthcare in Spain. In a stimulating analysis of the submissions of signatory states to the UN CRPD Committee on draft General

² Modernising the Mental Health Act. Final report of the Independent Review of the Mental Health Act 1983. GOV.UK, 2018.

Comment 1 (on Article 12: the right to legal capacity), Peter Bartlett comes to the conclusion that:

“Insofar as the submissions are representative, they suggest that States Parties are simply not interested in engaging with the CRPD project or, at least, the elements of it that concern equality before the law. Instead, there is little evidence that they see a problem that requires correction.”³

Bartlett seeks to find grounds for optimism, but remains cautious as to whether the message is getting out to stakeholders about the problems that need solving, “let alone the sorts of reform that are necessary, or the terms of any constructive dialogue that needs to happen.”⁴ It is a shame that we cannot be privy to the conversations that must have taken place between him and Jill Stavert at the workshop, as Stavert’s chapter takes a rather more optimistic view of how Scotland’s mental health and capacity law might be recast to comply with the CRPD.

Lucy Series’ chapter on the UK Supreme Court decision in *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor* [2014] UKSC 19 (*Cheshire West*) manages to mine the complexities of an English decision about deprivation of liberty to important, and wider, effect. The – deliberately – broad definition of the concept adopted by the majority in the so-called ‘acid test’⁵ has positives, identifying as it does that supervision, control and loss of freedom exist outside of institutions. It is also a definition which appears to be gaining traction with those working to champion the cause of the CRPD.⁶ However, as Series notes, it leads to its own difficulties, and also is, ironically, hard to reconcile with the CRPD, despite the fact that Lady Hale, for the majority, was deliberately seeking to cast the net widely so as to ensure that the definition of deprivation of liberty is the same for those with disabilities as it is for those without.⁷ She suggests possible ways forward, but the overriding impression left by the chapter is that there is much work yet to do in identifying what framework actually serves the interests of persons with disabilities in the post-carceral era.

RECOGNISING HUMAN RIGHTS IN DIFFERENT CULTURAL CONTEXTS

Unlike *Legacies of Institutionalisation*, this book did not arise out of a workshop. Rather, it arises out of the editors’ shared interest in the issue of cultural contexts and international human rights law developed when they worked

³ Spivakovsky, Steele and Weller, page 190.

⁴ Spivakovsky, Steele and Weller, page 192.

⁵ I.e. whether the person is subject to continuous supervision and control and not free to leave the place (or places) in question.

⁶ It was, for instance, used in a major study of disability-related detention carried out to support the work of the Special Rapporteur for Disability. See Flynn E, Pinilla-Rocancio and Gómez-Carrillo M. Disability-specific forms of deprivation of liberty. 2019.

⁷ See *Cheshire West* at paragraphs 36 and 37, where Lady Hale made express reference to the CRPD in highlighting that the “whole point about human rights is their universal character” (paragraph 37).

together at the University of Bristol in the United Kingdom. In doing so, they became, they note in their introduction, “increasingly aware of the complexity of interpreting the CRPD’s provisions into States Parties’ cultural contexts and saw the need for interdisciplinary approaches to exploring this.”⁸ The editors deliberately did not seek to guide contributors as to the interpretation of ‘culture’ that they adopted in this. This means that anyone who approaches the book thinking that they will be getting an overview of (for instance) the interaction between the CRPD and particular national legal and political cultures will, for the most part, be disappointed. It also means that the editors have had to work hard in their conclusion to seek to pull together themes from what is by any measure an extremely disparate group of papers. Conversely, the eclectic nature of the contributors’ approach to the concept of ‘culture’ throws up some unexpected and stimulating issues.

Part 1 of the book (4 chapters) looks at culture, disability and the CRPD. Gerard Quinn’s contribution on legal culture and Article 12 rehearses themes which will be familiar to those who have followed his work over the years. However, the challenge that he makes to the ‘legal fictions’ that underpin so many social and political frameworks never loses its ability to engage (if not sometimes also to enrage). James Rice promises a huge amount in his chapter looking from an anthropological point of view at the potential tensions between the CPRD and wider cultural values, in particular through examining how States Parties have sought (through Reservations and Objections) to respond to the universal norms advocated by the CRPD. If the chapter does not quite deliver on the promise, it does at least provide a very helpful jumping off-point for further investigations. Huhana Hickey in her chapter reflecting on indigeneity, colonisation and the CRPD from the Māori perspective makes a powerful case that the CRPD continues the history in which indigenous cultural issues are not taken into account, a case which could fruitfully have benefited from further space to be developed. Her chapter, further, prompted the reflection that the book contained strikingly little discussion of the intersection between disability and other forms of discrimination, perhaps reflecting the fact that the CRPD itself is all but silent on the issue.⁹ No doubt if the editors were to be starting their project post-Black Live Matters they would be inviting at least some contributors to reflect upon these questions.

Part 2 (4 chapters) looks at why and how countries ratified (or did not) the CRPD, addressing four countries: the US (Arlene Kanter); Ireland (Eilíónoir Flynn), Cyprus (Emily Julia Kakoullis) and Sri Lanka (Dinesha Samararatne). Whilst all of these chapters may appear to be of parochial interest to enthusiasts of the relevant jurisdictions, they each flesh out the point that can never be repeated frequently enough that international human rights law is, effectively, an empty vessel on the domestic political scene, that it is only

⁸ Kakoullis and Johnson, page 4.

⁹ Save for the reference in Preamble P that States Parties are “[c]oncerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status.”

through domestic political action that it becomes translated and 'domesticated,' and that that process is rarely anything other than slow and painful.

In Part 3 (4 chapters), the contributors look at challenges to implementation of specific articles of the CRPD. Three of the chapters relate to specific countries (China, Hungary and the Nordic States), of which the chapter on the Nordic States is perhaps the most interesting for those who instinctively feel that those States are 'CRPD-friendly' as having been held up for many years as more enlightened than most other States. Rather, Ciara Brennan and Rannveig Traustadóttir suggest, they show that the Nordic welfare model stands at distinct odds with the ethos of Article 19; further, "[i]n the light of the glowing reputation of the Nordic welfare states, criticism does not seem credible by the international community and tends to be rejected by Nordic governments as unreasonable."¹⁰ The final chapter by Matthew S. Smith and Michael Ashley Stein, sits a little oddly in this section, but does contain a fascinating, if perhaps rather optimistic, argument as to the potentially transformative effect of Article 30 CRPD, which requires States Parties to take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.

Part 4 (3 chapters, and conclusion) looks at monitoring the CRPD. Whilst this part could be said in reality to have little to do with the stated theme of the book, it contains, for me at least, the two most interesting chapters in the book. The first is the dense and nuanced chapter by Neil Crowther and Liz Sayce OBE looking at ten years of monitoring the implementation of the CRPD in the United Kingdom. Whilst it could on one view be read as a chapter of ten years of failure by the UK Government to live up to the commitments it so blithely signed up to, the authors identify a more complex picture, and, based on that picture, potential strategies for further action. The second chapter is that by Amita Dhanda reflecting on the Indian experience of State Party reporting, gaining particular interest – and piquancy – from the fact that she was intimately involved in the production of the Indian State Report, albeit in circumstances where the final report was very different to that which she had envisaged. Although the story is deeply local, her theme of the uncomfortable relationship between activism and governmental imperatives is of much wider resonance.

CONCLUSION

Whilst (as is always the case) not every part of both of these books works equally successfully, and the Kakoullis and Johnson book perhaps suffers from the editors' – very generous – decision to enable contributors such free reign in thinking about the term 'culture,' they contain interesting and important contributions to the second wave of CRPD studies. At the time of writing, what the third wave of such studies will look like is not yet clear, but at least some

¹⁰ Kakoullis and Johnson, page 265.

of the research agenda will have been set by the contributors to these two books.