

**THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH
DISABILITIES: DEFINITION OF DISABILITY AND PROHIBITION OF
DEPRIVATION OF LIBERTY ON THE BASIS OF MENTAL DISABILITY**

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The UN Convention on the Rights of Persons with Disabilities: Definition of Disability and Prohibition of Deprivation of Liberty on the Basis of Mental Disability

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ABSTRACT

This thesis focuses on the UN Convention on the Rights of Persons of Disabilities (CRPD), and seeks to determine two main issues. First, whether the CRPD adopts the British 'social model' approach to disability, or rather defines disability in a way which is closer to WHO's International Classification of Functioning, Disability and Health (ICF) conceptualisation. Second, whether the English law, in particular the Mental Health Act 1983 (MHA 1983) and the Mental Capacity Act 2005 (MCA 2005), complies with the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of mental disability.

With regard to the first issue, based on the examination of the British 'social model' approach, the ICF conceptualisation and the definition of disability in the CRPD, it finds that the CRPD defines disability in a way which is closer to the ICF conceptualisation.

With regard to the second issue, based on the examination of Article 14 of the CRPD, the MHA 1983 and the MCA 2005, it finds that the English law fails to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

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TABLE OF CONTENTS

ABSTRACT.....	i
ACKNOWLEDGMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	v
LIST OF ABBREVIATIONS.....	ix
CHAPTER 1 INTRODUCTION	1
1.1 Research Questions and Methodology	5
1.2 Thesis Structure.....	6
CHAPTER 2 THE SOCIAL APPROACH TO DISABILITY	8
2.1 Introduction	8
2.2 The British ‘Social Model’ of Disability.....	9
2.2.1 The development of the British ‘social model’ of disability	11
2.2.2 Criticism of the social model.....	19
2.3 WHO’s International Classification of Functioning, Disability and Health (ICF)	25
2.3.1 The balanced approach.....	25
2.3.2 The ICIDH (1980) and the ICF (2001)	27
2.4 The Social Approach in Relation to Mental Health	33
2.4.1 Relation between mental health and disability.....	34
2.4.2 Relevance of the ‘social model’ to mental impairment	36
2.4.3 Application of the ICF to mental health conditions.....	40
2.5 Conclusion	42
CHAPTER 3 THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES	45
3.1 Introduction	45

3.2	Overview of the CRPD	46
3.2.1	CRPD - Why was it necessary.....	48
3.2.2	CRPD - What kind of convention is it.....	50
3.2.3	The obligation under the CRPD to abolish discriminatory laws	54
3.3	The Definition of Disability under the CRPD	55
3.3.1	The definition of disability in the final text of the CRPD	56
3.3.2	The discussion on the definition of disability during the CRPD negotiations.....	62
3.4	Deprivation of Liberty based on Disability under the CRPD	69
3.4.1	The discussion on deprivation of liberty on the basis of disability during the CRPD negotiations	70
3.4.2	The view of the CRPD Committee on disability-based deprivation of liberty	82
3.4.3	Justification of deprivation of liberty based on mental disability ...	88
3.5	Conclusion	97
CHAPTER 4 DEPRIVATION OF LIBERTY OF PERSONS WITH MENTAL DISABILITIES UNDER THE ENGLISH LAW.....		99
4.1	Introduction	99
4.2	Mental Health Act 1983	101
4.2.1	Criteria for detention	104
4.3	Mental Capacity Act 2005	119
4.3.1	Lack of mental capacity	120
4.3.2	Deprivation of Liberty Safeguards (DoLS).....	124
4.3.3	Liberty Protection Safeguards (LPS)	131
4.4	Conclusion	134
CHAPTER 5 CONCLUSION		137
BIBLIOGRAPHY.....		145

LIST OF TABLES

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UNITED KINGDOM

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LIST OF ABBREVIATIONS

AHC	Ad Hoc Committee
CoP	Code of Practice
COs	Concluding Observations
CRPD	Convention on the Rights of Persons with Disabilities
DG	Drafting Group
DoLS	Deprivation of Liberty Safeguards
DPI	Disabled People's International
DSD	Daily Summary of Discussion
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EU	European Union
HRA	Human Rights Act
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICF	International Classification of Functioning, Disability and Health
ICIDH	International Classification of Impairments, Disabilities and Handicaps
IDC	International Disability Caucus
JC	Joint Committee
LPA	Lasting Power of Attorney
LPS	Liberty Protection Safeguards
MCA	Mental Capacity Act
MHA	Mental Health Act
RG	Reference Guide
UN	United Nations
UNHCHR	UN High Commissioner for Human Rights
UPIAS	Union of the Physically Impaired against Segregation
WG	Working Group
WHO	World Health Organisation
WNUSP	World Network of Users and Survivors of Psychiatry

Chapter 1 Introduction

The aim of this introduction is to provide an overview of the thesis. It seeks to explain its purpose and the main issues that will be examined, present its methodology and outline its structure.

The focus of the thesis is on the UN Convention on the Rights of Persons with Disabilities (CRPD).¹ The CRPD is one of the nine core international human rights treaties. It is the first legally binding instrument on the issue of disability and its purpose 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'.²

The CRPD applies to all persons with disabilities, including those with mental,³ or psychosocial,⁴ disabilities.⁵ It places mental health law in the context of disability law, and brings significant challenges to the way people with mental disabilities are treated. One area that is particularly challenged is the involuntary civil detention of persons with mental disabilities. People with mental disabilities have historically been subjected to special powers of compulsion and restriction of their rights. Several countries, including England, have in place legislation that allows for their involuntary detention.

The CRPD affirms that persons with disabilities shall enjoy their human rights without any discrimination on the basis of disability. Article 14 in particular requires States Parties to ensure that persons with disabilities enjoy the right to liberty on an equal basis with others and, more importantly, that 'the existence of disability shall in no case justify a deprivation of liberty'.⁶

¹ United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly on 13 December 2006, GA Res. 61/106, UN Doc. A/RES/61/106, 24 January 2007 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/61/106&Lang=E> accessed 16 December 2019.

² CRPD, Art 1.

³ The term used in the CRPD, taken to refer to the experience of mental health difficulties.

⁴ The term preferred by some, especially - but not only - service users, over 'mental disabilities'.

⁵ CRPD, Art 1.

⁶ CRPD, Art 14(1)(b).

The CRPD does not challenge only detention; there are others areas of mental health law that would need to be reconsidered, such as mental health treatment without consent and the removal of legal capacity.

The compulsory treatment of persons with mental disabilities is dealt with in the context of Article 17, which protects the right of every person with disabilities ‘to respect for his or her physical and mental integrity on an equal basis with others’. Whilst there is no reference to compulsory treatment in this provision, it is evident from its drafting history that it aims to address that issue.⁷ In particular, there was a previous version of Article 17 which contained three more paragraphs, and a specific reference was made in paragraph 2 to the right of persons with disabilities to be protected ‘from forced intervention or forced institutionalisation aimed at correcting, improving or alleviating any actual or perceived impairment’.⁸ This earlier version was nevertheless eventually abandoned, and Article 17 as it stands does not explicitly prohibit compulsory treatment.

The right of persons with disabilities to equal recognition before the law is protected by Article 12, and paragraph 2 in particular provides that they shall ‘enjoy legal capacity on an equal basis with others in all aspects of life’. However, Article 12 does not contain an express prohibition against interference with the exercise of legal capacity either.

Article 14 by contrast explicitly prohibits deprivation of liberty on the basis of disability and directly challenges the involuntary detention of persons with mental disabilities, hence the focus of the thesis on this Article.

⁷ See Peter Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75 MLR 752, 769.

⁸ Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its Seventh Session, UN Doc. A/AC.265/2006/2, 13 February 2006, 15 <<https://documents-dds-ny.un.org/doc/UNDOC/GEN/N06/240/42/PDF/N0624042.pdf?OpenElement>> accessed 16 December 2019.

The UK ratified the CRPD on 8 June 2008.⁹ The CRPD has not been incorporated into domestic law, but it is binding on the UK as a matter of international law. As an effect of ratification, the UK undertakes that its laws and practices will comply with the requirements of the CRPD. The main obligation of States Parties, as stated in Article 4(1), is to 'ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability'. In order to meet their obligations under Article 4, States Parties must take a number of measures. Importantly, they are required to adopt appropriate legislation for the implementation of the CRPD rights,¹⁰ and also modify or even abolish existing discriminatory laws.¹¹

Currently in England there are two statutes that include provisions in relation to the deprivation of liberty of persons with mental disabilities; the Mental Health Act 1983 (MHA 1983) and the Mental Capacity Act 2005 (MCA 2005), both as amended by the Mental Health Act 2007 (MHA 2007). The MHA 1983 allows for detention mainly under sections 2 and 3, and the MCA 2005 allows for detention under the Deprivation of Liberty Safeguards (DoLS) in Schedules A1 and 1A.¹²

Although both statutes provide powers to deprive persons with mental disabilities of their liberty, they are very different pieces of legislation. On the one hand, the MHA 1983 provides the legal framework for the compulsory admission and treatment of people in hospital for their mental disorder; the disorder must be of a nature or degree that justifies detention, either for their own health or safety or for the protection of others.

On the other hand, the MCA 2005 provides the legal framework for making decisions, including those in relation to health and welfare matters, on behalf of people who lack the mental capacity to decide for themselves; they must lack

⁹ Department for Work and Pensions, *Explanatory Memorandum on the United Nations Convention on the Rights of Persons with Disabilities* (Cm 7564, 2009).

¹⁰ CRPD, Art 4(1)(a).

¹¹ CRPD, Art 4(1)(b).

¹² Note that the Mental Capacity (Amendment) Act 2019 (MC(A)A 2019) has been passed that will replace the DoLS with a new scheme called the 'Liberty Protection Safeguards' (LPS). However, the DoLS are still in force until at least Spring 2020.

the mental capacity to make a specific decision at a specific time, and decisions must be made in their best interests. The DoLS in particular provide the legal framework for deprivation of liberty in hospitals and care homes of people who lack capacity to decide about accommodation for the purpose of being given care or treatment.

If the English law is found not to comply with Article 14 of the CRPD, meeting the CRPD obligations would require fundamental changes that might lead to not simply reform but even abolition of non-compliant provisions. In order to understand the implications and the rationale behind the prohibition of deprivation of liberty on the basis of disability, it is important to understand where it stems from; namely the way the CRPD views the concept of disability.

The CRPD defines disability as follows:

[D]isability is an evolving concept and ... results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.¹³

There is a generally accepted view that the CRPD is based on the 'social model of disability'. This term refers to the best known social approach to disability, developed in Britain during the 1970s and 1980s by disabled people themselves. The British 'social model' approach understands disability as a socially created problem, caused by social and environmental barriers that exclude people with impairments from participating in society, and which is entirely distinguished from their individual impairment.

However, a different understanding of disability that might be closer to the CRPD definition is found in WHO's International Classification of Functioning, Disability and Health (ICF),¹⁴ which is also the theoretical framework adopted by this thesis. The ICF describes disability as the multi-dimensional and interactive

¹³ CRPD, PmbI, para(e).

¹⁴ World Health Organisation (WHO), *International Classification of Functioning, Disability and Health (ICF)*, endorsed in May 2001, Res. WHA 54.21 of the 54th World Health Assembly (WHO 2001).

experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment.

1.1 Research Questions and Methodology

Having explained the main issues that will be addressed in the thesis and how those are linked, this section identifies the specific research questions that will be examined and how they will be methodologically approached.

The following questions will be examined:

First, whether the CRPD adopts the 'social model' approach to disability, or rather defines disability in a way which is closer to the ICF conceptualisation, and second, whether the English law complies with the obligation under Article 14(1)(b) of the CRPD to prohibit deprivation of liberty on the basis of mental disability.

Since this thesis seeks to examine the law as it is - how does the CRPD define disability, what is required by Article 14 of the CRPD as far as deprivation of liberty is concerned, what the criteria for deprivation of liberty under the English law are -, the method of study will be following the doctrinal legal approach. The research questions will be addressed by relying on legal sources and critically reviewing and analysing relevant literature. In answering the first question, the thesis will explore the 'social model' approach to disability and the ICF conceptualisation before examining the definition of disability in the CRPD to determine which one it adopts. The main sources that will be used are the Union of the Physically Impaired against Segregation (UPIAS) document on disability, Michael Oliver's work, WHO's International Classification of Impairments, Disabilities and Handicaps (ICIDH) and ICF, the text of the CRPD - paragraph (e) of the Preamble - and the related *travaux préparatoires*. In answering the second question, the thesis will examine the requirements of Article 14 of the CRPD

regarding the use of mental disability as a factor in deprivations of liberty and then proceed to determine whether the English law is compliant with the CRPD by examining the grounds on which it allows persons to be deprived of their liberty. The main sources that will be used are Article 14 and its *travaux préparatoires*, documents of the CRPD Committee in relation to Article 14, sections 2 and 3 of the MHA 1983, government publications during the reform process of the MHA 1983 and the DoLS in the MCA 2005.

1.2 Thesis Structure

The thesis is divided into three main chapters.

Chapter two is concerned with the social approach to disability. It focuses on the British 'social model' approach and the ICF, and seeks to assess whether they offer adequate conceptualisation of the experience of disability. It begins by exploring the development of the British 'social model' approach and its limitations, and argues that it fails to describe disability sufficiently. It then argues that balanced approaches offer adequate understandings of disability. It goes on to examine the ICF, and argues that it offers the most accurate conceptualisation of disability. It finally examines the social approach to disability specifically within the mental health context. It considers the relation between mental health and disability, and examines the relevance of the 'British 'social model' approach to people with mental health problems as well as the application of the ICF to mental health conditions.

Chapter three focuses on the CRPD, and deals with two main issues, namely the definition of disability, and the use of disability as a factor in deprivation of liberty. It has in particular a dual purpose; first, it aims to determine whether the CRPD adopts the British 'social model' approach to disability or not, and second, it seeks to identify the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability. It begins by providing an overview of the CRPD. It then examines how the CRPD defines disability, and how this definition was discussed during the CRPD negotiations. It argues that the CRPD does not adopt the British 'social model' approach to disability, but rather

defines disability in a way similar to the ICF understanding. It then focuses on the second issue, and considers the CRPD prohibition of deprivation of liberty on the basis of disability. It examines the relevant discussion during the CRPD negotiations, and argues that the CRPD prohibits the use of disability as a factor in deprivations of liberty, either alone or in combination with other factors. It then examines how the Committee on the Rights of Persons with Disabilities (CRPD Committee) interprets Article 14 of the CRPD, and its view on deprivation of liberty on the basis of disability. Finally, it considers whether deprivation of liberty based on mental disability can be justified. It is argued that it cannot.

Chapter four seeks to determine whether the English law complies with the obligation under Article 14 of the CRPD to prohibit deprivation of liberty on the basis of mental disability. It first focuses on the MHA 1983, and examines the factors that need to be considered for detention. It argues that the MHA 1983 is non-compliant. It then focuses on the MCA 2005, and examines the requirements for deprivation of liberty under the DoLS. It argues that the MCA 2005 fails to comply with Article 14 too.

Chapter 2 The Social Approach to Disability

2.1 Introduction

This chapter is concerned with the social approach to disability. It focuses in particular on the 'social model of disability' and WHO's International Classification of Functioning, Disability and Health (ICF),¹ and seeks to assess whether they offer adequate conceptualisation of the experience of disability.

The 'social model of disability' is the best known social approach to disability, developed in Britain during the 1970s and 1980s by disabled people themselves. The various social approaches that have been developed reject the idea that disability is simply a medical problem arising from individual impairment, and draw attention to environment's and society's role in creating disability. The British 'social model' approach in particular understands disability as a social situation, and specifically a form of social oppression imposed on people with impairments, which is caused by social and environmental barriers that exclude them from participating in society and which is entirely distinguished from their individual impairment.

The ICF on the other hand understands disability as the multi-dimensional and interactive experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment.

Section two begins by exploring the development of the British 'social model' approach, followed by the identification of a number of limitations in this understanding; this leads to the conclusion that the 'social model of disability' fails to describe disability sufficiently.

¹ World Health Organisation (WHO), *International Classification of Functioning, Disability and Health (ICF)*, endorsed in May 2001, Res. WHA 54.21 of the 54th World Health Assembly (WHO 2001).

Section three then argues that balanced approaches offer adequate understandings of disability. It goes on to examine the ICF, as well as its previous version, namely the International Classification of Impairments, Disabilities and Handicaps (ICIDH),² and argues that the ICF offers the most accurate conceptualisation of disability.

Section four is concerned with the social approach to disability specifically within the mental health context. It first considers the relation between mental health and disability, and then examines the relevance of the 'social model of disability' to people with mental health problems as well as the application of the ICF to mental health conditions.

2.2 The British 'Social Model' of Disability

Prior to the late 1960s and 1970s, disability, viewed from a medical perspective, was regarded as the result of individual impairment which requires medical care, rehabilitation and individual adjustment. During that period, however, a social approach to understanding the nature and consequences of disability emerged, as disabled activists and organisations controlled and run by disabled people³ drew attention to their social and economic exclusion and began campaigning for social changes to improve their lives. The previously dominant medical and individual understandings of disability were challenged, and focus was placed instead on the impact of social and environmental barriers and the discrimination and disadvantage experienced by people with impairments.

The social approach was further developed, as disabled people's political activism led to a growing interest in the issue of disability within the academy,

² WHO, *International Classification of Impairments, Disabilities and Handicaps (ICIDH)*, endorsed in May 1976, Res. WHA 29.35 of the 29th World Health Assembly (WHO 1980, rpt in 1993).

³ Organisations controlled and run by disabled people themselves are usually referred to as organisations 'of' disabled people, as opposed to organisations run and controlled by non-disabled people 'for' disabled people. On the various categories of and differences between disability organisations, see Michael Oliver, *The Politics of Disablement* (Macmillan 1990) 117-118; Colin Barnes and Geof Mercer, *Disability* (Polity Press 2003) 112-114. Some authors refer to the activities and actions of organisations controlled and run by disabled people themselves as the 'disabled people's movement': see Colin Barnes, Geof Mercer and Tom Shakespeare, *Exploring Disability: A Sociological Introduction* (Polity Press 1999) 2.

especially within sociology. Although disability was traditionally studied within the sub-field of medical sociology, and particularly the sociology of chronic illness and disability,⁴ the new discipline ‘disability studies’ that was developed in the 1980s and 1990s began approaching disability from a social perspective.⁵

The best known social approach was developed in Britain, namely the ‘social model of disability’. However, social understandings of disability have been advanced by disabled activists and disability studies scholars in several countries. As Tom Shakespeare states in *Disability Rights and Wrongs*, there is a ‘family of social-contextual approaches to disability’,⁶ including, besides the British approach, the Nordic ‘relational’ understanding and the North America ‘minority group’ approach.⁷ Nonetheless, since the British ‘social model’ approach has been the most influential, this term is often associated with the many social understandings of disability. This however can be misleading because, despite sharing many similarities, the various social approaches also have unique characteristics. What distinguishes the British ‘social model’ is the radical idea that the cause of disability is found exclusively within society, whereas the role of impairment in creating disability is entirely denied. This strong view is only

⁴ Within medical sociology, disability was viewed initially from Parsons’ functionalist perspective as a form of social deviance. That was followed by interactionist perspectives focusing on the social processes of labelling and Goffman’s study on ‘stigma’, and later by interpretative accounts that drew attention to the individual experience of disability. More recently, post-structuralism has influenced social constructionist analyses of disability, which have nonetheless been challenged by critical realist perspectives. For a review of the sociological approaches to chronic illness and disability, see Colin Barnes and Geof Mercer, *Exploring Disability* (2nd edn, Polity Press 2010) 43-70.

⁵ Note that, although referred to above as ‘discipline’, disability studies are best described as interdisciplinary. On the development of disability studies, see Colin Barnes, Mike Oliver and Len Barton, ‘Introduction’ in Colin Barnes, Mike Oliver and Len Barton (eds), *Disability Studies Today* (Polity Press 2002) 1-15; Rannveig Traustadóttir, ‘Disability Studies, the Social Model and Legal Developments’ in Oddný Arnardóttir and Gerard Quinn (eds), *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijhoff Publishers 2009) 4-7.

⁶ Tom Shakespeare, *Disability Rights and Wrongs* (Routledge 2006) 9.

⁷ The ‘relational’ approach understands disability as a relationship between the individual and the environment, whereas the ‘minority group’ approach focuses on the discrimination against persons with disabilities and regards civil rights legislation as the appropriate response: see generally Shakespeare, *Disability Rights and Wrongs* (n 6) 23-26. On the ‘relational’ approach see more specifically Jan Tøssebro and Anna Kittelsaa (eds), *Exploring the Living Conditions of Disabled People* (Studentlitteratur 2004). On the ‘minority group’ approach see more specifically Harlan Hahn, ‘The Politics of Physical Differences: Disability and Discrimination’ (1988) 44 *Journal of Social Issues* 39; Harlan Hahn, ‘Antidiscrimination Laws and Social Research on Disability: The Minority Group Perspective’ (1996) 14 *Behavioral Sciences and the Law* 41.

adopted by the British ‘social model’, which has been called by Tom Shakespeare and Nicholas Watson for that reason the ‘strong version of the social model of disability’.⁸ It is therefore important to emphasise that it is only the British approach that makes the distinction between impairment and disability; thus, a social approach to disability does not necessarily rely on that distinction.

2.2.1 The development of the British ‘social model’ of disability

The British social approach was developed by disabled activists such as Vic Finkelstein⁹ and disability studies scholars such as Michael Oliver¹⁰ and Colin Barnes,¹¹ based on a materialist understanding of disability.¹² The term and conceptualisation of the ‘social model of disability’ was invented by Oliver in 1981; however, the basic ideas of this new understanding, most importantly as regards the cause of disability, were introduced in 1976, in a document called the ‘Fundamental Principles of Disability’, published by the Union of the Physically Impaired Against Segregation (UPIAS).

2.2.1.1 Union of the Physically Impaired against Segregation (UPIAS)

UPIAS was a disabled people’s organisation, created in the 1970s, and among its leaders were Paul Hunt and Vic Finkelstein. Disability is described in the document as follows:

⁸ Tom Shakespeare and Nicholas Watson, ‘The Social Model of Disability: An Outdated Ideology?’ (2002) 2 Research in Social Science and Disability 9, 6 <<https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Shakespeare-social-model-of-disability.pdf>> accessed 16 December 2019. Note that Shakespeare and Watson mean ‘approach’ by using the term ‘model’. It is suggested that, in order to avoid confusion as well as recognise and emphasise the distinction between the British approach and other social approaches, the term ‘social model’ should only be used to refer to the British approach.

⁹ Victor Finkelstein, *Attitudes and Disabled People: Issues for Discussion* (World Rehabilitation Fund 1980).

¹⁰ Oliver, *The Politics of Disablement* (n 3); Michael Oliver, *Understanding Disability: From Theory to Practice* (Palgrave 1996).

¹¹ Colin Barnes, *Disabled People in Britain and Discrimination: A Case for Anti-Discrimination Legislation* (Hurst & Company 1991).

¹² According to this understanding, disability is linked to the rise of capitalism and particularly the capitalist mode of production: For an overview of materialist accounts of disability, see Barnes, Mercer and Shakespeare (n 3) 83-86. See also Brendan Gleeson, ‘Disability Studies: A Historical Materialist View’ (1997) 12 Disability & Society 179; Mark Priestley, ‘Constructions and Creations: Idealism, Materialism and Disability Theory’ (1998) 13 Disability & Society 75.

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called 'disability', of people with such impairment. Thus we define impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression.¹³

As evident in the above statement, UPIAS advocates a new understanding of disability, which has two main characteristics. First, a distinction is made between impairment and disability, which has been crucial to the British social 'model' of disability. It can be said in particular that this distinction is relied upon to argue that disability is not a problem of functional limitations, but one of social and economic structures. Second, the UPIAS document advances an interpretation of disability as oppression, which points to the relationship between those with impairments and the rest of society. These characteristics will now be examined, starting with the way in which impairment and disability are separated in the UPIAS document.

As a starting point, it can be argued that there are two different ways of understanding this distinction; however, only the first one can be regarded unproblematic. In particular, one way of understanding the distinction between impairment and disability is related to their separation in terms of their different meaning. UPIAS highlights that impairment and disability are not synonymous,

¹³ UPIAS and the Disability Alliance, *Fundamental Principles of Disability: Being a Summary of the Discussion Held on 22nd November, 1975 and Containing Commentaries from Each Organisation* (UPIAS 1976) 20 <<https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-fundamental-principles.pdf>> accessed 16 December 2019.

through the inclusion in the document of definitions of these terms: Impairment is defined as 'lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body', whereas disability as 'disadvantage or restriction of activity'.¹⁴ It is therefore clear that the use of the term disability implies something different than the impairment, and vice versa. It can be argued that this reading of distinction as simply referring to the different meanings given to impairment and disability would not have been particularly controversial. It would have been sensible to suggest that impairment describes a problem with the body, whereas disability refers to something else, namely a difficulty in performing activities.

UPIAS however goes further than that and advances a second way of understanding the distinction between impairment and disability. In particular, besides separating impairment from disability in the sense that they do not share the same definition, the two terms are also distinguished in terms of causality. Thus, the separation of impairment and disability also refers to the relationship between them, and specifically the absence of a causal link between them. Not only is it asserted that disability *is* not impairment, but also that disability is not *caused* by impairment. The lack of connection between impairment and disability is evident in the UPIAS document, as it is clearly stated that disability is 'caused by a contemporary social organisation which takes no or little account of people who have physical impairments'.¹⁵ According therefore to the UPIAS interpretation, the cause of disability, which is defined as the restriction of activity of people with impairments, is not impairment, but society's failure to include them in social activities. As explained by Finkelstein, UPIAS took the view that having an impairment may be a 'personal tragedy', but at the social level, people are prevented from functioning - they are thus disabled - because of the way in which the social and physical environment is constructed.¹⁶

¹⁴ *ibid.*

¹⁵ *ibid.*

¹⁶ Vic Finkelstein, 'Representing Disability' in John Swain and others (eds), *Disabling Barriers – Enabling Environments* (2nd edn, SAGE 2004) 15.

As already mentioned, this second way of distinguishing disability from impairment appears to be problematic. The reason for that is that impairment is considered by UPIAS to be entirely irrelevant to how disability is caused. It can be argued that it would have been accurate simply to suggest that impairment is not the only cause of disability, or that the existence of impairment does not necessarily lead to disability. Indeed, a person is not disabled simply because he or she has an impairment; the role of society is also important, because the experience of disability is dependent on social responses to people with impairments, either positive or negative. In other words, it can be argued that two individuals who have the same impairment, but live in different societies, will not experience disability in the same way. However, the UPIAS document explicitly states that 'it is society which disables physically impaired people'¹⁷ and emphasises that disability is socially imposed on people with impairments. It is also clearly stated that the cause of disability is the 'social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities'.¹⁸ It is therefore suggested that the only reason why people with impairments experience restrictions in performing activities, is because society ignores them and refuses to accommodate their needs. Impairment is causally de-linked from disability, and the two terms are thereby entirely distinguished. Importantly, it is the distinction in *that* sense that constitutes, as mentioned above, the unique feature of the British social model of disability. Nevertheless, such a 'strong' approach that denies any relationship between impairment and disability appears to be flawed, for reasons that will be explained in the following subsection.

The second characteristic of the social approach found in the UPIAS document is a conceptualisation of disability as the social oppression of people with impairments. In particular, having being 'disconnected' from impairment, disability is understood as the disadvantage experienced by people with

¹⁷ UPIAS, *Fundamental Principles of Disability* (n 13) 20.

¹⁸ *ibid.*

impairments due to their social exclusion; since it is society that creates this disadvantage, disability is seen as a form of social oppression. It should be noted that, as Carol Thomas correctly points out, the UPIAS document refers to the relationships between two groups of people and therefore has a 'social relational' character;¹⁹ it is argued in particular that people with impairments are subject to social oppression by those without impairments. Thomas accepts this argument and advocates the adoption of a 'social oppression paradigm' to the study of disability.²⁰ Moreover, she has further developed the UPIAS view by claiming that people with impairments experience 'disablism', which refers to the 'social imposition of *avoidable restrictions* on [their] life activities, aspirations and psycho-emotional well-being ... by those deemed "normal" and should be understood 'alongside sexism, racism, ageism, and homophobia'.²¹ Nevertheless, the claim that people with impairments are disabled because they are socially oppressed is questionable. Viewing disability as a form of social oppression does not seem appropriate because, as Shakespeare argues, social relations between disabled and non-disabled people also have a 'positive dimension'.²² Therefore, although it would not be wrong to view disability in terms of social relations, nor it is denied that these may occasionally be negative, it is wrong to argue that the reactions of those without impairments to people with impairments are always negative.

The UPIAS understanding of disability and impairment was subsequently adopted by other disabled people's organisations, including Disabled People's International (DPI), an international body of national organisations of disabled people, and the British Council of Organisations of Disabled People (BCODP), the umbrella body for disabled people's organisations in the United Kingdom. It is important to note at this point that, although the definition of impairment

¹⁹ See Carol Thomas, 'How Is Disability Understood? An Examination of Sociological Approaches' (2004) 19 *Disability & Society* 569.

²⁰ Carol Thomas, 'Theorising Disability and Chronic Illness: Where Next for Perspectives in Medical Sociology?' (2012) 10 *Social Theory & Health* 209, 215.

²¹ Carol Thomas, 'Medical Sociology and Disability Theory' in Graham Scambler and Sasha Scambler (eds) *New Directions in the Sociology of Chronic and Disabling Conditions: Assaults on the Lifeworld* (Palgrave Macmillan 2010) 37.

²² Tom Shakespeare, *Disability Rights and Wrongs Revisited* (2nd edn, Routledge 2014) 77.

initially concerned only physical conditions, it later included all types of impairment.²³ This is evident in the definitions adopted by DPI in 1982, which also endorsed the separation of impairment and disability:

Impairment is the functional limitation within the individual caused by physical, mental or sensory impairment.

Disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers.²⁴

Impairment – physical, as well as mental or sensory - is therefore distinguished from disability. Although both are defined as limitations, the former is described in medical terms whereas the latter in social terms. Furthermore, no causal link exists between them, since disability does not result from impairment but is rather created by barriers to participation in society. Interestingly, disability as defined by the DPI may be experienced even by individuals without impairments. This approach however seems unfortunate because, as Jerome Bickenbach and others have noted, it suggests that anyone who is excluded from participation in society may be regarded as disabled.²⁵

2.2.1.2 Conceptualisation from Oliver

Influenced by the ideas found in the UPIAS document, Michael Oliver decided to provide a framework for the distinction between impairment and disability. To that end, he conceptualised in 1983 the ‘social model of disability’ and distinguished it from the ‘individual model of disability’.²⁶ The latter is underpinned by the idea of ‘personal tragedy’, whereas the former is based on the theory of ‘social oppression’.²⁷

²³ Colin Barnes, ‘Understanding the Social Model of Disability: Past, Present and Future’ in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 14.

²⁴ DPI, *Proceedings of the First World Class Congress* (DPI 1982).

²⁵ Jerome Bickenbach and others, ‘Models of Disablement, Universalism and the International Classification of Impairments, Disabilities and Handicaps’ (1999) 48 *Social Science & Medicine* 1173, 1176.

²⁶ Oliver, *Understanding Disability* (n 10) 30.

²⁷ Oliver, *The Politics of Disablement* (n 3) 1.

It should be noted at this point that medical approaches to disability are usually referred to as the 'medical model' of disability.²⁸ According to this model, disability is considered an individual deficit and is seen from a biomedical perspective as the outcome of impairment. It is understood in terms of functional limitations which require medical solutions; accordingly, the appropriate responses include prevention, cure, treatment and care. The 'social' model is more commonly contrasted to this 'medical' model of disability. Nevertheless, Oliver avoids the use of that term and rather refers to the 'individual' model. His view, as stated in *Understanding Disability*, is that 'there is no such thing as the medical model of disability'; there is instead medicalisation,²⁹ which, albeit significant, is merely an aspect of the individual model.³⁰ He similarly states in *The Politics of Disablement* that individualism is the 'core' ideology that determines how disability is understood, whereas medicalisation is a 'peripheral' ideology which makes disability 'a particular kind of problem'.³¹ This can be understood by considering that Oliver's aim is to emphasise the exclusion and isolation faced by people with impairments and the need for social change instead of individual adjustment. Consequently, he chooses not to focus on the medical aspect of disability, but to point out that disability is perceived as a personal, instead of a social problem.

According therefore to Oliver's conceptualisation, disability can be viewed either from an 'individual' or from a 'social' perspective. The individual model views the problem as located in the individual and caused by functional limitations,

²⁸ See for example Simon Brisenden, 'Independent Living and the Medical Model of Disability' (1986) 1 *Disability, Handicap & Society* 173; Jonathan Gabe, Mike Bury and Mary Ann Elston, *Key Concepts in Medical Sociology* (SAGE 2004) 125-129; Juliet Rothman, 'The Challenge of Disability and Access: Reconceptualizing the Role of the Medical Model' (2010) 9 *Journal of Social Work in Disability & Rehabilitation* 194. Note that Bickenbach, in order to highlight the significance of the biological impairment, has used the term 'bio-medical model': see Jerome Bickenbach, *Physical Disability and Social Policy* (University of Toronto Press 1993).

²⁹ The 'medicalisation' of disability refers to the dominance of medical explanations for disability and reliance on medical expertise as regards that issue. It is linked to the rise and growth of medicine and the medical profession, and particularly to the role of medicine as a mechanism for social control. For Oliver's view on medicalisation, see Oliver, *The Politics of Disablement* (n 3) 49-54; Michael Oliver and Colin Barnes, *The New Politics of Disablement* (2nd edn, Palgrave Macmillan 2012) 83-85. See also Barnes and Mercer, *Exploring Disability* (n 4) 59-63.

³⁰ Oliver, *Understanding Disability* (n 10) 31.

³¹ Oliver, *The Politics of Disablement* (n 3) 46, 58.

whereas the social model views it as located within society and caused by society's failure to address the needs of persons with impairments.³² The 'social model' approach places great emphasis on the 'disabling' environment which excludes people with impairments from participation in society. Disability is therefore understood as the consequence of externally imposed barriers to social inclusion. Finkelstein argues in *Attitudes and Disabled People* that, as long as social barriers to the reintegration of persons with impairments are not removed, disability will continue to exist. Accordingly, social action is required and particularly 'changes in society, changes to the environment, changes in environmental control systems, changes in social roles, and changes in attitudes by people in the community as a whole'.³³ Oliver similarly states that the purpose of the social model is to draw attention, not to functional limitations of persons with impairments, but to the economic, environmental and cultural barriers they face, such as inaccessible education systems and transport, discriminatory health services and negative attitudes.³⁴

The 'social model' approach claims that economic and social forces create disability and consequently the appropriate response for its elimination is the removal of disabling barriers to participation in society. It is also based on radical ideas that describe disability in terms of social oppression and deny any causal link between disability and impairment. It can nevertheless be argued that this is not an adequate understanding of disability and the 'social model' approach appears to be problematic for a number of reasons. These reasons will now be examined.

³² Oliver, *Understanding Disability* (n 10) 32.

³³ Finkelstein, *Attitudes and Disabled People* (n 9) 22.

³⁴ Mike Oliver, 'The Social Model in Action: If I Had a Hammer' in Colin Barnes and Geof Mercer (eds), *Implementing the Social Model of Disability: Theory and Research* (The Disability Press 2004) 6 <<https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Barnes-implementing-the-social-model-chapter-2.pdf>> accessed 16 December 2019.

2.2.2 Criticism of the social model

The British 'social model' has exercised great influence on disabled people and their organisations as well as disability studies.³⁵ However, it has also been challenged, even within disability studies, over recent years.³⁶ The argument that the 'social model' approach is inadequate can be based on three grounds: The first concerns the relevance of impairment in the experience of disability; the second, the focus on removal of disabling barriers, and the third, the distinction between impairment and disability.

2.2.2.1 Significance of impairment

The first reason why it can be argued that the social model does not provide an adequate understanding of disability is that it ignores the personal experience of impairment and the impact it has on disabled people's lives. As noted by feminist writers such as Jenny Morris,³⁷ Liz Crow³⁸ and Sally French,³⁹ impairment causes pain and limitation, the experience of which is denied by the social model. Focus is placed only on social barriers and exclusion, while the significance of impairment is overlooked. In response to that criticism, Oliver emphasises that the social model does not approach disability as a 'personal tragedy' or individual problem, but rather rests on the idea that it is society which disables people with impairments and draws attention to socially imposed barriers. Accordingly, he states that the social model 'is not about the personal experience of impairment

³⁵ Importantly, the focus on challenging the discrimination and inequality faced by people with impairments, which led to the passage of anti-discrimination legislation in 1995, was inspired by the 'social model' of disability: see Barnes, *Disabled People in Britain and Discrimination* (n 11). An overview of the social model's major influences on disability studies and disability policy is provided for in Barnes, 'Understanding the Social Model of Disability: Past, Present and Future' (n 23) 17-21.

³⁶ For an overview of the main criticisms of the social model, see Carol Thomas, 'Rescuing a Social Relational Understanding of Disability' (2004) 6 *Scandinavian Journal of Disability Research* 22, 25-27. Tom Shakespeare summarises the debates around the social model and then makes his own critique: see Shakespeare, *Disability Rights and Wrongs* (n 6) 34-50. See also Shakespeare, *Disability Rights and Wrongs Revisited* (n 22) 21-42.

³⁷ Jenny Morris, *Pride against Prejudice: Transforming Attitudes to Disability* (Women's Press 1991).

³⁸ Liz Crow, 'Including All of Our Lives: Renewing the Social Model of Disability' in Colin Barnes and Geof Mercer (eds) *Exploring the Divide: Illness and Disability* (The Disability Press 1996).

³⁹ Sally French, 'Disability, Impairment or Something in Between?' in John Swain and others (eds), *Disabling Barriers – Enabling Environments* (SAGE 1993).

but the collective experience of disablement’;⁴⁰ thus, it represents ‘a pragmatic attempt to identify and address issues that can be changed through collective action rather than medical or professional treatment’.⁴¹ He therefore admits that impairment is ignored deliberately, since a focus on personal experiences of impairment would have the effect of weakening the social model, while at the same time reinforcing medical or individual understandings of disability. In considering this argument, it seems that the social model is more concerned with achieving its aim, which is to bring about social change for people with impairments, than describing disability adequately. Although Oliver seems to suggest that this is acceptable, it can be argued that, however worthy the aim, a description of disability should provide sufficient understandings of that experience, rather than being used simply as a means to an end. In other words, whatever the benefits of ignoring a central element to the experience of disability, namely impairment, for the disabled people’s movement, this element should be fully considered and included in an adequate account of disability.

2.2.2.2 Removal of barriers

It can be argued that the social model places too much emphasis on the removal of disabling barriers, which is the second reason for its limitations. It is not denied that the physical and social environment has an impact on the experience of disability; however, as Shakespeare correctly notes, barrier removal as the appropriate response to disability involves ‘major practical and intrinsic obstacles’.⁴² The accessibility of the natural environment is one of these obstacles. Whilst removing barriers from urban areas is relatively possible, it is more difficult to make natural environment accessible.⁴³ Another problem is that it is impossible to create an inclusive environment for all forms of impairments, because the accommodation of one type of impairment is often in conflict with that of another; for example, as Shakespeare explains, while ramps are essential

⁴⁰ Oliver, ‘The Social Model in Action: If I Had a Hammer’ (n 34) 7.

⁴¹ Oliver, *Understanding Disability* (n 10) 38.

⁴² Shakespeare, *Disability Rights and Wrongs Revisited* (n 22) 42.

⁴³ *ibid* 36.

for wheelchair users, steps may be safer for those with mobility problems.⁴⁴ It is therefore unrealistic to argue that an environment to which everyone has equal access can be created.⁴⁵ There are also practical problems to removing barriers in order to make environments accessible; the main practical problem certainly concerns resource limitations.⁴⁶ One final obstacle to accommodating every impairment and need is that this would mean, as stated by Shakespeare, 'rebuilding society'.⁴⁷ The creation of a fully accessible and inclusive world seems impossible, not only because of the issue of resources, but also because of the wide range of impairments that would need accommodation.

2.2.2.3 Distinction between disability and impairment

It can be argued that the unique characteristic of the British 'social model', namely the distinction between impairment and disability, is problematic; this is the third reason why the British 'social model' fails to describe disability adequately, and probably the most common criticism made against it. As stated in the previous subsection, the 'social model' approach takes the view that disability is causally de-linked from impairment. Even more, impairment is considered entirely irrelevant to the creation of disability. Impairment is therefore understood in terms of biology, whereas disability is seen as socially created. It seems however that this distinction cannot be sustained. As Shakespeare and Watson correctly point out, 'impairment and disability are not dichotomous, but describe ... different aspects of a single experience'; accordingly, 'it is difficult to determine where impairment ends and disability starts'.⁴⁸

The distinction between disability and impairment can be challenged on a number of grounds. First, as noted by Shakespeare, the two concepts are connected because disability does not exist in the absence of impairment; it may

⁴⁴ *ibid* 37.

⁴⁵ *ibid*.

⁴⁶ *ibid* 38.

⁴⁷ *ibid* 39.

⁴⁸ Shakespeare and Watson (n 8) 24.

only be experienced by people with impairments.⁴⁹ Thus, a person must have an impairment in order to face disabling barriers. If disability is separated from impairment, it simply refers to the imposition of any social restriction. Secondly, it does not seem accurate to claim that impairment is a biological concept, distinct from the 'social' disability concept. As Paul Abberley argues, impairment itself may have social origins.⁵⁰ Abberley considered the material disadvantage caused by impairment, when he developed his well-known social oppression theory of disability in 1987. He drew parallels in particular between racial and sexual oppression and the oppression experienced by disabled people. As he states, unlike in the case of women and black people where no material difference exists, in the case of disabled people 'the biological difference ... is itself a part of the oppression'.⁵¹ He is however right to suggest that, apart from biological causes, impairment may sometimes have social origins; it may be the cause of socio-economic factors, such as poverty or war.⁵² Seeing impairment as a biological concept is inaccurate also because, as Shakespeare notes, its definition is dependent on 'social judgment'.⁵³ The social and cultural factors of impairment cannot be denied, and, as Shakespeare and Watson state, drawing on post-structuralist approaches, impairment is socially and culturally determined by 'the words we use and the discourses we deploy to represent [it]'.⁵⁴

In addition to these reasons for arguing against the distinction between disability and impairment, of most interest and relevance here is the claim that, notwithstanding any social or cultural causes, the main cause of disability is impairment. Thus, as impairment cannot be regarded a purely biological concept, disability cannot be seen as purely social either. It is important to note at this point that disability is understood in its common meaning, as restriction of

⁴⁹ Shakespeare, *Disability Rights and Wrongs Revisited* (n 22) 22.

⁵⁰ Paul Abberley, 'The Concept of Oppression and the Development of a Social Theory of Disability' (1987) 2 *Disability, Handicap & Society* 5.

⁵¹ *ibid* 8.

⁵² *ibid* 9-13.

⁵³ Shakespeare, *Disability Rights and Wrongs Revisited* (n 22) 22-23. See also Shakespeare and Watson (n 8) 15-19.

⁵⁴ Shakespeare and Watson (n 8) 16.

activity. The argument of the British 'social model' that disability, namely restriction of activity, is only caused by social barriers is false, as is the claim that impairment does not cause restrictions of activity. As Mike Bury states from within the field of medical sociology, disability is primarily caused by chronic illness or impairment.⁵⁵ The British 'social model' denies the causal connection between disability and impairment; Bury is therefore right to characterise it as 'oversocialised'.⁵⁶

It should be noted that Carol Thomas takes the view that the understanding of disability found in the UPIAS document has been misinterpreted.⁵⁷ She argues that UPIAS does not suggest that 'all restrictions of activity experienced by people with impairment are caused by social barriers'; it is instead accepted that ability to perform activities may also be limited by impairment.⁵⁸ However, restrictions of activity caused by impairment 'do not constitute *disability*', but are rather, as she calls them, 'impairment effects'.⁵⁹ Disability is thus redefined in the UPIAS document and should not be seen as simply meaning 'restriction of activity'; rather, Thomas states that the British 'social model' understands disability as the restriction of activity which is caused *specifically* by social barriers.⁶⁰ It can be argued however that, even if the 'social model' understanding of disability is seen according to Thomas' view, it is still an inadequate approach. In particular, this is because of the reason why a model, description or explanation of disability is needed. It can be argued that it is needed in order to understand why people with impairments are experiencing difficulties and limitations in executing activities. Thus, the purpose of any model of disability is to explain what causes these restrictions. However, unless all the relevant causes are taken into account, disability is not explained adequately.

⁵⁵ Michael Bury, 'On Chronic Illness and Disability', in Chloe Bird and others (eds), *Handbook of Medical Sociology* (5th edn, Prentice Hall 2000) 179.

⁵⁶ Mike Bury, 'A Comment on the ICIDH2' (2000) 15 *Disability and Society* 1073, 1074.

⁵⁷ Carol Thomas, 'Disability Theory' in Colin Barnes, Mike Oliver and Len Barton (eds), *Disability Studies Today* (Polity Press 2002) 43. See also Thomas, 'How Is Disability Understood? An Examination of Sociological Approaches' (n 19) 578-79.

⁵⁸ *ibid.*

⁵⁹ *ibid* 43-44.

⁶⁰ *ibid.*

Therefore, a model of disability that is concerned only with certain restrictions does not provide a sufficient understanding of disability. For example, the individual or medical model is inadequate because it describes only restrictions that are caused by impairment. Since the British 'social model' describes only those that are caused by social barriers, it is also an insufficient explanation for disability.

Based on the above difficulties of the 'social model' approach, namely the denial of the importance of impairment, the limitations of the barrier removal and the false distinction between disability and impairment, it can be argued that it fails to describe disability adequately. This has been recognised by Oliver, who states that 'the social model of disability is a practical tool like a hammer ... not a theory, an idea or a concept' and it should be used as a 'tool to produce social and political change'.⁶¹ He therefore clarifies that its purpose is not to offer an adequate explanation of disability, but to be used by the disabled people's movement - which is a political movement - as a means to achieving social change, removal of disabling barriers and inclusion of people with impairments in society. In order to achieve this goal, the British 'social model' ignores the medical aspect of disability, while at the same time social and environmental factors are over-emphasised. Strong views, such as the argument that disability is never caused by impairment, serve the aim of the 'social model' approach, but cannot be considered accurate.

Therefore, and as Oliver admits, the British 'social model' is inadequate and fails to provide a comprehensive account of disability. However, this does not mean that all the ideas that inform it should be abandoned. Although not entirely valid, the 'social model' approach is valuable. It can be argued in particular that a social dimension of disability does exist, and certain ideas of the British 'social model' should be reflected in an appropriate understanding of disability. For example, the argument that social barriers prevent people with impairments from participating in society is correct; it is however incorrect to argue that they

⁶¹ Michael Oliver, *Understanding Disability: From Theory to Practice* (2nd edn, Palgrave Macmillan 2009) 57.

constitute the only cause of exclusion. It can therefore be argued that the radical views of the British 'social model' should be abandoned, whereas an adequate approach to disability should take into account that the experience of disability includes social factors.

2.3 WHO's International Classification of Functioning, Disability and Health (ICF)

It has been argued so far that the British 'social model' has problematic aspects and can be challenged for its limitations. However, as already mentioned, a social approach to disability need not necessarily take a strong position; other approaches have been developed that, although they view disability from a social perspective, do not adopt the radical views of the British 'social model'.

2.3.1 The balanced approach

A balanced understanding of disability is found for example in the Nordic 'relational' approach, which, as Tøssebro describes, understands disability as 'situational' and 'relative to the environment'.⁶² This approach in particular does not make a distinction between disability and impairment, but recognises instead the role of environment in the creation of disability. Another balanced approach is the alternative to the British 'social model', developed by Shakespeare, which is closely related to the Nordic 'relational' approach.⁶³ He and Watson argued in 2001 that disability 'should not be reduced to a medical condition ... [n]either should it be reduced to an outcome of social barriers alone'; it is a 'complex dialectic of biological, psychological, cultural and socio-political factors'.⁶⁴ On the basis of these ideas, he proposed in *Disability Rights and Wrongs* an 'interactional' understanding of disability.⁶⁵ This approach seems to understand disability accurately; it recognises the various factors that are relevant to the experience of disability, without reducing it to either a medical or social concept.

⁶² Jan Tøssebro, 'Introduction to the Special Issue: Understanding Disability' (2004) 6 *Scandinavian Journal of Disability Research* 3, 4.

⁶³ Shakespeare, *Disability Rights and Wrongs* (n 6) 58.

⁶⁴ Shakespeare and Watson (n 8) 24.

⁶⁵ Shakespeare, *Disability Rights and Wrongs* (n 6) 54-55.

The 'interactional' approach is based on critical realism; this theoretical perspective, as Shakespeare states, accepts the existence of an external reality that is independent of our ideas and knowledge about it.⁶⁶ It can be argued that a critical realistic perspective offers adequate understandings of disability, because it avoids explanations which are strictly either social or medical, and allows instead for description of the various aspects of disability. This perspective is used for example by Simon Williams, who understands disability as follows:

Disability ... is *neither* the sole product of the impaired body or a socially oppressive society. Rather, it is ... an *emergent* property, one involving the interplay of physiological impairment, structural enablements/constraints and socio-cultural elaboration over time.⁶⁷

The above description combines biological, economic, social and cultural aspects of disability and points out the interplay between them. Similarly, Shakespeare adopts an approach to disability as the complex interaction between individual factors, such as the type of impairment and the person's attitudes to it, and structural or contextual factors, such as other people's attitudes, environments and other cultural and economic issues.⁶⁸ The 'interactional' approach is therefore based on the idea that 'people are disabled by society *and* by their bodies'.⁶⁹ This holistic understanding of disability seems appropriate, because a wide range of factors that are relevant to the experience of disability are taken into account, including impairment. It should be emphasised that health is an important aspect of the multi-dimensional character of disability; as Shakespeare states, disability is 'almost always associated with impairment' and therefore 'still a health issue'.⁷⁰

It can be argued that adequate explanations of disability can only be offered by balanced approaches that combine medical and social understandings. WHO's

⁶⁶ Shakespeare, *Disability Rights and Wrongs Revisited* (n 22) 72-73.

⁶⁷ Simon Williams, 'Is Anybody There? Critical Realism, Chronic Illness and the Disability Debate' (1999) 21 *Sociology of Health & Illness* 797, 813.

⁶⁸ Shakespeare, *Disability Rights and Wrongs* (n 6) 55-56.

⁶⁹ *ibid* 2.

⁷⁰ Shakespeare, 'Still a Health Issue' (2012) 5 *Disability and Health Journal* 129.

ICF,⁷¹ which is a classificatory instrument for the description of health and health-related states,⁷² as well as its previous version, namely the ICIDH,⁷³ are examples of the significant changes that were brought to international understandings of disability by the development and influence of the social approach to disability. However, although they recognise its social aspect, both the ICIDH and the ICF conceptualise disability as multi-dimensional and can therefore be considered balanced accounts.

2.3.2 The ICIDH (1980) and the ICF (2001)

The ICF seems to provide a full and adequate description of disability. As explained below, disability is conceptualised in the ICF, not as restriction of ability to perform activities, but as the experience of difficulty at one or more of three levels of human functioning, namely at the body, person, or social level. It is therefore experienced as problems in body function or structure, in executing activities, or in involvement in life situations respectively. Furthermore, these problems arise from the interaction between the underlying health condition and contextual factors, namely features of the physical, social, and attitudinal environment as well as personal attributes.⁷⁴ It can be argued that this is the most accurate understanding of disability, one that acknowledges the various factors that are relevant to the experience of people with impairments, and the relationship between these factors. Before considering in depth the conceptualisation of disability in the ICF, it would be useful first to examine how

⁷¹ WHO, *ICF* (n 1).

⁷² The ICF belongs to the WHO's 'family' of international classifications. The other major classification is the ICD-10: WHO, *International Statistical Classification of Diseases and Related Health Problems: Tenth Revision (ICD-10)*, endorsed in May 1990, Res. WHA 43.24 of the 43rd World Health Assembly (WHO 1992). Note the difference between the ICD-10 and the ICF: The ICD-10 provides an etiological framework for the classification, by diagnosis, of diseases, disorders and other health conditions, whereas the ICF provides a framework for the classification of functioning and disability associated with health conditions.

⁷³ WHO, *ICIDH* (n 2).

⁷⁴ See the overview of the ICF: WHO, *ICF* (n 1) 11. For a short and helpful description of the ICF conception of disability, see WHO and the World Bank, *World Report on Disability* (WHO 2011) 5. See also WHO, *Towards a Common Language for Functioning, Disability and Health: ICF* (WHO 2002) <<http://www.who.int/classifications/icf/training/icfbeginnersguide.pdf>> accessed 16 December 2019.

disability was understood in the ICIDH and how that understanding was influenced by the social approach.

2.3.2.1 The ICIDH

The ICIDH was published for field trial purposes in 1980. It was a classificatory instrument for the 'consequences of disease (as well as of injuries and other disorders) and of their implications for the lives of individuals'.⁷⁵

There were three main classifications in the ICIDH, namely impairment, which represented 'disturbances at the organ level', disability, which reflected 'disturbances at the level of the person' and handicap, which reflected 'interaction with and adaptation to the individual's surroundings'.⁷⁶ Specifically, impairment was defined as 'any loss or abnormality of psychological, physiological, or anatomical structure or function',⁷⁷ disability as 'any restriction or lack ... of ability to perform an activity in the manner or within the range considered normal for a human being'⁷⁸ and handicap as 'a disadvantage for a given individual ... that limits or prevents the fulfillment of a role that is normal ... for that individual'.⁷⁹ Regarding the relationship between them, disability was considered the result of impairment and handicap the result of impairment or disability.⁸⁰

It can be noted that the ICIDH distinguishes between impairment, disability and handicap. Interestingly, as Bickenbach and others note, the British 'social model' definition of disability is very similar to the ICIDH definition of handicap.⁸¹ Both terms refer to the social exclusion and disadvantage experienced by persons with impairments; nevertheless, the ICIDH understands social disadvantage as the consequence of disability, whereas the 'social model' approach understands it as

⁷⁵ WHO, *ICIDH* (n 2) 1. In particular, the purpose of the ICIDH was to be used as a conceptual framework for information on the long-term consequences of disease, injuries, or disorders. It applied to personal health care and to the mitigation of environmental and societal barriers and was also used for the study of health care systems: see WHO, *ICIDH* (n 2) 2.

⁷⁶ *ibid* 14.

⁷⁷ *ibid* 27.

⁷⁸ *ibid* 28.

⁷⁹ *ibid* 29.

⁸⁰ *ibid* 28-29.

⁸¹ Bickenbach and others (n 25) 1177.

the cause of disability. Therefore, whilst the ICIDH recognises three levels of the experience relating to disease or other health conditions, the 'social model' approach only accepts the existence of impairment and disability; the latter is defined not as restriction of activity, but rather as the disadvantage created by social and environmental barriers. Thus, the British 'social model' suggests that persons with impairments inevitably experience activity limitations, due to the social disadvantage they face. This understanding can be explained with reference to the political aims of the 'social model'; in particular, as Bickenbach and others suggest:

In order to highlight the difference between what is intrinsic to a person ... and what is a socially constructed disadvantage ... the authors of the model needed a clear and ambiguous line between the intrinsic and the extrinsic. Rightly criticizing the medical model for swallowing up the extrinsic into the intrinsic (and turning a socially constructed disadvantage into a problem with a person's body or mind), they went to the other extreme and brought into the extrinsic side all human activities.⁸²

As noted above, there are a number of flaws in this approach; it seems therefore appropriate that there is a separate category in the ICIDH for the limitations that people may experience in performing activities at the person-level.

Furthermore, the ICIDH explicitly recognised that people with impairments experience social disadvantage, and the role of social and environmental factors in that experience. It can therefore be argued that the ICIDH was a positive step towards the development of a social understanding of disability. As Mike Bury states, those who developed the ICIDH took the view that 'the WHO was moving away from a narrow medical model of health and disease ... to one which recognised the consequences of health-related phenomena'.⁸³ Since the ICIDH drew attention to the social consequences of impairment, it can be argued that, although it did not entirely adopt the 'social model' approach, it did pose challenges to the medical model of disability.

⁸² *ibid.*

⁸³ Bury, 'A Comment on the ICIDH2' (n 56) 1073.

However, the proponents of the social approach opposed the ICIDH on the basis that it reflected the ideas of the medical model, because of the relationship between the three categories and particularly the causal link between impairment and disability.⁸⁴ It can be argued that the ICIDH failed to recognise that social and environmental barriers may also have disabling effects and may therefore create disadvantage for people with impairments. The one-way causal connection between impairment, disability and handicap can be considered problematic, which is why this linear progression was later changed in the ICF. As explained in particular in the foreword to the 1993 reprint, the ICIDH needed to be revised mainly in order to address problems regarding the relationship between the three categories and also to draw more attention to the role of environment in the development of handicap.⁸⁵

2.3.2.2 The ICF

The revised version of the ICIDH, namely the ICF, was published by WHO in 2001. The ICF is 'a multipurpose classification intended to serve various disciplines and different sectors'⁸⁶ and its aim is to offer 'a unified and standard language and framework for the description of health and health-related states'.⁸⁷ It is now a classification of the 'components of health'; it is no longer concerned, as the ICIDH was, with the 'consequences' of disease.⁸⁸ Thus, the new version seeks to identify the 'constituents of health', whereas the previous focused on the 'impacts of diseases or other health conditions that may follow as a result'.⁸⁹ The problematic aspects of the ICIDH regarding the causes of disability are therefore avoided in the ICF, which rather 'takes a neutral stand with regard to etiology'.⁹⁰

⁸⁴ See Finkelstein (n 9); Oliver (n 3).

⁸⁵ WHO, *ICIDH* (n 2) 4.

⁸⁶ WHO, *ICF* (n 1) 5. For a summary of the aims and applications of the ICF, see WHO, *ICF* (n 1) 5, 6.

⁸⁷ *ibid* 3.

⁸⁸ *ibid* 4.

⁸⁹ *ibid*.

⁹⁰ *ibid*.

The ICF provides a framework for 'situations with regard to human functioning and its restrictions',⁹¹ and describes a wide range of experiences, negative as well as positive. Importantly, the understanding of disability is changed; whilst in the ICIDH disability was understood as restriction of ability to perform activities, it now refers to problems in functioning. In particular, the ICF defines disability as 'an umbrella term for impairments, activity limitations and participation restrictions'.⁹² Thus, as Bickenbach states, disability is viewed as 'parasitical on positive, multidimensional notions of human functioning'.⁹³

The ICF identifies three levels of human functioning, namely the body, person, or social level; disability is conceptualised as the experience of difficulty in one or more of them. The concepts that indicate problematic aspects of health are included in the first part of the ICF, which is called 'Functioning and Disability'.⁹⁴ These are in particular 'impairments', which are 'problems in body function or structure'; 'activity limitations', which replace the ICIDH term 'disabilities' and are 'difficulties in executing activities'; and 'participation restrictions', which replace the ICIDH term 'handicaps' and are 'problems in involvement in life situations'.⁹⁵

It can be argued that one significant development in the ICF is the recognition of the multi-dimensional character of disability. The ICF is therefore based on a 'synthesis' of the medical and social models of disability; it integrates in particular all the aspects of functioning by adopting a 'biopsychosocial' approach.⁹⁶ This term is more commonly associated with George Engel, who used it in 1977 when he argued for the need to abandon the traditional

⁹¹ *ibid* 7.

⁹² *ibid* 213.

⁹³ Jerome Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 53.

⁹⁴ WHO, *ICF* (n 1) 8.

⁹⁵ *ibid* 10.

⁹⁶ *ibid*.

biomedical model of disease and advance instead a 'biopsychosocial model'.⁹⁷ In particular, he saw the former as reductionist and therefore claimed that it is insufficient for understanding what causes diseases and how they can be treated. As he stated, it places too much emphasis on biology and 'leaves no room within its framework for the social, psychological, and behavioral dimensions of illness'.⁹⁸ Engel therefore argued that a 'biopsychosocial model' of disease is needed, which takes into account not only biological factors but also 'the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system'.⁹⁹ In adopting this approach, the ICF correctly recognises that the experience of disability depends on biological, individual and societal factors.

Another significant development is that the ICF avoids making any direct causal links between impairment and disability; its conceptualisation is instead interactional. In particular, a person's disability, as well as functioning, 'is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors'.¹⁰⁰ Thus, focus is placed on the whole experience associated with a health condition. The ICF therefore departs from the ICIDH linear conceptualisation and correctly suggests that the components of health interact with one another. The contextual factors are described in the second part of the ICF and are personal, which are not classified, and environmental. The environmental factors that are relevant in determining disability are barriers that exist in the physical, social or attitudinal environment and may be individual or societal. Individual factors include settings such as home, workplace and school, whereas societal include organisations and services

⁹⁷ George Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine' (1977) 196 *Science* 129. Note that, as Nassir Ghaemi states, the term actually originated in 1954 and was invented by Roy Grinker, who 'applied it to psychiatry to emphasise the "bio" against psychoanalytic orthodoxy'; Engel then used it in 1977 to privilege the 'psychosocial' over the 'bio': Nassir Ghaemi, 'The Rise and Fall of the Biopsychosocial Model' (2009) 195 *The British Journal of Psychiatry* 3, 3.

⁹⁸ *ibid* 130.

⁹⁹ *ibid* 132.

¹⁰⁰ WHO, *ICF* (n 1) 8.

related to the work environment, community activities, communication and transportation services, and informal social networks as well as laws, regulations, attitudes and ideologies.¹⁰¹

As a final point, it should be mentioned that the ICF, in spite of the revision process, has still been subject to considerable criticism.¹⁰² It is important to emphasise, however, that it does not adopt a medical model of disability. It is based on a 'biopsychosocial' approach, which views disability from various perspectives, combines medical and social understandings and recognises the relevance of a number of different factors to the experience of disability. The ICF therefore does not reduce disability to any of its factors, but recognises instead its multi-dimensional and interactive character, as well as the role of both impairment and environment in the whole experience.

The social approach to disability will now be examined specifically within the mental health context.

2.4 The Social Approach in Relation to Mental Health

A large body of sociological work exists in the area of mental health¹⁰³ and there is increasing interest in developing social approaches to understanding mental disorder or distress.¹⁰⁴ The British 'social model' of disability provides a

¹⁰¹ *ibid* 17.

¹⁰² For an overview of critiques of the ICF, see Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 93) 60-63. See also Barnes and Mercer, *Exploring Disability* (n 4) 38-40.

¹⁰³ For an overview of various sociological understandings of concepts and categories of mental disorder, see Joan Busfield, 'Introduction: Rethinking the Sociology of Mental Health' in Joan Busfield (ed), *Rethinking the Sociology of Mental Health* (Blackwell 2001) 2-6.

¹⁰⁴ See for example Jerry Tew, *Social Approaches to Mental Distress* (Palgrave Macmillan 2011). See also Jerry Tew (ed), *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress* (Jessica Kingsley 2005).

framework that might be useful for this purpose.¹⁰⁵ The social approach to disability will therefore be examined within the mental health context and particular focus will be placed on the relevance of the British 'social model' to mental health issues. This section first considers the relation between mental health and disability; thus, it examines whether the situation of those with mental health problems can be related to that of people with physical or sensory impairments. It then considers how the 'social model' of disability applies specifically to people with mental health problems and particularly whether there is something distinctive to mental health that makes the 'social model' inapplicable to them. It finally examines the application of the ICF understanding of functioning and disability to mental health conditions.

2.4.1 Relation between mental health and disability

As a starting point, it should be mentioned that there is no agreement among users of mental health services on whether mental health should be linked to disability. As Peter Beresford notes, people with mental health problems do not usually see themselves as disabled and reject the use of terms like 'mental disability' to describe their situation.¹⁰⁶ They also avoid being involved with the disabled people's movement and have rather developed their own, separate movement, namely the mental health service user/survivor movement.¹⁰⁷ Mental health service user activists believe that their situation is different from

¹⁰⁵ The applicability of the social model of disability to the study of mental disorder has been examined mainly by Peter Beresford: see Peter Beresford, 'What Have Madness and Psychiatric System Survivors Got to Do with Disability and Disability Studies?' (2000) 15 *Disability and Society* 167; Peter Beresford, 'Thinking About "Mental Health": Towards a Social Model' (2002) 11 *Journal of Mental Health* 581. See also Julie Mulvany, 'Disability, Impairment or Illness? The Relevance of the Social Model of Disability to the Study of Mental Disorder' (2000) 22 *Sociology of Health & Illness* 582; Rachael Andersen-Watts, 'Recognising our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness' (2008) 12 *Michigan State University Journal of Medicine and Law* 141.

¹⁰⁶ Peter Beresford, 'Psychiatric System Survivors: An Emerging Movement' in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 155.

¹⁰⁷ For a brief discussion of the service user/survivor movement, see Peter Campbell, 'The Service User/Survivor Movement' in Jill Reynolds and others (eds) *Mental Health Still Matters* (Palgrave Macmillan 2009) 46-52.

that of people who have physical or sensory impairments and are therefore reluctant to be associated or work with them.¹⁰⁸

This reluctance is also highlighted in a study published in 2010.¹⁰⁹ This research project involved the participation of mental health service users and its aim was to explore their views regarding the various models that are relevant to mental health issues and determine which one is the most helpful to the understanding of these issues. According to the study's findings, some participants do not consider themselves as having an impairment.¹¹⁰ It was stated in particular that impairment is 'fixed' and 'permanent', whereas the experience of a mental health problem 'can fluctuate'.¹¹¹ It can be argued however that the link between those with mental health problems and those with physical or sensory impairments is not a similarity in impairments, but the common experience of limitations in performing activities. A mental health problem can be related to disability if it has long-term implications to the person's life; this may happen even in the case of a fluctuating condition. Thus, a longstanding or chronic mental condition, even if it fluctuates, may still have disabling effects. A relationship therefore exists between mental health problems and disability. At this point it should be noted that not all mental health conditions have long-term effects. However, as Julie Mulvany states, 'a small, but significant category of people' that have 'serious mental disorders' experience 'severe restrictions on social, psychological and physical wellbeing'.¹¹² Since these persons have conditions with long-term effects in their lives, their situation can be associated with that of people with physical or sensory impairments.

¹⁰⁸ Anne Plumb, 'Distress or Disability? A Discussion Document' (Greater Manchester Coalition of Disabled People 1994); Beresford, 'What Have Madness and Psychiatric System Survivors Got to Do with Disability and Disability Studies?' (n 105).

¹⁰⁹ Peter Beresford, Mary Nettle and Rebecca Perring, 'Towards a Social Model of Madness and Distress? Exploring What Service Users Say' (Joseph Rowntree Foundation 2010) <<http://www.jrf.org.uk/publications/social-model-madness-distress>> accessed 16 December 2019.

¹¹⁰ *ibid* 29.

¹¹¹ *ibid* 26.

¹¹² Mulvany (n 105) 583.

2.4.2 Relevance of the ‘social model’ to mental impairment

As mentioned above, many people with mental health problems avoid being associated with the disabled people’s movement and emphasise the differences between themselves and ‘disabled people’. Accordingly, they take the view that the ‘social model of disability’ is not relevant to mental health issues.¹¹³ However, as also mentioned above, a link can be found between mental health and disability, since a number of mental health problems have long-term disabling effects. It can then be argued that the ‘social model’ is relevant not only to physical or sensory impairments, but could also be applied to mental health problems, at least those with a certain degree of severity. This application can be useful for people who experience these problems; some changes would be needed however to the ‘social model’ of disability, in order to cover and address difficulties that are specific to those with mental health conditions.

It should first be noted that the initial development of the social approach by the disabled people’s movement concerned only those with physical impairments. This is evident in the UPIAS document, which explicitly refers to ‘physically impaired people’.¹¹⁴ Furthermore, the specific focus on physical impairments was emphasised by UPIAS in its policy statement, which stated that:

[P]eople who are called “mentally handicapped”, or those labelled “mentally ill”, clearly have a great deal in common with us. Full membership of our Union is however based simply on the fact of physical impairment.¹¹⁵

Since the ‘social model’ of disability did not originally address mental health issues, Beresford argues that it ‘should not automatically be assumed to relate to

¹¹³ Plumb, ‘Distress or Disability?’ (n 108); Beresford, ‘What Have Madness and Psychiatric System Survivors Got to Do with Disability and Disability Studies?’ (n 105).

¹¹⁴ UPIAS, *Fundamental Principles of Disability* (n 13) 20.

¹¹⁵ UPIAS, *Policy Statement* (adopted 3 December 1974) 7 <<https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-UPIAS.pdf>> accessed 16 December 2019.

[them] directly'.¹¹⁶ However, despite its explicit exclusion in the UPIAS document, mental impairment was subsequently included in definitions of disability; for example, as mentioned above, DPI included mental impairment in its definitions of impairment and disability.¹¹⁷ Furthermore, when Oliver first began formulating the 'social model' framework in 1990, he clarified that 'mental handicap' is included in the term 'disabled people', because disability is conceptualised as 'social restriction'.¹¹⁸ Thus, people become disabled because of the social restrictions that are imposed on them. Consequently, Oliver stated that 'categories based upon medical or social scientific constructions' must be rejected:

All disabled people experience disability as social restriction, whether those restrictions occur as a consequence of inaccessible built environments, questionable notions of intelligence and social competence, the inability of the general population to use sign language, the lack of reading material in braille or hostile public attitudes to people with non-visible disabilities.¹¹⁹

The 'social model' of disability adopts an inclusive approach, which concerns also people who have non-visible impairments and experience restrictions caused by negative attitudes from the public. It therefore incorporates all types of impairment, including impairment due to a mental health condition.

It can be argued that the experience of negative public attitudes indicates the relevance of the 'social model' to people with mental health problems. Although the issue of negative attitudes is relevant to all disabled people, it is particularly significant for them, because they seem to face more discrimination than other disabled groups.¹²⁰ As found in a recent study, persons with mental health

¹¹⁶ Peter Beresford, 'Madness, Distress, Research and a Social Model' in Colin Barnes and Geof Mercer (eds), *Implementing the Social Model of Disability: Theory and Research* (The Disability Press 2004) 3 <<https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Barnes-implementing-the-social-model-chapter-13.pdf>> accessed 16 December 2019.

¹¹⁷ DPI, *Proceedings of the First World Class Congress* (n 24).

¹¹⁸ Oliver, *The Politics of Disablement* (n 3) xiii.

¹¹⁹ *ibid* xiv.

¹²⁰ On the wider issue of discrimination and social exclusion of people suffering from mental illness, see Liz Sayce, *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (Palgrave Macmillan 2000).

conditions 'are more likely to encounter prejudice from members of the public in their day-to-day life' and people feel more comfortable interacting with persons with sensory or physical impairments.¹²¹ It would therefore appear that it is the removal of that barrier, namely negative attitudes and prejudice, which is of more importance to people with mental health problems. Pilgrim and Tomasini usefully identify the differences in the way non-disabled people respond to people with mental health problems, as compared to those with physical impairments.¹²² As they state, the 'range of emotional reactions' faced by the latter includes 'pity, guilt, embarrassment and occasionally disgust', whereas the former face a different range that 'tends much more towards fear and distrust'.¹²³

The experience of mental health problems, or mental distress, is affected by social circumstances and relations, and social approaches are necessary for an adequate understanding of mental health issues. However, as Beresford notes, no equivalent to the 'social model of disability' has been developed within the mental health service user/survivor movement, even though their activities are not restricted to the mental health service system, but also include wider concerns and focus on action for social and political change.¹²⁴ Since many mental health service user activists are unwilling to be included in the disabled people's movement, Beresford suggested in 2002 that the 'social model of disability' could be adapted to the needs and situation of mental health service users/survivors in order to develop a new 'social model of madness and

¹²¹ Luke Staniland, 'Public Perceptions of Disabled People: Evidence from the British Social Attitudes Survey 2009' (Office for Disability Issues 2011) 41 <<http://odi.dwp.gov.uk/docs/res/ppdp/ppdp.pdf>> accessed 16 December 2019.

¹²² David Pilgrim and Floris Tomasini, 'On Being Unreasonable in Modern Society: Are Mental Health Problems Special?' (2012) 27 *Disability & Society* 631.

¹²³ *ibid* 634.

¹²⁴ Beresford, 'Madness, Distress, Research and a Social Model' (n 116) 10.

distress'.¹²⁵ This model will draw on the ideas of the social approach to disability and will be based on 'support, personal assistance and non-medicalised provision'.¹²⁶ As Beresford explains, an example of the implications of a 'social model of madness and distress' is that:

[I]nstead of conceiving of a mental health service user as someone who has a crisis when their 'illness' becomes acute ... we might be able to think of ensuring they can purchase with state support, the kind of ongoing help they need (whatever form that might take) which might often avoid such difficulties developing.¹²⁷

As Rachael Andersen-Watts notes, there is a 'full spectrum' of factors that are relevant to the experience of people with mental health problems, such as 'the value of identity, stigma and social barriers' as well as the 'lived suffering and danger to oneself or others'.¹²⁸ Provided that all these factors are taken into account, a social approach to mental health issues, either through the application of the 'social model of disability' or through the development of a 'social model of madness and distress', can be particularly useful to those with mental health problems.

It can therefore be said that the 'social model' of disability can be associated not only with physical or sensory impairments, but also with certain mental impairments. Nevertheless, as mentioned in the previous section, disability is multi-dimensional; an account that focuses only on its social aspect and fails to recognise the biological and individual ones would be inadequate. Consequently, although not inapplicable to mental health problems, it would be insufficient to understand disability related to mental impairment under the 'social model'

¹²⁵ Beresford, 'Thinking About "Mental Health": Towards a Social Model' (n 105) 583. Note that the issue of terminology is particularly important in the mental health context, and the term 'madness' is contentious. Beresford states however that many service users now choose to use this term; as he explains, this is because mental health service users/survivors, following the example of other oppressed groups such as black people and gay men or lesbians, have sought to 're-appropriate and reclaim existing language' that is used against them. Consequently, the term 'madness' is now commonly used, 'in a nonpejorative way', among service users: Beresford, 'Psychiatric System Survivors: An Emerging Movement' (n 106) 155.

¹²⁶ Beresford, 'Thinking About "Mental Health": Towards a Social Model' (n 105) 583.

¹²⁷ *ibid.*

¹²⁸ Andersen-Watts (n 105) 156.

conceptual framework. Rather, as already argued, disability is most accurately conceptualised in the ICF. The ICF framework of disability will now be examined specifically in relation to mental health conditions.

2.4.3 Application of the ICF to mental health conditions

In the previous section it was argued that the ICF provides the most adequate understanding for the human functioning and disability. This subsection examines how the ICF framework conceptualises the disability that is associated specifically with mental health conditions.

Importantly, the ICF is based on the general principle of 'parity'; it does not distinguish between 'physical' or 'mental' health conditions.¹²⁹ The experience of disability can therefore be classified for people with physical and mental health conditions alike. This is a new development in the ICF, since the ICIDH, as Cille Kennedy states, 'segregate[d] disabilities associated with mental disorders'.¹³⁰ For example, the 'Classification of Impairments' section of the ICIDH includes nine categories and mental impairments are separately described in the first two, namely 'Intellectual Impairments' and 'Other Psychological Impairments'.¹³¹ Also, as Kennedy notes, the definition of disability is altered when it is associated with mental disorders.¹³² In particular, the ICIDH defines disability as 'any restriction or lack ... of ability to perform an activity ...';¹³³ however, the first category in the 'Classification of Disabilities' section of the ICIDH, namely 'Behaviour Disabilities', states that these disabilities 'refer to an individual's awareness and ability to conduct himself - both in everyday activities and

¹²⁹ WHO, *Towards a Common Language for Functioning, Disability and Health: ICF* (n 74) 14. Note that, in the context of mental health, the two primary classifications are Chapter V (Mental and Behavioural Disorders) of WHO'S ICD-10, and the American Psychiatric Association's (APA) DSM-5: APA, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (5th edn, APA 2013). However, both the ICD-10 and the DSM-5 are *diagnostic* classifications; they are used for the *diagnosis* of mental disorders. In contrast, the ICF classifies *functioning and disability* associated with health (including mental health) conditions; it focuses, not on diagnosis, but on the level of human functioning.

¹³⁰ Cille Kennedy, 'Functioning and Disability Associated with Mental Disorders: The Evolution Since ICIDH' (2003) 25 *Disability and Rehabilitation* 611, 616.

¹³¹ WHO, *ICIDH* (n 2) 46.

¹³² Kennedy, (n 130) 613.

¹³³ WHO, *ICIDH* (n 2) 28.

towards others ...'.¹³⁴ As mentioned above, the ICF departs from this position; disability associated with mental health conditions is not treated differently from disability associated with physical conditions. As Bickenbach succinctly points out, difficulties associated with mental health conditions, because of the stigma that is attached to them, 'obviously' differ from difficulties associated with most physical conditions; nevertheless, 'the appropriate health and social intervention to enhance participation must ... be designed in light of the seriousness and character of the participation restriction, not its etiology'.¹³⁵

Perhaps even more importantly, the ICF is also based on the principle of 'universality';¹³⁶ it applies to all people and is relevant to all health conditions. Thus, it is presumed that 'anyone may experience disability at some point in their lives, whether permanent or temporary, intermittent or continuous'.¹³⁷ Bickenbach also argues that:

Health – good or otherwise – is a universal feature of human beings; likewise functioning, at optimal or less than optimal levels, is part of the human condition. Epidemiologically, less than optimal functioning in one or more domains is universally prevalent among humans across the lifespan.¹³⁸

The universal application of the ICF was not always recognised. The ICIDH, as Bedirhan Üstün and others state, 'was felt to be a classification of people with disabilities, rather than a neutral classification of human functioning useful for describing decrements of functioning'.¹³⁹ The ICF is however applicable to all people and it is not its purpose 'to label persons with disabilities as a separate

¹³⁴ *ibid* 148.

¹³⁵ Jerome Bickenbach, 'Ethics, Disability and the International Classification of Functioning, Disability and Health' (2012) 91 *American Journal of Physical Medicine & Rehabilitation* S163, S166.

¹³⁶ WHO, *Towards a Common Language for Functioning, Disability and Health: ICF* (n 74) 14.

¹³⁷ WHO, *How to Use the ICF: A Practical Manual for Using the International Classification of Functioning, Disability and Health (ICF): Exposure Draft for Comment* (WHO 2013) 12 <<http://www.who.int/classifications/drafticfpracticalmanual.pdf>> accessed 16 December 2019.

¹³⁸ Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 93) 57.

¹³⁹ Bedirhan Üstün and others, 'The International Classification of Functioning, Disability and Health: A New Tool for Understanding Disability and Health' (2003) 25 *Disability and Rehabilitation* 565, 567.

social group’.¹⁴⁰ This is therefore explicitly stated in the Introduction of the new version; the view that the ICF is only about people with disabilities is referred to in particular as a ‘widely held misunderstanding’.¹⁴¹ Going even further, Annex 5 states that, in fact:

ICF is not a classification of people at all. It is a classification of people’s health characteristics within the context of their individual life situations and environmental impacts. It is the interaction of the health characteristics and the contextual factors that produces disability.¹⁴²

The adoption in the ICF of a universalist and etiologically neutral approach to disability seems appropriate, as the experience of disability, namely the difficulties a person experiences in functioning, is not determined by the underlying health condition. Indeed, those with the same health condition do not necessarily have the same experience; each person’s experience is different. Accordingly, some people may experience the same difficulties, while having different health conditions. The assessment of disability should therefore be made, as in the ICF, irrespective of whether the underlying condition is physical or mental.

2.5 Conclusion

This chapter began by assessing the adequacy of the most commonly known social approach to disability, namely the British ‘social model of disability’. This understanding rejects the view that disability is an individual and medical problem caused by impairment, and rather suggests that disability is a form of social oppression, caused by social barriers that exclude people with impairments from participation in society. It was found that, although the British ‘social model’ approach correctly recognises the social and environmental factors that are relevant to the experience of disability, it fails to accurately describe it, most importantly because of the distinction it makes between impairment and

¹⁴⁰ WHO, *How to Use the ICF* (n 137) 12.

¹⁴¹ WHO, *ICF* (n 1) 7.

¹⁴² *ibid* 242.

disability and the denial of any causal link between them. The medical aspect of disability is thus ignored, while the role of social and environmental factors is over-emphasised.

It was then suggested that disability is more adequately described in balanced approaches that recognise the various factors that are relevant to this experience, without reducing it to only some of them. Disability is not simply functional limitation due to impairment; neither is it merely a socially created disadvantage for people with impairments. Balanced approaches understand the complexity of disability and, by integrating medical and social understandings, describe the experience of disability accurately.

The most adequate framework for understanding disability was found to be provided for by the ICF. Adopting a balanced, 'biopsychosocial' approach to disability, it correctly understands it as multi-dimensional and interactive. Disability is conceptualised as the experience of a wide range of problems in functioning, including impairments, limitations in performing activities and restrictions in participating in life situations; this experience is seen as arising out of the complex interaction between a health condition, personal factors and barriers in the physical and social environment.

Both the British 'social model' approach and the ICF conceptualisation of disability were finally examined within the mental health context. It was found that a relationship exists between mental health and disability. People with serious mental health problems experience long-term disabling effects in their lives; their situation can therefore be related to that of people with physical or sensory impairments.

The British 'social model' of disability was found to be relevant to people with mental health problems, although a potential application would require some changes in order for specific difficulties to be covered and addressed. It was however suggested that, since disability is not accurately described in the British 'social model', it would not be desirable to understand the experience of people with mental health problems in accordance with this approach.

It was finally examined how the disability associated specifically with mental health conditions is conceptualised in the ICF, which is regarded as offering the most adequate understanding of disability. It was found that the ICF correctly avoids distinguishing between mental and physical conditions and understands difficulties in functioning, namely the experience of disability, irrespective of the underlying health condition.

Chapter 3 The UN Convention on the Rights of Persons with Disabilities

3.1 Introduction

The previous chapter focused on the concept of disability, and particularly sought to determine how it can be best understood. It was found that the British ‘social model’ approach fails to adequately describe the experience of disability, whereas WHO’s International Classification of Functioning, Disability and Health (ICF)¹ provides the most accurate understanding. This chapter focuses on the UN Convention on the Rights of Persons with Disabilities (CRPD),² and deals with two main issues, namely the definition of disability, and the use of disability as a factor in deprivation of liberty. It has in particular a dual purpose; first, it aims to determine whether the CRPD adopts the British ‘social model’ approach to disability or not, and second, it seeks to identify the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability.

To this end, it begins in section two with an overview of the CRPD, focusing particularly on what kind of convention it is and why it was necessary, as well as the obligation it imposes on States Parties regarding the abolition of laws that discriminate against persons with disabilities.

Section three then provides an examination of how the CRPD defines disability, and also how this definition was discussed during the CRPD negotiations. It is argued that the CRPD does not adopt the British ‘social model’ approach to disability, but rather defines disability in a way similar to the ICF understanding.

¹ WHO, *ICF*, endorsed in May 2001, Res. WHA 54.21 of the 54th World Health Assembly (WHO 2001).

² UN Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly on 13 December 2006, GA Res. 61/106, UN Doc. A/RES/61/106, 24 January 2007 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/61/106&Lang=E> accessed 16 December 2019.

Section four considers the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability. It examines in particular the relevant discussion that took place during the CRPD negotiations, and argues that the CRPD prohibits deprivations of liberty that are based on the existence of disability; not only in cases where disability is the only factor, but also when deprivation of liberty is based on other factors as well.

Section four also examines how the Committee on the Rights of Persons with Disabilities (CRPD Committee) interprets Article 14 of the CRPD, and its view on deprivation of liberty on the basis of disability.

Finally, it considers whether deprivation of liberty based on mental disability can be justified. It is argued that it cannot.

3.2 Overview of the CRPD

The CRPD was adopted by the UN General Assembly on 13 December 2006, opened for signature on 30 March 2007 and entered into force on 3 May 2008. It is one of the nine core international human rights treaties³ and, as of December 2019, 163 States have signed it and 181 have ratified it.⁴

The CRPD is the first legally binding instrument on the issue of disability⁵ and its purpose 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’.⁶

³ See <<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx>> accessed 16 December 2019.

⁴ See the UN Enable website: <<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>> accessed 16 December 2019.

⁵ Previous international ‘soft law’ instruments on the issue of disability include the *Declaration on the Rights of Mentally Retarded Persons 1971*, the *Declaration on the Rights of Disabled Persons 1975*, the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health 1991* and the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1993*.

⁶ CRPD, Art 1.

The CRPD applies to all persons with disabilities, including those with mental,⁷ or psychosocial,⁸ disabilities.⁹

The negotiations of the CRPD were conducted by the Ad Hoc Committee (AHC). In particular, following a proposal by the Government of Mexico to develop a convention for the human rights protection of persons with disabilities,¹⁰ the General Assembly adopted in December 2001 Resolution 56/168,¹¹ which established the AHC. The CRPD is the fastest negotiated human rights treaty; the process of negotiation and drafting began in August 2002 and ended in December 2006. It also had the highest level of participation by representatives

⁷ The term used in the CRPD, taken to refer to the experience of mental health difficulties.

⁸ The term preferred by some, especially - but not only - service users, over 'mental disabilities': see for example World Network of Users and Survivors of Psychiatry (WNUSP), 'Psychosocial Disability' <<http://www.wnusp.net/index.php/crpd.html>> accessed 16 December 2019; WNUSP, 'Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities' (2008)9<http://www.wnusp.net/documents/WNUSP_CRPD_Manual.pdf> accessed 16 December 2019.

⁹ CRPD, Art 1.

¹⁰ Similar proposals had been made, unsuccessfully, by Italy in 1987 and Sweden in 1989. For a brief and helpful overview of the history of the CRPD, as well as the issue of disability in the UN prior to the adoption of the CRPD, see Department of Economic and Social Affairs, Office of the United Nations High Commissioner for Human Rights and Inter-Parliamentary Union, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (UN 2007) 9-12 <<http://www.ipu.org/PDF/publications/disabilities-e.pdf>> accessed 16 December 2019; Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 HRL Rev 1, 12-19; Gerard Quinn, 'A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities' in Gerard Quinn and Lisa Waddington (eds), *European Yearbook of Disability Law: Volume 1* (Intersentia 2009) 93-99; Michael Ashley Stein and Janet Lord, 'Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities' in Oddný Mjöll Arnardóttir and Gerard Quinn (eds), *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijhoff Publishers 2009) 18-23. For a more detailed examination see Gerard Quinn and Theresia Degener, 'The Application of Moral Authority: The Shift to the Human Rights Perspective on Disability Through United Nations "Soft" Law' in Gerard Quinn and Theresia Degener and others, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (UN 2002) 29-46 <<http://www.ohchr.org/Documents/Publications/HRDisabilityen.pdf>> accessed 16 December 2019; Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2006-2007) 34 Syracuse J Int'l L & Com 563, 574-583, 586-590. On international instruments dealing specifically with the human rights of persons with mental disabilities, see Annegret Kämpf, 'The Disabilities Convention and its Consequences for Mental Health Laws in Australia' in Bernadette McSherry (ed), *International Trends in Mental Health Laws* (The Federation Press 2008) 16-17.

¹¹ Resolution on a Comprehensive and Integral International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities, GA Res. 56/168, UN Doc. A/RES/56/168, 26 February 2002 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/56/168> accessed 16 December 2019.

of civil society of any human rights convention. Importantly, the AHC decided in its First Session to grant permission to non-governmental organisations (NGOs), including disabled people's organisations (DPOs), to participate and be actively involved in the negotiation process.¹² It should be noted that among those was the World Network of Users and Survivors of Psychiatry (WNUSP), an international organisation run and governed by users and survivors of psychiatry, which promotes and advocates for the human rights of persons with mental - or psychosocial, to use their preferred term - disabilities.

The implementation of the CRPD is monitored by the Committee on the Rights of Persons with Disabilities (CRPD Committee), which was established pursuant to Article 34 of the CRPD. The CRPD Committee provides authoritative - albeit not binding on States Parties - interpretation of the CRPD, and also reviews reports submitted by the States Parties on measures taken for the implementation of the CRPD and makes recommendations in the form of concluding observations.

3.2.1 CRPD - Why was it necessary

One important question regarding the CRPD is why it was necessary to have a specific convention for the protection of the rights of persons with disabilities. Human rights treaties have universal scope, which means that they apply to all human beings. In theory, therefore, there was no need for a specific convention; people with disabilities were included in and protected by already existing human rights instruments. In practice, however, that was not realised. As stated in the General Assembly's Resolution 56/168, the full and effective participation of people with disabilities in economic, social, cultural and political life had not been sufficiently promoted, and people with disabilities around the world continued to face a 'disadvantaged and vulnerable situation'.¹³ The inadequacies of previous human rights conventions in protecting persons with disabilities were

¹² Report of the AHC on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its First Session, UN Doc. A/57/357, 27 August 2002, para 10 <<https://documents-dds-ny.un.org/doc/UNDOC/GEN/N02/550/22/PDF/N0255022.pdf?OpenElement>> accessed 16 December 2019.

¹³ Resolution on a Comprehensive and Integral International Convention (n 11) 2.

noted by the UN High Commissioner for Human Rights (UNHCHR), in a statement she made during the Seventh Session of the AHC:

The existing human rights system was meant to promote and protect the rights of persons with disabilities. There is also no doubt that the existing standards and mechanisms have in fact, failed to provide adequate protection in the specific cases of person with disabilities.¹⁴

During the final Session of the AHC the Chairman, Ambassador Don MacKay, noted too that 'equal human rights for all' had not been part of persons' with disabilities reality. He stated that 'as a group they have not enjoyed those rights', and that the CRPD would bring a 'major shift' in the way this group of people was treated.¹⁵

The importance of the CRPD was emphasised by the UN Secretary-General, who characterised the day of its adoption by the General Assembly as 'the dawn of a new era' which would bring an end to the unequal treatment of people with disabilities. In his own words:

Throughout the ages, the treatment of people with disabilities has brought out some of the worst aspects of human nature. Too often, those living with disabilities have been seen as objects of embarrassment, and at best, of condescending pity and charity. Societies have even gone out of their way to ensure that persons with disabilities are neither seen nor heard. On paper, they have enjoyed the same rights as others; in real life, they have often been relegated to the margins and denied the opportunities that others take for granted.¹⁶

The UNHCHR also stated, on the day the CRPD was adopted by the AHC, that the reason why the CRPD is significant is because it brings about a change in

¹⁴ Statement by Louise Arbour, UNHCHR, General Assembly AHC, 7th session, New York, 27 January 2006 <<https://static.un.org/esa/socdev/enable/rights/ahc7stathchr.htm>> accessed 16 December 2019.

¹⁵ Press Conference by Chairman of AHC on Convention on Disabled Persons' Rights, 15 August 2006 <http://www.un.org/press/en/2006/060815_Disabilities.doc.htm> accessed 16 December 2019.

¹⁶ Secretary-General Hails Adoption of Landmark Convention on Rights of People with Disabilities, 13 December 2006 <<http://www.un.org/press/en//2006/sgsm10797.doc.htm>> accessed 16 December 2019.

attitudes; the ‘paradigm shift’ of the CRPD means that persons with disabilities will no longer be seen as objects of charity, medical treatment and social protection, but subjects of rights and active members of society.¹⁷ It is worth noting that the shift from a ‘charity’ towards a ‘human rights’ approach was highlighted in the well-known study of Gerard Quinn and Theresia Degener on the United Nations protection of the human rights of people with disabilities. The human rights perspective on disability, as stated in the report, views people with disabilities as ‘subjects’ and not as ‘objects’; not as ‘problems’, but as ‘holders of rights’.¹⁸ It can be argued, however, that the adoption alone of the CRPD cannot bring about a ‘paradigm shift’ in the treatment of people with disabilities. Although the CRPD offers stronger legal protection to their rights, it cannot possibly guarantee that these rights will be realised. It is an international convention; international law needs to be translated into domestic law, and then the law needs to be translated into practice, before its full impact can be assessed. What is more, even with a change in law and policy, a ‘change in attitudes’ in relation to disability would still not necessarily be guaranteed. The CRPD promises a new reality for people with disabilities. However, turning rhetoric into reality is not an easy task, and the ‘paradigm shift’ in the lives of people with disabilities depends on how, if at all, the CRPD will be implemented by States Parties. It is therefore effective implementation which determines whether the purpose of the CRPD will be achieved or not.

3.2.2 CRPD - What kind of convention is it

Another important question regarding the CRPD is what kind of convention it is. First it should be noted that the CRPD is a ‘comprehensive and integral international convention’; that is stated in the Preamble,¹⁹ and was also stated in

¹⁷ Statement by Louise Arbour, UNHCHR to the Resumed 8th Session of the AHC on the Convention on the Rights of Persons with Disabilities, New York, 5 December 2006 <<https://static.un.org/esa/socdev/enable/rights/ahc8hrcmsg.htm>> accessed 16 December 2019.

¹⁸ Gerard Quinn and Theresia Degener and others, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (UN 2002) 1 <<http://www.ohchr.org/Documents/Publications/HRDisabilityen.pdf>> accessed 16 December 2019.

¹⁹ CRPD, Preamble, para (y).

the mandate given by the General Assembly to the AHC.²⁰ In particular, the mandate was to

consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities, based on the holistic approach in the work done in the fields of social development, human rights and non-discrimination and taking into account the recommendations of the Commission on Human Rights and the Commission for Social Development.²¹

As Kayess and French note, the word ‘comprehensive’ means that the CRPD is based on the ‘holistic approach’ which incorporates ‘social development, human rights and non-discrimination elements’, while the word ‘integral’ means that the CRPD is a ‘core constituent of international humanrights law, rather than a subsidiary of existing law’.²²

Moreover, it is stated in the Preamble that the CRPD reaffirms the ‘universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms’.²³ It is therefore, as characterised by Ambassador MacKay, a ‘hybrid’ convention, containing civil and political rights, as well as economic, social and cultural rights.²⁴

It should be noted that the options regarding the nature, elements and structure of the CRPD were discussed by a panel during the Second Session of the AHC, which explored in particular three different models of an international convention.²⁵ The first option was to follow the ‘holistic rights model’ and draft a comprehensive and holistic in nature convention, such as the Convention on the

²⁰ Resolution on a Comprehensive and Integral International Convention (n 11) 2.

²¹ *ibid.*

²² Kayess and French (n 10) 20.

²³ CRPD, PmbI, para (c).

²⁴ Don MacKay, ‘The United Nations Convention on the Rights of Persons with Disabilities’ (2006-2007) 34 *Syracuse J Int'l L & Com* 323, 330; Kämpf (n 10) 25. See also Amita Dhanda, ‘Constructing a New Human Rights Lexicon: Convention on the Rights of Persons with Disabilities’ (2008) 8 *International Journal on Human Rights* 43, 48-50.

²⁵ Report of the AHC on its Second Session, UN Doc. A/58/118 and Corr. 1, 3 July 2003, Annex II <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/58/118> accessed 16 December 2019.

Rights of the Child. The second option was to draft a convention similar to the Convention on the Elimination of All Forms of Discrimination against Women and the International Convention on the Elimination of All Forms of Racial Discrimination, which are based on the 'non-discrimination model'. Such a convention would simply guarantee the equal exercise for persons with disabilities of their human rights, but without taking into account their specific needs. The third option was to address the specific situation of persons with disabilities, by following a 'hybrid model' that would combine existing human rights and the principles of equality and non-discrimination.

The CRPD was eventually based on the third model. It is therefore, as aptly characterised by Gerard Quinn, a 'non-discrimination treaty focused on substantive rights'.²⁶ As he explains, the CRPD is neither a substantive convention 'containing stand-alone substantive rights', nor a simple non-discrimination convention 'containing a bald proscription against unfair treatment'; instead, it 'blends together a large continuum of substantive rights ... then animates them from the perspective of the equal effective enjoyment of these rights using the non-discrimination tool'.²⁷ The rationale behind that choice is that the CRPD 'does not create any new rights'.²⁸ People with disabilities have the same rights as those without disabilities; what the CRPD aims to achieve, is to make these rights effective for them. As Ambassador MacKay stated during the 2006 Press Conference, 'though the Convention did not create any new rights or entitlements, it expressed the existing rights in a manner that addressed the needs and situation of persons with disabilities'.²⁹ Quinn and Degener had also noted in their *Human Rights and Disability* report that:

²⁶ Gerard Quinn, 'Bringing the UN Convention on Rights for Persons with Disabilities to Life in Ireland' (2009) 37 *British Journal of Learning Disabilities* 245, 247.

²⁷ *ibid.* See also Gerard Quinn, 'The United Nations Convention on the Rights of Persons with Disabilities: Toward a New International Politics of Disability' (2009) 15 *Texas Journal on Civil Liberties & Civil Rights* 33, 42.

²⁸ UN Enable website, Frequently Asked Questions regarding the CRPD <<https://static.un.org/esa/socdev/enable/convinfaq.htm#gg>> accessed 16 December 2019.

²⁹ Press Conference by Chairman of AHC (n 15).

The disability rights debate is not so much about the enjoyment of specific rights as it is about ensuring the equal effective enjoyment of all human rights, without discrimination, by people with disabilities. The non-discrimination principle helps make human rights in general relevant in the specific context of disability, just as it does in the contexts of age, sex and children.³⁰

It should finally be mentioned that the CRPD is a human rights convention, but it also has social development aspects.³¹ In fact, as Quinn notes, the United Nations initially viewed disability as a social development issue:

The disability issue figured in the general UN system through the UN Commission for Social Development, as distinct from the Commission on Human Rights. That in itself, demonstrated that the issue was framed more as a social policy issue than a human rights issue.³²

The General Assembly specifically stated in Resolution 56/168 that the convention should address both social development and human rights. It was noted in particular that it should be 'based on the holistic approach in the work done in the fields of social development, human rights and non-discrimination'.³³ The Secretary-General has also stated that 'as a human rights instrument with an explicit social development dimension, the [CRPD] is both a human rights treaty and a development tool'.³⁴ As the CRPD views disability from both a human

³⁰ Quinn and Degener and others (n 18) 1.

³¹ See Stefan Trömel, 'A Personal Perspective on the Drafting History of the United Nations Convention on the Rights of Persons with Disabilities' in Gerard Quinn and Lisa Waddington (eds), *European Yearbook of Disability Law: Volume 1* (Intersentia 2009) 119. See also Kayess and French (n 10) 17-18. Economic growth and sustainable development is one of the key issues and priorities of the UN. The main UN office working on development is the UN Department of Economic and Social Affairs (DESA). Part of the DESA is the Division for Inclusive Social Development (DISD), which is concerned with social development issues, such as ageing, disability, employment and poverty. See <<https://www.un.org/development/desa/dspd/what-we-do.html>> accessed 16 December 2019.

³² Quinn, 'A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities' (n 10) 93.

³³ Resolution on a Comprehensive and Integral International Convention (n 11) 2.

³⁴ Report of the Secretary-General, Implementation of the outcome of the World Summit for Social Development and of the twenty-fourth special session of the General Assembly, UN Doc. A/63/133, 16 July 2008, para 61 <<https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/425/68/PDF/N0842568.pdf?OpenElement>> accessed 16 December 2019.

rights and social development perspective, it can be described as a human rights *and* social development convention.

The following subsection will examine the obligation undertaken by States Parties under the CRPD to abolish discriminatory laws.

3.2.3 The obligation under the CRPD to abolish discriminatory laws

The general obligations of States Parties under the CRPD are found in Article 4. Before examining them, it is worth noting that the obligation to implement a treaty is imposed only on those States which have chosen to ratify, and therefore be bound by, that treaty. The UK signed the CRPD on 30 March 2007 and ratified it on 8 June 2008.³⁵ It should be noted however that the CRPD has not been incorporated into domestic law. It is therefore binding on the UK as a matter of international law, but it is not part of the domestic legal system or directly applicable in courts, although courts may take into account its provisions when interpreting domestic law.

Nevertheless, as an effect of ratification, the UK undertakes that its laws and practices will comply with the requirements of the CRPD. The main obligation of States Parties, as stated in Article 4, is to ‘ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability’.³⁶ The definition of ‘discrimination on the basis of disability’ is found in Article 2:

Discrimination on the basis of disability means 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,

³⁵ Department for Work and Pensions, *Explanatory Memorandum on the United Nations Convention on the Rights of Persons with Disabilities* (Cm 7564, 2009). See also Joint Committee on Human Rights, *The UN Convention on the Rights of Persons with Disabilities* (2008-09, HL 9, HC 93); Joint Committee on Human Rights, *UN Convention on the Rights of Persons with Disabilities: Government Response to the Committee’s First Report of Session 2008–09* (2008-09, HL 46, HC 315).

³⁶ CRPD, Art 4(1). Note that Art 5(2) of the CRPD on Equality and Non-Discrimination requires States Parties to ‘prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds’.

cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

In order to meet their obligation under Article 4, States Parties must take a number of measures. Importantly, they are required to adopt appropriate legislation for the implementation of the CRPD rights,³⁷ and also to modify or even abolish existing discriminatory laws.³⁸ Thus, the CRPD requires the abolition of any law that discriminates against persons with disabilities.

This requirement is particularly important in the mental health law context, as it means that States Parties must review any laws that may distinguish, exclude or restrict on the basis of mental disability, and therefore discriminate against persons with mental disabilities. If any laws, or any of their provisions, are found not to comply with the CRPD, States Parties are under an obligation to abolish them, or repeal the discriminatory provisions. Mental health laws that could possibly be discriminatory are those that provide power to deprive a person of liberty on the basis of mental disability. In order to determine whether such laws comply with the CRPD or not, it is first important to examine the protection offered by the CRPD to the right to liberty of persons with disabilities, and particularly whether disability can justify deprivation of liberty, either alone or in combination with other factors. This will be examined later in this chapter; in particular, section four will consider the meaning that the AHC sought to give to the prohibition under the CRPD of deprivation of liberty on the basis of disability.

Section three now examines how the CRPD defines disability, and also how this definition was discussed during the CRPD negotiations.

3.3 The Definition of Disability under the CRPD

As explained in the previous chapter, the British ‘social model’ approach understands disability as a social situation, and particularly a form of social oppression imposed on people with impairments, which is caused by social and environmental barriers that exclude them from participating in society and which

³⁷ CRPD, Art 4(1)(a).

³⁸ CRPD, Art 4(1)(b).

is entirely distinguished from their individual impairment. On the other hand, the ICF describes disability as the multi-dimensional and interactive experience of a wide range of difficulties in functioning; in particular, these difficulties include impairments, limitations in performing activities and restrictions in participating in life situations, and arise out of the complex interaction between health conditions, personal factors and barriers in the physical and social environment.

Having identified how disability is understood under the 'social model' approach and in the ICF, this section seeks to determine which understanding aligns more closely to the definition of disability in the text of the CRPD.

3.3.1 The definition of disability in the final text of the CRPD

It will now be examined how disability is conceived in the text of the CRPD. The relevant definition is found in the Preamble to the CRPD, which states that:

[D]isability is an evolving concept and ... results from the *interaction* between persons with impairments and attitudinal and environmental *barriers* that *hinders* their full and effective participation in society on an equal basis with others.³⁹

It would also be useful at this point to note that the ICF defines disability as follows:

Disability ... denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).⁴⁰

In considering the definition of disability in the CRPD, it is apparent that an inclusive and open-ended approach to disability has been preferred. As regards the question of whether the CRPD approach is closer to the British 'social model' or the ICF, two key observations can be made; one supports the argument that the CRPD adopts the ICF understanding of disability, and the other the argument that the CRPD does not adopt the British 'social model' approach.

³⁹ CRPD, PmbI, para (e) (emphasis added).

⁴⁰ WHO, *ICF* (n 1) 213.

The first observation concerns the use of the word ‘interaction’. In particular, disability is defined as resulting from the *interaction* between persons with impairments and attitudinal and environmental barriers. This definition resembles the ICF conceptualisation of disability as the interaction between individuals with health conditions and their personal and environmental factors. Disability in both the CRPD and the ICF is understood dynamically, as an interactive process between persons and their environment; it is also noteworthy that the CRPD uses the exact same word that is used in the ICF, namely ‘interaction’. In contrast, the British ‘social model’ understands disability statically, as the result of social barriers that exclude people with impairments from participating in society. It is not difficult to see that the CRPD defines disability in a way that looks closer to the ICF than the British ‘social model’ approach.

The second observation concerns the use of the word ‘hinders’. In particular, the definition of disability contains a relative clause, which reads ‘that *hinders* their full and effective participation in society on an equal basis with others’. In order to determine whether the CRPD adopts the British ‘social model’ approach or not, it is important to identify whether that clause relates to the noun ‘interaction’, or the noun ‘barriers’; thus, whether it is the attitudinal and environmental barriers that hinder participation in society, or the interaction between persons with impairments and these barriers. Since the CRPD uses the singular form of the verb ‘hinder’, there can be no doubt that it relates to the also singular word ‘interaction’, instead of the plural ‘barriers’. Therefore, the view taken in the CRPD is that the participation of persons with impairments in society is hindered by the interaction between these persons and attitudinal and environmental barriers. Importantly, it is not the barriers that hinder participation in society, but rather the interaction between persons and barriers. This is not, however, the approach adopted by the British ‘social model’. In particular, the British ‘social model’ suggests that social participation is only hindered by the presence of disabling barriers; thus, persons with impairments have nothing to do with the social exclusion they face, and no connection or

interaction exists between them and the barriers that prevent them from participating in society. Had the CRPD wished to adopt this approach, it would have used the plural form of the verb 'hinder', in order to emphasise that social exclusion is caused only by disabling barriers.⁴¹

It is also important to note that it would be wrong to assume that the use of the word 'barriers' in the CRPD definition points towards the adoption of the British approach; although this particular term has been associated with the 'social model of disability',⁴² it is *also* used in the ICF. In particular, the ICF recognises the relevance of environmental factors to human functioning or disability, and uses the term 'barriers' to denote the negative effects of the environment - as opposed to 'facilitators', which are positive effects of the environment.⁴³

Based on the above considerations, it can be argued that the CRPD does not adopt the British 'social model' approach to disability, but rather defines disability in a way similar to the ICF understanding. This argument has also been made by Jerome Bickenbach, who stated in 2009 that 'the link between the ICF conception of disability and CRPD is obvious upon inspection',⁴⁴ and again in 2012 that 'the ICF conceptualization does surface in the preamble of the CRPD'.⁴⁵ However, the connection between the CRPD and ICF has often been overlooked in the CRPD literature, and in fact, many authors seem to hold the mistaken view that the CRPD adopts the so-called 'social model of disability', as will be seen below.

⁴¹ To clarify, the sentence in that case would read: 'Disability ... results from the interaction between persons with impairments and attitudinal and environmental barriers that *hinder* their full and effective participation in society on an equal basis with others.' Thus, the verb 'hinder' would relate to the noun 'barriers' and it would be clear that it is the barriers that hinder participation in society, not the interaction between these barriers and persons with impairments.

⁴² See for example the Disabled People's International (DPI) definition of disability: DPI, *Proceedings of the First World Class Congress* (DPI 1982); John Swain and others (eds), *Disabling Barriers – Enabling Environments* (SAGE 1993). See also Victor Finkelstein, *Attitudes and Disabled People: Issues for Discussion* (World Rehabilitation Fund 1980) 22.

⁴³ WHO, *ICF* (n 1) 22, 171. For the full definition of 'barriers' see WHO, *ICF* (n 1) 214.

⁴⁴ Jerome Bickenbach, 'Disability, Culture and the UN Convention' (2009) 31 *Disability and Rehabilitation* 1111, 1112.

⁴⁵ Jerome Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' in Nick Watson, Alan Roulestone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge 2012) 60.

It should be noted at this point that there can be some confusion regarding the meaning of the term 'social model of disability'. As mentioned in the previous chapter, the 'social model of disability' is a unique, strong social approach to disability, developed in Britain in the 1970s and 1980s; in fact, the term was invented by Oliver in 1981. It denies any causal link between impairment and disability and suggests in particular that disability is entirely caused by social barriers that prevent people with impairments from participating in society. The British 'social model' approach is very well known and most authors are familiar with it. It would therefore be sensible to assume that they use the term 'social model of disability' correctly, as a reference to the British approach.

However, this term is sometimes used in the wrong way. The British 'social model' is only one of the various social approaches to disability that have been developed; others include the Nordic 'relational' understanding and the North America 'minority group' approach. These are weaker approaches, and they do not share the special characteristics of the British 'social model'. They simply emphasise the role of society and the environment in creating disability, without necessarily entirely rejecting its medical or individual aspects. However, because of the popularity of the British approach, the term 'social model of disability' might be used, incorrectly, as a general reference to approaches that view disability from a social perspective, without intention to specifically refer to the British approach. Thus, some authors might use the term 'social model', when they would actually mean 'social approach'.

As noted above, there seems to be a mistaken view that the CRPD adopts the 'social model of disability'. In the examples mentioned below, the authors use the term 'social model'; it is not clear, however, what they mean by using that term. They could refer to the British approach, or they could simply imply that the CRPD generally adopts a social approach to disability. As previously stated, the former possibility is more probable and it will therefore be assumed that by using the term 'social model', they refer to the British approach. Nevertheless, it can be argued that in any case this view is wrong. If they refer specifically to the British 'social model', they are mistaken because, as already found, the CRPD

does not adopt this approach. If they generally refer to a social approach, they are mistaken too. The statement that the CRPD adopts a social approach to disability, albeit not entirely wrong, is inaccurate; the CRPD, as found above, adopts the ICF 'biopsychosocial' approach to disability. It would therefore be inadequate to simply state that it adopts a social approach, because it actually adopts an approach which is based on a 'synthesis' of the medical and social 'models' of disability.⁴⁶

Before mentioning a few examples of authors who misinterpret the CRPD definition of disability, it is worth noting an author who describes it correctly. Eilionóir Flynn states that the definition of disability adopted in the CRPD is 'based on the understanding that disability is not solely the result of a medical impairment, but also stems from societal barriers to participation'.⁴⁷ Flynn refers to 'societal barriers', but carefully avoids mentioning the 'social model'. Furthermore, by using the word 'solely', she recognises that the CRPD understanding is that disability is caused by both impairment and barriers. Therefore, despite the lack of reference to the ICF, her statement is entirely accurate and consistent with the language of paragraph (e) of the Preamble.

Usually, however, the definition of disability in the CRPD is misunderstood. Rosemary Kayess and Phillip French state in *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, which is one of the leading texts on the CRPD, that:

[P]aragraph (e) of the Preamble makes it clear that disability is to be understood according to the precepts of the social model. 'Disability' is conceptualised as the product of the interaction of persons with impairments with environmental barriers that hinder their full and effective participation in society on an equal basis with others.⁴⁸

Stefan Trömel also notes that 'the paragraph in the preamble provides a social model definition of disability, based on the interaction between impairment and

⁴⁶ WHO, *ICF* (n 1) 10.

⁴⁷ Eilionóir Flynn, *From Rhetoric to Action: Implementing the UN Convention on the Rights of Persons with Disabilities* (CUP 2011) 18.

⁴⁸ Kayess and French (n 10) 24.

barriers’.⁴⁹ Charles O’ Mahony states that ‘there is no doubt that the CRPD has adopted the approach of the social model of disability’.⁵⁰ Shivaun Quinlivan and Peter Bartlett refer to the definition of persons with disabilities, found in Article 1 of the CRPD, which reads:

Persons with disabilities include 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.⁵¹

It is worth noting that in this definition, the verb ‘hinder’ clearly relates to the noun ‘impairments’. Therefore, like paragraph (e) of the Preamble to the CRPD, Article 1 too recognises that impairments - in interaction with various barriers - may hinder persons’ with disabilities participation in society. This is the view adopted in the ICF rather than the British ‘social model’. However, Quinlivan states that ‘this definition clearly endorses the social model of disability’ and goes on to say that ‘the focus of this definition is on the barriers and obstacles that hinder or prevent full, equal and effective participation in society ...’.⁵² Bartlett similarly states that ‘the reference to barriers to participation emphasises the social model of disability adopted by the CRPD’.⁵³

Kayess and French, Quinlivan, O’ Mahony, Trömel and Bartlett all strongly suggest that the CRPD adopts the ‘social model’ of disability. The first two go so far as to argue that this is *clear*,⁵⁴ and O’ Mahony states that *there is no doubt* about it.⁵⁵ As already explained, however, it is far from clear and highly doubtful

⁴⁹ Trömel (n 31) 121.

⁵⁰ Charles O’Mahony, ‘Legal Capacity and Detention: Implications of the UN Disability Convention for the Inspection Standards of Human Rights Monitoring Bodies’ (2012) 16 IJHR 883, 885.

⁵¹ CRPD, Art 1.

⁵² Shivaun Quinlivan, ‘The United Nations Convention on the Rights of Persons with Disabilities: An Introduction’ (2012) 13 ERA Forum 71, 76.

⁵³ Peter Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75 MLR 752, 758.

⁵⁴ Kayess and French (n 10) 24; Quinlivan (n 52) 76. Note that Kayess and French mention that the ‘social model’ influenced the development of the CRPD primarily as a ‘disability rights manifesto’, rather than a ‘theory of disability’. As they explain, the former tends to see disability from a ‘radical social constructionist view ... in which impairment has no underlying reality’: Kayess and French (n 10) 7.

⁵⁵ O’Mahony (n 50) 885.

that disability in the CRPD is understood in accordance with the British 'social model' approach. It is interesting to note that Kayess and French and Quinlivan incorrectly state that, according to the CRPD understanding of disability, participation in society is hindered by the various barriers; however, as mentioned above, the CRPD understanding is that social participation is hindered by the interaction between persons with impairments and disabling barriers. It can therefore be argued that a close examination of the actual wording of the CRPD shows that it resembles the ICF conceptualisation of disability.

The reason why the ICF has not been explicitly endorsed in the CRPD is because of the significant disagreement and the concerns that were expressed during the CRPD negotiations. In particular, the adoption of the ICF understanding was opposed by those in favour of a more radical approach to disability, such as the British 'social model'. This has been acknowledged by Kayess and French, who note that 'any attempt to use the ICF to interpret the CRPD will inevitably be fraught with controversy',⁵⁶ and also by Bickenbach, both in 2009 and 2012. In particular, Bickenbach mentioned in 2009 that 'the political environment surrounding the drafting of CRPD made the explicit adoption of the ICF conception politically inexpedient',⁵⁷ and in 2012 that the ICF is 'never referenced and only paraphrased'⁵⁸ in the CRPD. It is therefore useful to examine now the discussion that took place during the CRPD negotiations regarding the definition of disability.

3.3.2 The discussion on the definition of disability during the CRPD negotiations

The negotiations of the CRPD were conducted by the AHC, which was established pursuant to General Assembly Resolution 56/168.⁵⁹ The AHC met in eight sessions; the First Session was held from 29 July to 9 August 2002 and the Eighth Session from 14 to 25 August 2006.

⁵⁶ Kayess and French (n 10) 24.

⁵⁷ Bickenbach, 'Disability, Culture and the UN Convention' (n 44) 1112.

⁵⁸ Bickenbach, 'The International Classification of Functioning, Disability and Health and its Relationship to Disability Studies' (n 45) 60.

⁵⁹ Resolution on a Comprehensive and Integral International Convention (n 11).

During its Second Session, the AHC decided to establish a 'Working Group' (WG),⁶⁰ with the task to draft a text of a convention on the rights of persons with disabilities. This decision was endorsed by the General Assembly in its Resolution 58/246.⁶¹ The WG met from 5 to 16 January 2004 and based on that draft text, the Member States and observers negotiated in the following sessions the final text of the CRPD. Also, following the Sixth Session and pursuant to General Assembly Resolution 60/232,⁶² the Chairman of the AHC prepared a draft text that was considered during the Seventh Session.

The fact that the definition of disability was the subject of much debate during the negotiations is well documented.⁶³ During the Second Session, a panel was organised in order to discuss approaches to definitions of disability. According to the Chairman's summary, the purpose of the panel was to explore various concepts of disability in order to 'aid in the systematic determination of the convention's scope'.⁶⁴ In considering the need for a definition of disability, the panel took the view that it was essential to discuss 'contextual variables' and also distinguished between 'experiences of impairment and experiences of disability'.⁶⁵

The draft text prepared by the WG intended to define disability in Article 3 (Definitions), alongside the other definitions; the term was nevertheless left undefined. Instead it was stated in the footnote that:

Many members of the Working Group emphasized that a convention should protect the rights of all persons with disabilities (i.e. all

⁶⁰ Report of the AHC on its Second Session (n 25) para 15.

⁶¹ Resolution on the AHC, GA Res. 58/246, UN Doc. A/RES/58/246, 11 March 2004, para 3 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/58/246> accessed 16 December 2019.

⁶² Resolution on the AHC, GA Res. 60/232, UN Doc. A/RES/60/232, 31 January 2006, para 4 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/60/232> accessed 16 December 2019.

⁶³ Arlene Kanter, 'The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities' (2006-2007) 34 *Syracuse J Int'l L & Com* 287, 291; Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (n 10) 593; Kayess and French (n 10) 23; Quinn, 'A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities' (10) 101.

⁶⁴ Report of the AHC on its Second Session (n 25) Annex II.

⁶⁵ *ibid.*

different types of disabilities) and suggested that the term ‘disability’ should be defined broadly. Some members were of the view that no definition of ‘disability’ should be included in the Convention, given the complexity of disability and the risk of limiting the ambit of the Convention. Other delegations pointed to existing definitions used in the international context, including the World Health Organization’s International Classification of Functioning, Disability and Health (ICF). There was general agreement that if a definition was included, it should be one that reflected the social model of disability, rather than the medical model.⁶⁶

During the Third Session, the AHC undertook a reading of the WG draft text; it was decided however not to consider Article 3, but to defer discussion to the next Session. In particular, the Chair noted that it is ‘imperative’ to defer this Article, because ‘the following articles will tackle related matters, and it is not appropriate here and now to hammer this out until we deal with other issues’.⁶⁷

The definition of disability in draft Article 3 was considered during the Fourth Session of the AHC. Importantly, there was significant disagreement not only as regards the proper definition of disability, but also the question of whether disability should be defined at all in the convention. It would be useful to note now the main points that were made. The EU⁶⁸ argued against a definition of ‘disability’ or ‘persons with disabilities’, on the basis that ‘they risk becoming

⁶⁶Report of the WG to the AHC, UN Doc. A/AC.265/2004/WG.1, 27 January 2004, fn12 <<http://www.un.org/esa/socdev/enable/documents/ahcwgreport.pdf>> accessed 16 December 2019.

⁶⁷Daily Summary of Discussion (DSD) at the Third Session, 24 May 2004, 10 <<https://static.un.org/esa/socdev/enable/rights/ahc3sum24may.htm>> accessed 16 December 2019.

⁶⁸Note that the European Union (EU) participated - alongside the EU Member States - in the drafting of the CRPD, and the positions of the EU Member States were coordinated during the negotiations. The EU ratified the CRPD on 23 December 2010 (articles 43 and 44 of the CRPD allow for ‘regional integration organisations’ to become parties to the Convention) - this is the first EU accession to an international human rights treaty: See Grainne de Burca, ‘The European Union in the Negotiation of the UN Disability Convention’ (2010) 35 E L Rev 174. See also Lisa Waddington, ‘The European Union and the United Nations Convention on the Rights of Persons with Disabilities: A Story of Exclusive and Shared Competences’ (2011) 18 Maastricht Journal of European and Comparative Law 431.

exclusive instead of inclusive’.⁶⁹ The Republic of Korea pointed out that ‘the definition of disability has evolved and ICF now embraces a broad, social model definition’ and Canada that ‘definitions on disability tend to change ... and it will be difficult to come up with a definition of disability that stands the test of time’.⁷⁰ Australia then suggested that a definition of disability ‘should be broad and inclusive’; it was stated however that, the importance of the ‘social model of disability’ notwithstanding, ‘disability seen purely as a function of the environment would render a definition unworkable’.⁷¹ The National Human Rights Institutions finally warned that ‘there is a danger in not defining disability – States may refuse to ratify the convention if its meaning and obligations are uncertain’.⁷²

Article 3 and the definition of disability were not discussed during the Fifth and Sixth Sessions of the Ad Hoc Committee. The Chairman, in the draft text that he prepared for discussion at the Seventh Session, stated that:

Views are divided as to whether it is necessary to define ‘Disability’ and ‘Persons with disabilities’. I tend to think that we don’t, as this will be very difficult, and there is a risk that we will unintentionally exclude someone.⁷³

The Definitions Article (now Article 2) was discussed during the Seventh Session and included a lengthy debate regarding the definition of disability. The Chair, in summarising the relevant views heard, noted that there was still disagreement over the inclusion of such a definition in the convention; this issue could be addressed either by referencing a definition or the scope of the meaning of disability in the Preamble, or by including such a reference in the final report of

⁶⁹ DSD at the Fourth Session, 23 August 2004, 9-10 <<https://static.un.org/esa/socdev/enable/rights/ahc4sum23aug.htm>> accessed 16 December 2019.

⁷⁰ *ibid* 10-11.

⁷¹ *ibid* 11.

⁷² *ibid* 13-14.

⁷³ Letter dated 7 October 2005 from the Chairman to all members of the Committee, UN Doc. A/AC.265/2006/1, 14 October 2005, para 17 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/AC.265/2006/1> accessed 16 December 2019.

the AHC.⁷⁴ He recognised however that the ‘overall consensus’ would be to include a definition of disability in Article 2, and finally stated that ‘a proposal addressing the issue would be forthcoming’.⁷⁵ Indeed, a possible definition of disability was later proposed by the Chair:

‘Disability’ results from the interaction between persons with impairments, conditions or illnesses and the environmental and attitudinal barriers they face. Such impairments, conditions or illnesses may be permanent, temporary, intermittent or imputed, and include those that are physical, sensory, psychosocial, neurological, medical or intellectual.⁷⁶

It can be noted that the Chair’s proposed understanding of disability, as resulting from the interaction between persons with impairments and the barriers they face, is in line with the ICF conceptualisation. It should also be noted that several delegations referred to the ICF understanding of disability during the discussion at the Seventh Session. In particular, the ICF was mentioned by Australia as a possible source of a definition for disability. Australia also referred to the social model, but opposed the adoption of a ‘strict social model approach’ that would release States from their obligations towards persons with disabilities once the barriers created by society were removed.⁷⁷ Serbia and Montenegro suggested a possible reference to the ICF, or the social model approach, in the preamble.⁷⁸ Norway supported Australia’s proposal for a definition of disability along the lines of the ICF and social model definitions.⁷⁹ Jamaica was drafting legislation on people with disabilities at the time, and mentioned that they ‘had decided upon the WHO-ICF approach, which distinguishes between impairment, disability and

⁷⁴DSD at the Seventh Session, 31 January 2006, 21 <<https://static.un.org/esa/socdev/enable/rights/ahc7sum31jan.htm>> accessed 16 December 2019.

⁷⁵ *ibid.*

⁷⁶Possible Definition of ‘Disability’: Discussion Text Suggested by the Chair <<https://static.un.org/esa/socdev/enable/rights/ahc7pddisability.htm>> accessed 16 December 2019.

⁷⁷ DSD at the Seventh Session (n 74) 8.

⁷⁸ *ibid.* 9.

⁷⁹ *ibid.*

handicap’;⁸⁰ it should be noted however that the distinction between impairment, disability and handicap is made, not in the ICF, but in its previous version, namely the International Classification of Impairments, Disabilities and Handicaps (ICIDH).⁸¹ India and Chile also referred to the ICF in discussing the possible definition of disability.⁸² Finally, International Disability Caucus (IDC)⁸³ described the ICF as ‘very controversial’ and noted that many disability organisations do not accept it as a definition of disability.⁸⁴ This lack of approval seems to be the reason why, as mentioned above, the similarity between the CRPD and the ICF understandings of disability, although readily apparent, is not expressly recognised either in the CRPD literature or the text itself.

During its Eighth and final Session, the draft text of a convention on the rights of persons with disabilities was concluded, and it was adopted by the AHC on 25 August 2006. The AHC then decided to establish an open-ended ‘Drafting Group’ (DG), with the task to ensure ‘uniformity of terminology throughout the text of the draft convention, harmonising the versions in the official languages of the United Nations’;⁸⁵ following that, on 5 December 2006 recommended to the General Assembly for adoption a draft resolution entitled ‘Convention on the Rights of Persons with Disabilities’.⁸⁶

Although the DG produced four revised texts, the definition of disability in this draft convention was eventually adopted in the final text of the CRPD without a single modification. In particular, disability was defined in the draft convention as follows:

[D]isability is an evolving concept and ... results from the interaction between persons with impairments and attitudinal and

⁸⁰ *ibid* 14.

⁸¹ WHO, *ICIDH* (WHO 1980).

⁸² DSD at the Seventh Session (n 74) 15-16.

⁸³ The IDC was a coalition of international, regional, and national DPOs and allied NGOs.

⁸⁴ DSD at the Seventh Session (n 74) 17.

⁸⁵ Interim Report of the AHC on its Eighth Session, UN Doc. A/AC.265/2006/4, 1 September 2006, para 13 <<http://www.un.org/esa/socdev/enable/rights/ahc8docs/ahc8intreporte.pdf>> accessed 16 December 2019.

⁸⁶ Final Report of the AHC, UN Doc. A/61/611, 6 December 2006, <https://treaties.un.org/doc/source/docs/A_61_611_E.pdf> accessed 16 December 2019.

environmental barriers that hinders their full and effective participation in society on an equal basis with others⁸⁷

It is worth noting that in the first revised text of the DG, it was suggested to add a comma after the word ‘barriers’, ‘to ensure that the phrase thereafter refers to “interaction” and not to “barriers”’.⁸⁸ Apparently, it was considered significant for the DG to leave no doubt about the position of the CRPD regarding the cause of social exclusion and disability. This therefore supports the argument made in the previous subsection, namely that the CRPD takes the view that participation in society is hindered not by barriers alone, but by the interaction between barriers and persons with impairments, and also that the difference between the two opposing views is actually meaningful.

The comments made in the second revised text - as well as the third and fourth texts - simply regarded the use of correct grammar. It was noted in particular that ‘if a comma is put after barriers, in that case “that” must be replaced by “which”; there can be no comma in front of “that”’.⁸⁹ The editor also recommended putting a comma after ‘interaction’, if the comma after ‘barriers’ was to be kept.⁹⁰ In the third revised text, ‘that’ was still replaced by ‘which’, but the commas were omitted.⁹¹ Finally, ‘that’ replaced ‘which’ in the fourth revised text of the DG, and therefore it was decided to maintain in the CRPD the old definition of disability.⁹² It seems indeed that the proposed changes were not actually needed; in fact, if adopted, they would have made the meaning of the text less understandable.

⁸⁷ Interim Report of the AHC (n 85) Annex II.

⁸⁸ AHC, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: First revised text, 13 September 2006, fn 3 <<https://static.un.org/esa/socdev/enable/drafting.htm>> accessed 16 December 2019.

⁸⁹ AHC, Draft Convention: Second revised text, 3 October 2006, fn 4 <<https://static.un.org/esa/socdev/enable/drafting.htm>> accessed 16 December 2019.

⁹⁰ *ibid.* To clarify, the sentence read: ‘... disability results from the interaction, between persons with impairments and attitudinal and environmental barriers, which hinders ...’

⁹¹ AHC, Draft Convention: Third revised text, 10 October 2006 <<https://static.un.org/esa/socdev/enable/drafting.htm>> accessed 16 December 2019. The sentence read: ‘... disability results from the interaction between persons with impairments and attitudinal and environmental barriers which hinders ...’

⁹² AHC, Draft Convention: Fourth revised text, 30 October 2006 <<https://static.un.org/esa/socdev/enable/drafting.htm>> accessed 16 December 2019.

The examination of the discussion on the definition of disability during the CRPD negotiations reveals that the AHC intended to emphasise that disability is the result of the interaction between barriers and persons with impairments, which is the same way that the ICF understands disability. The proposals of the DG, and especially their will to ensure that participation in society is hindered by both impairment and barriers, confirm that they adopt a different view than the British 'social model', which only regards disabling barriers as the cause of social exclusion. It therefore seems to be confirmed that the CRPD does not adopt the British 'social model' approach to disability, but rather defines disability in a way similar to the ICF understanding.

The following section turns to the issue of deprivation of liberty on the basis of disability. It examines in particular the protection offered by the CRPD to the right to liberty of persons with disabilities, and specifically whether disability can justify deprivation of liberty, either alone or in combination with other factors.

3.4 Deprivation of Liberty based on Disability under the CRPD

The right to liberty and security of person is protected under the CRPD in Article 14. Paragraph 1(a) affirms that persons with disabilities must enjoy that right on an equal basis with others. The first part of paragraph 1(b) specifically prohibits the unlawful or arbitrary deprivation of liberty of persons with disabilities and requires that any deprivation of liberty must be in conformity with the law, whereas the second part of paragraph 1(b) states that 'the existence of a disability shall in no case justify a deprivation of liberty'.

It can be argued that, from a mental health law perspective, and depending on how it is understood, this phrase is the most significant statement of Article 14. In particular, it is important to determine whether the meaning of that phrase is that disability cannot be used as the only ground for depriving a person of their liberty, or whether it cannot be used at all as a ground for deprivations of liberty. It should be noted that the UNHCHR clearly took the latter view, when making

one of the earliest interpretations of that phrase in a thematic study on the CRPD, published in 2009.⁹³ She mentioned in particular that the AHC had rejected proposals to only prohibit those cases of detentions that are ‘solely’ determined by disability, and therefore stated that ‘unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment’.⁹⁴

The following subsection will now examine the discussion on the right to liberty, and specifically on deprivation of liberty on the basis of disability, during the negotiations of the CRPD.

3.4.1 The discussion on deprivation of liberty on the basis of disability during the CRPD negotiations

The AHC began discussing the right to liberty at its Third Session. In the draft text which had previously been prepared by the WG, paragraph 1(b) of the Article on the right to liberty (then draft Article 10) read as follows:

1. States Parties shall ensure that persons with disabilities ...

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty shall be in conformity with the law, and in no case shall be based on disability.⁹⁵

It is interesting to note that draft Article 10(1)(b) and Article 14(1)(b) of the final text of the CRPD are almost identical. The exact wording of Article 14(1)(b) of the CRPD is:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others ...

⁹³ OHCHR, *Thematic Study by the OHCHR on Enhancing Awareness and Understanding of the CRPD*, UN Doc. A/HRC/10/48, 26 January 2009, para 48 <<http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf>> accessed 16 December 2019.

⁹⁴ *ibid.*

⁹⁵ Report of the WG to the AHC (n 66) 15-16.

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

It therefore seems that the WG did not find the prohibition of deprivation of liberty as problematic as the issue of defining disability. It should also be mentioned that the WG made three suggestions to the AHC in relation to draft Article 10(1)(b). The first, found in the footnote to the phrase ‘are not deprived of their liberty’, was to consider ‘whether civil and criminal cases should be dealt with separately’ and ‘whether the text needs further elaboration on civil cases of deprivation of liberty’.⁹⁶ The WG pointed out that although, according to the jurisprudence of the Human Rights Committee, deprivation of liberty is interpreted by States ‘too narrowly’ and taken to apply only to the criminal justice system, the right to liberty ‘applies to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, mental illness or intellectual disability, vagrancy, drug addiction, educational purposes or immigration control’.⁹⁷ The second suggestion to the AHC, found in the footnote to the word ‘unlawfully’, was to discuss ‘whether the wording of paragraph 1(b) does or does not prohibit civil commitment and whether it should’.⁹⁸ Finally the third suggestion, found in the footnote to the phrase ‘and in no case shall be based on disability’, was to ‘consider adding a provision that obliges States to reform laws and procedures that perpetuate the arrest and detention of persons with disabilities on the basis of disability’.⁹⁹

Draft Article 10(1)(b) was discussed during the Third Session of the AHC, and the main points will now be noted. New Zealand mentioned the first suggestion of the WG, as noted above, and stated that ‘it is not clear whether Article 10 deals with civil commitment, or criminal incarceration, or both’.¹⁰⁰ It was also stated that the convention on the rights of persons with disabilities could not ‘accept a

⁹⁶ *ibid* fn 35.

⁹⁷ *ibid*.

⁹⁸ *ibid* fn 36.

⁹⁹ *ibid* fn 37.

¹⁰⁰ DSD at the Third Session, 26 May 2004, 10 <<https://static.un.org/esa/socdev/enablr/rights/ahc3sum26may.htm>> accessed 16 December 2019.

lesser standard' than the Article 9 (liberty and security of person) of the International Covenant on Civil and Political Rights (ICCPR).¹⁰¹ The EU agreed on that latter point, but noted that Article 9 of the ICCPR covers criminal detentions and may therefore not apply to health-related detentions.¹⁰² It was stated that 'forced institutionalisation is illegal', and that, since 'consent is the issue', the 'more appropriate' term 'involuntary institutionalisation', instead of 'forced institutionalisation', should be used.¹⁰³ It was further stated that 'it needs to be clear that involuntary commitment should only be allowed in exceptional circumstances, and with clear legal safeguards'.¹⁰⁴

An important, mainly because it was eventually rejected, proposal was made by Canada; it was suggested to add the word 'solely' to draft Article 10(1)(b), so it would read '... any deprivation of liberty ... in no case shall be based solely on disability'.¹⁰⁵ Uganda supported Canada, while also stating that 'there must be a legitimate reason for deprivation, either an offense committed by the person or a potential threat, and not on the basis of disability'.¹⁰⁶ Mexico pointed out that 'the addition of the word "solely" may cause problems by implying that [persons with disabilities] should be deprived of their liberty'.¹⁰⁷ Australia was uncertain too about whether the draft Article 10 covers criminal, civil, or both cases, and also agreed with Canada's proposal regarding the word 'solely'.¹⁰⁸ The WNUSP/Support Coalition International rejected any qualifications to draft Article 10(1)(b) such as the word 'solely'.¹⁰⁹ They stated in particular that:

Deprivation of liberty based on disability encompasses civil commitment and forced institutionalisation as well as private deprivation of liberty. If the [AHC] adds the term 'solely', it would open the door for States to deprive persons with disabilities of their liberty for being 'a danger to society', which is discriminatory because

¹⁰¹ *ibid.*

¹⁰² *ibid.*

¹⁰³ *ibid.*

¹⁰⁴ *ibid.*

¹⁰⁵ *ibid.*

¹⁰⁶ *ibid.* 11.

¹⁰⁷ *ibid.*

¹⁰⁸ *ibid.*

¹⁰⁹ *ibid.*

people without disabilities are not subject to the same standard. If there is no crime, a State cannot lock up person who is not considered mentally ill or intellectually disabled. [Persons with disabilities] should not be subject to a different standard. There is a moral obligation to move society toward inclusiveness. If a person with a disability is deprived of liberty, that imposes a social disadvantage and therefore, under the social model, that is discrimination.¹¹⁰

Inclusion International recommended a change in draft Article 10, 'so that no law could force people to live in institutions'.¹¹¹ It was argued that institutionalisation is 'very destructive' to persons with disabilities and 'leads to dehumanisation of both [persons with disabilities] and staff, leading to abuse'.¹¹² It was also argued that institutions are a 'costly form of segregation', whereas persons with disabilities 'need integration in school, housing, employment, and recreation'.¹¹³

The AHC continued the discussion on draft Article 10(1)(b) during its Fourth Session. China and New Zealand supported the proposal of Canada to add the word 'solely', whereas South Africa opposed it, as it would 'impl[y] that other types of discrimination may be tolerated'.¹¹⁴ The EU proposed to rephrase draft Article 10(1)(b), and particularly change the sentence 'any deprivation of liberty shall be in conformity with the law, and in no case shall be based on disability' to 'any deprivation of liberty including any involuntary institutionalisation, shall be in conformity with the law, and in no case shall be based exclusively on disability'.¹¹⁵ Serbia and Montenegro supported the proposal of the EU, whereas Thailand supported the EU proposal on forced institutionalisation, but rejected

¹¹⁰ *ibid* 11-12.

¹¹¹ *ibid* 12.

¹¹² *ibid*.

¹¹³ *ibid*.

¹¹⁴ DSD at the Fourth Session, 26 August 2004, 5-6 <<https://static.un.org/esa/socdev/enable/rights/ahc4sum26aug.htm>> accessed 16 December 2019.

¹¹⁵ EU, Contributions submitted by Governments in electronic format at the Fourth Session: Proposed Modifications to Draft Article 10 <<https://static.un.org/esa/socdev/enable/rights/ahc4sum26aug.htm>> accessed 16 December 2019.

the inclusion of the term ‘exclusively’.¹¹⁶ Disability Caucus was ‘strongly opposed’ to the use of the word ‘solely’, and proposed a single sentence for paragraph 1 of draft Article 10, also supported by DPI, as follows: ‘States Parties shall ensure that no one is deprived of liberty based in whole or in part on disability’.¹¹⁷

The discussion on draft Article 10(1)(b) continued during the Fifth Session of the AHC. According to the Coordinator’s report, the main issue was whether or not to insert the word ‘solely’, or ‘exclusively’, before the words ‘on disability’.¹¹⁸ By the end of the Session the latter view had prevailed, as well as the alternative proposal to add to the end of the paragraph the words ‘in no case shall the existence of a disability justify a deprivation of liberty’; however, some delegations stated that the text would need to be further considered.¹¹⁹

The relevant statements will now be noted in detail, but first it would be useful to remind Article 10(1)(b) of the WG draft text, which formed the basis for discussion:

1. States Parties shall ensure that persons with disabilities ...

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty shall be in conformity with the law, and in no case shall be based on disability.

Jordan proposed to delete the phrase ‘and in no case shall be based on disability’.¹²⁰ In response, the Coordinator noted that draft Article 10(1)(b) emphasises that people with disabilities must not be deprived of their liberty due to disability, as has historically been the case.¹²¹ He stated that if that qualification was deleted, deprivations of liberty on the basis of disability would

¹¹⁶ DSD at the Fourth Session (n 114) 6.

¹¹⁷ *ibid* 6-7.

¹¹⁸ Report of the AHC on its Fifth Session, UN Doc. A/AC.265/2005/2, 23 February 2005, Annex II para27<<http://documents-dds-ny.un.org/doc/UNDOC/GEN/N05/248/29/pdf/N0524829.pdf?OpenElement>> accessed 16 December 2019.

¹¹⁹ *ibid*.

¹²⁰ DSD at the Fifth Session, 26 January 2005, 15 <<https://static.un.org/esa/socdev/enable/rights/ahc5sum26jan.htm>> accessed 16 December 2019.

¹²¹ *ibid* 16.

be allowed under draft Article 10, as long as they were in conformity with the law, and that it is ‘an essential element’ of draft Article 10 that ‘States cannot lock someone up just because of a disability’.¹²² The EU suggested that, in order to make clear that the Article also deals with civil commitment, the words ‘and involuntary institutionalisation’ could be added after the word ‘liberty’.¹²³ Thus, the text would read ‘... any deprivation of liberty and involuntary institutionalisation shall be in conformity with the law ...’

The EU also proposed adding the words ‘exclusively based on’ before the word ‘disability’;¹²⁴ the text would thus read ‘... any deprivation of liberty ... in no case shall be exclusively based on disability’. Japan stated that ‘in exceptional cases, people with mental disabilities may be subject to forced institutionalisation, taking into account the risk of harm to themselves or others’ and supported EU’s latter proposal, while Costa Rica disagreed and stated that it is ‘too risky to support’.¹²⁵ Mexico opposed the addition of words such as ‘exclusively’ or ‘solely’, because ‘this could lead to misinterpretation’, and ‘adding a qualifier could imply permission for States to discriminate in other ways’.¹²⁶ Thailand also objected to adding the word ‘solely’, because ‘this could allow disability to be used as one factor, along with other factors, in decisions to deprive someone of liberty’.¹²⁷ Russian Federation supported adding the word ‘exclusively’, and stated in particular that:

Functional limitations of [persons with disabilities] could lead to negative consequences for other people, and may therefore be a factor in some loss of liberty; but disability itself, without any negative consequences, should not be a basis for depriving liberty.¹²⁸

Kenya took instead the view that draft Article 10(1)(b) should not include any qualifiers, because, as race or gender are prohibited under other Conventions to

¹²² *ibid.*

¹²³ *ibid* 15.

¹²⁴ *ibid.*

¹²⁵ *ibid* 15-16.

¹²⁶ *ibid* 16.

¹²⁷ *ibid* 17.

¹²⁸ *ibid.*

be used as a basis for deprivations of liberty, it is important to prohibit using disability to deprive a person of their liberty.¹²⁹ Uganda recognised that ‘historically [persons with disabilities] have been unfairly confined’; they nevertheless stated that there are circumstances, such as ‘serious illness or mental illness’, in which persons with disabilities ‘may require some level of confinement, either to receive medication or to be prevented from hurting themselves or others’.¹³⁰ They therefore took the view that it should be clear in draft Article 10 that there are instances where it is needed to confine persons with disabilities, and suggested adding the words ‘exceptional circumstances’ or ‘solely based on disability’, ‘meaning that confinement could be justified based on other reasons such as being dangerous or not taking medications’.¹³¹

Recognising the difference of opinion between the various delegations, Australia proposed, as a compromise, the following revision: ‘The existence of a disability shall not of itself be a sufficient reason to justify the deprivation of liberty.’¹³² Norway found Australia’s proposal interesting; they mentioned that although disability cannot be the reason for deprivation of liberty, its effects may render deprivation necessary.¹³³ Therefore, they suggested that either the words ‘solely’ or ‘exclusively’ should be added, or the phrase ‘and in no case shall be based on disability’ should be deleted, as Jordan had suggested.¹³⁴ Yemen noted that ‘disability should not be a reason to deprive someone of liberty, either on its own or in combination with other reasons’, and therefore stated that Australia’s proposal is as problematic as the word ‘solely’.¹³⁵

The Coordinator suggested that it is probably the phrase ‘disability shall not of itself’ in Australia’s proposal which seems problematic and concerning for some delegations, and therefore asked whether the problem could be solved by

¹²⁹ *ibid.*

¹³⁰ *ibid.*

¹³¹ *ibid.*

¹³² *ibid.*

¹³³ *ibid* 18.

¹³⁴ *ibid.*

¹³⁵ *ibid.*

removing the words ‘of itself’ from the phrase.¹³⁶ Thus, draft Article 10(1)(b) would read ‘the existence of a disability shall not be a sufficient reason to justify the deprivation of liberty’, which means that deprivations of liberty must not be based on disability alone. In other words, draft Article 10 would require the existence of other reasons, along with disability, in order for a deprivation of liberty to be justified. This wording accepted therefore that disability could be one of the reasons for a deprivation of liberty, as long as it is not the only reason. Australia approved the Coordinator’s suggestion.¹³⁷ Colombia stated that draft Article 10 should ‘consider the safety of individuals’ and supported deleting the words ‘of itself’, since that would make clear that ‘while disability cannot justify deprivation of liberty, other factors can’.¹³⁸ Jamaica stated that Article 10(1)(b) of the WG draft text ‘ensures rights for [persons with disabilities] similar to the rights enjoyed by other groups’, and that ‘trying to qualify that language could create difficulties’, as the words ‘solely’ and ‘exclusively’ ‘are open to all kinds of interpretation’.¹³⁹

The Coordinator noted that whether or not to add the words ‘solely’ or ‘exclusively’ was indeed the main issue regarding draft Article 10(1)(b). He mentioned that there was ‘a fair level of support’ for retaining Article 10(1)(b) of the WG draft text, but also asked whether any delegations objected to Australia’s proposal.¹⁴⁰ Thailand stated that, even with the removal of the words ‘of itself’, this proposal would still be problematic, because of the word ‘sufficient’.¹⁴¹ They therefore could not support it, as it would allow disability to be a reason for depriving a person of their liberty.¹⁴² Thus, Thailand pointed out that draft Article 10(1)(b) should not simply require the existence of other reasons, besides disability, for a deprivation of liberty; it should instead make clear that disability cannot be used as a factor in deprivations of liberty, either alone or in combination with other factors.

¹³⁶ *ibid.*

¹³⁷ *ibid.*

¹³⁸ *ibid.*

¹³⁹ *ibid.* 19.

¹⁴⁰ *ibid.*

¹⁴¹ *ibid.*

¹⁴² *ibid.*

The Coordinator asked Australia whether the word ‘sufficient’ could be removed.¹⁴³ Australia agreed with the removal, and revised their proposal so that it would read ‘the existence of a disability shall not justify the deprivation of liberty’.¹⁴⁴ Australia’s new proposal was supported by Canada.¹⁴⁵ Thailand stated that this proposal had merit, but noted that Article 10(1)(b) of the WG draft text, which read ‘any deprivation of liberty ... in no case shall be based on disability’, was ‘quite clear’, and therefore had doubts as to whether Australia’s proposal was a better alternative.¹⁴⁶ It can be argued however that the choice between the above versions would not be particularly significant, because their meaning is essentially the same; both prohibit disability to be used as a factor in deprivations of liberty. Instead, the meaning in the three previously proposed versions was significantly different, namely that disability can be a reason for depriving a person of liberty: ‘... any deprivation of liberty ... in no case shall be solely/exclusively based on disability’, ‘the existence of a disability shall not of itself be a sufficient reason to justify the deprivation of liberty’, and ‘the existence of a disability shall not be a sufficient reason to justify the deprivation of liberty’. It is also worth noting that they seem to all have the same meaning, as they all allow disability to be a factor in depriving a person of liberty, as long as the deprivation is based on other factors as well. Therefore, if any of these three versions were chosen, the meaning of draft Article 10(1)(b) would have altered significantly.

The Coordinator closed the discussion by stating that the report would reflect a ‘strong level of support’ for Article 10(1)(b) of the WG draft text, as well as the issue regarding the addition or not of the words ‘solely’ or ‘exclusively’.¹⁴⁷ It is finally worth mentioning that some comments regarding draft Article 10(1)(b) were also made by the delegation from the IDC the following day, when the sessions were opened in formal plenary. In particular, the IDC supported Article 10(1)(b) of the WG draft text and stated that adding words such as ‘solely’ or

¹⁴³ *ibid.*

¹⁴⁴ *ibid.*

¹⁴⁵ *ibid.*

¹⁴⁶ *ibid.*

¹⁴⁷ *ibid.*

‘exclusively’ would be ‘a threat to human rights’.¹⁴⁸ The Coordinator’s report stated that, following the relevant discussion during the Fifth Session, Article 10(1) read:

1. States parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law and in no case [based solely [exclusively] on disability] [shall the existence of a disability justify a deprivation of liberty].¹⁴⁹

Draft Article 10 (now draft Article 14) was not discussed during the Sixth Session of the AHC. The Chairman’s draft text, which was prepared for discussion at the Seventh Session, stated that:

You will recall that there was extensive discussion around the need for a qualifier such as ‘solely’ or ‘exclusively’ before the words ‘on disability, in paragraph 1(b) ... Some delegations strongly supported those words, but many opposed them. I suggest that [the phrase ‘shall the existence of a disability justify a deprivation of liberty’] should be an acceptable compromise, and think we came close to that point in our discussions. I have revised the text accordingly, and urge all delegations to accept this outcome.¹⁵⁰

During its Seventh Session, the AHC continued the discussions on draft Article 14. It is important to note that the IDC amended the Chairman’s draft text regarding Article 14(1)(b), in a background document that was submitted prior to the discussion, as follows:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

¹⁴⁸ DSD at the Fifth Session, 27 January 2005, 10 <<https://static.un.org/esa/socdev/enable/rights/ahc5sum27jan.htm>> accessed 16 December 2019.

¹⁴⁹ Report of the AHC on its Fifth Session (n 118) Annex II para 28.

¹⁵⁰ Letter dated 7 October 2005 from the Chairman (n 73) para 57.

(b) are not deprived of their liberty unlawfully or arbitrarily, (DELETE: 'and that any deprivation of liberty is in conformity with the law'), and in no case shall (DELETE: 'the existence of a') disability (REPLACE: 'justify' WITH 'be a factor in') a deprivation of liberty.¹⁵¹

As regards the justification for the proposed first deletion, the IDC stated that the phrase 'deprivation of liberty shall be in conformity with the law' would make the Convention 'a least common denominator of domestic laws':

If mental health laws give power to the authorities to detain people with psychiatric diagnoses (or suspected of such 'disorders'), then this part of the sentence says that this deprivation of liberty is in compliance with the Convention. The same would be true for laws authorizing custody of people deemed 'insane' or 'of unsound mind'.¹⁵²

As regards the proposed second amendment, the IDC stated that the phrase 'in no case shall the existence of a disability justify a deprivation of liberty' 'does not help to fix the previous concern':

Deprivation of liberty will be not justified by the existence of the disability, but by other factors that, however, only apply to people with psychiatric diagnoses or suspected of them. This formulation has all the problems the earlier proposal had ('exclusively', 'solely').¹⁵³

In relation to that second amendment and its justification, it can be noted that the view taken by the IDC seems to be mistaken. Since it proposes to replace the phrase 'in no case shall the existence of a disability justify a deprivation of liberty' with the phrase 'in no case shall disability be a factor in a deprivation of liberty', it seems to suggest that the meaning of the former is that disability *can* be a factor, among others, in the deprivation. It is however unclear how the IDC came to that conclusion, given the absence of words such as 'solely', 'exclusively', 'of itself' or 'sufficiently' in that phrase. It can therefore be argued

¹⁵¹ Comments, Proposals and Amendments submitted electronically, Seventh Session, <<https://static.un.org/esa/socdev/enable/rights/ahcstata14sevscomments.htm#idc>> accessed 16 December 2019.

¹⁵² *ibid.*

¹⁵³ *ibid.*

that the IDC's statement is unsupported, and the phrase should be taken to mean that disability does not justify deprivations of liberty, either alone or in combination with other factors. Thus, the IDC's second amendment is meaningless, because the two phrases substantively have the same meaning.

Because of the wide consensus on draft Article 14(1)(b), the relevant discussion at the Seventh Session of the AHC was very brief. The addition of the words 'solely' or 'exclusively' was once again proposed, this time by Japan.¹⁵⁴ There were some proposals to amend draft Article 14(1)(b), but the Chair stated that 'the changes were either not substantive or represented issues that had already been thoroughly debated'.¹⁵⁵ He also stated that:

[T]he text as written is reasonably balanced and should be retained. This is essentially a non-discrimination provision. The debate has focused on the treatment of [persons with disabilities] on the same basis as others. [Persons with disabilities] who represent a legitimate threat to someone else should be treated as any other person would be.¹⁵⁶

The Chair took the view that this balance was achieved, and concluded the discussion on draft Article 14. Finally, the DG only made a minor change in the wording of Article 14(1)(b) 'for clarity'; in its first revised text, the phrase 'and in no case shall the existence of a disability justify a deprivation of liberty' became 'and that the existence of a disability shall in no case justify a deprivation of liberty'.¹⁵⁷ As stated above, and based on the discussion during the CRPD negotiations, this provision means that any deprivation of liberty which is based on the existence of disability, irrespective of whether it is based on other reasons as well, is prohibited as discriminatory under the CRPD. Accordingly, any law or

¹⁵⁴ DSD at the Seventh Session, 18 January 2006, 15 <<https://static.un.org/esa/socdev/enable/rights/ahc7sum18jan.htm>> accessed 16 December 2019.

¹⁵⁵ DSD at the Seventh Session, 19 January 2006, 2 <<https://static.un.org/esa/socdev/enable/rights/ahc7sum19jan.htm>> accessed 16 December 2019.

¹⁵⁶ *ibid.*

¹⁵⁷ AHC, Draft Convention on the Rights of Persons with Disabilities and Draft Optional Protocol: First revised text, 13 September 2006, fn 30 <<https://static.un.org/esa/socdev/enable/drafting.htm>> accessed 16 December 2019.

provision that allows for such deprivation is incompatible with the CRPD, and States Parties have an obligation to abolish or repeal it.

The following subsection will now discuss how the CRPD Committee interprets Article 14 of the CRPD, and its view on deprivation of liberty on the basis of disability.

3.4.2 The view of the CRPD Committee on disability-based deprivation of liberty

As already noted, the CRPD Committee is the independent body that monitors the implementation, and provides authoritative interpretation, of the CRPD. The primary function of the CRPD Committee is to review reports submitted by the States Parties on measures taken for the implementation of the CRPD, and to make recommendations and further suggestions to the States Parties in the form of concluding observations (COs).

It was found in the previous subsection that the AHC took the view that any deprivation of liberty based on disability is prohibited under the CRPD. Thus, it would constitute a violation of the CRPD to use disability, either as the only ground or one of the grounds, for depriving a person of their liberty. Article 14 is especially important for people with mental disabilities. Several States Parties, including the UK, have in place legislation that allows for deprivation of liberty on the basis of mental disability.

The CRPD Committee's view on deprivation of liberty on the basis of disability can be found firstly in its concluding observations on States Parties reports. Also, the CRPD Committee issued in September 2014 a *Statement*,¹⁵⁸ and one year later adopted *Guidelines*,¹⁵⁹ replacing the previous Statement, on Article 14 of

¹⁵⁸ CRPD Committee, *Statement on Article 14 of the Convention on the Rights of Persons with Disabilities*, September 2014 <<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E>> accessed 16 December 2019.

¹⁵⁹ CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*, September 2015 <<http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>> accessed 16 December 2019.

the CRPD, which clarify the obligations of States Parties in relation to the right to liberty of persons with disabilities.

3.4.2.1 Concluding Observations (COs)

The CRPD Committee has repeatedly advised States Parties to abolish laws that authorise deprivation of liberty on the basis of mental disability. Firstly in 2011, in its COs on Tunisia's initial report, it expressed concerns 'that having a disability, including an intellectual or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation',¹⁶⁰ and recommended the 'repeal of legislative provisions which allow for the deprivation of liberty on the basis of disability.'¹⁶¹

A few more examples include the CRPD Committee's COs on the initial report of New Zealand, where it recommended that the State 'take all the immediate necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any medical facility on the basis of actual or perceived disability'.¹⁶² It also recommended that the State 'ensure that all mental health services are provided on the basis of the free and informed consent of the person concerned.'¹⁶³

In its COs on Germany's initial report, the CRPD Committee recommended that the State take all measures to 'amend legislation to prohibit involuntary placement and promote alternative measures that are in keeping with article 14'.¹⁶⁴

More recently, in its COs on Slovenia's initial report, the CRPD Committee recommended that the State 'repeal all legislation providing for the involuntary

¹⁶⁰ CRPD Committee, *COs on the Initial Report of Tunisia*, UN Doc. CRPD/C/TUN/CO/1, 13 May 2011, para 24 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/TUN/CO/1> accessed 16 December 2019.

¹⁶¹ *ibid* para 25.

¹⁶² CRPD Committee, *COs on the Initial Report of New Zealand*, UN Doc. CRPD/C/NZL/CO/1, 31 October 2014, para 30 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/NZL/CO/1> accessed 16 December 2019.

¹⁶³ *ibid*.

¹⁶⁴ CRPD Committee, *COs on the Initial Report of Germany*, UN Doc. CRPD/C/DEU/CO/1, 13 May 2015, para 30 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/DEU/CO/1> accessed 16 December 2019.

commitment and non-consensual psychiatric treatment of persons with disabilities on the grounds of their actual or perceived impairment in any circumstances, including alleged risk and dangerousness'.¹⁶⁵

As regards the UK, it should first be noted that in its initial report to the CRPD Committee,¹⁶⁶ the UK government did not identify any incompatibility between the English law and the CRPD in relation to Article 14. In particular, it was stated in the report that 'no one in the UK can be deprived of his or her liberty because he or she is disabled.'¹⁶⁷ Obviously, what was meant here is that no one can be deprived of liberty *simply* because he or she is disabled. The government went on to acknowledge that the law *does* allow for the detention of persons with mental disorders, but it was emphasised that this only happens in situations when it is necessary, and that 'strict safeguards are in place to ensure that the needs of the individual are taken into account and respected'.¹⁶⁸ The main functions and provisions of the relevant statutes were also briefly noted, but the view seemed to be that they are in compliance with the CRPD.

Nevertheless, when the CRPD Committee published its COs on the UK's initial report,¹⁶⁹ it expressed concerns about the existence of legislation that 'provides for involuntary, compulsory treatment and detention both inside and outside hospitals on the basis of actual or perceived impairment'.¹⁷⁰ It went on to recommend that the State 'repeal legislation and practices that authorize non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment'.¹⁷¹ The CRPD

¹⁶⁵ CRPD Committee, *COs on the Initial Report of Slovenia*, UN Doc. CRPD/C/SVN/CO/1, 16 April 2018, para 23 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/SVN/CO/1> accessed 16 December 2019.

¹⁶⁶ Office for Disability Issues (ODI), *UK Initial Report on the UN CRPD*, 24 November 2011 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345120/uk-initial-report.pdf> accessed 16 December 2019.

¹⁶⁷ *ibid* para 133.

¹⁶⁸ *ibid*.

¹⁶⁹ CRPD Committee, *COs on the Initial Report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc. CRPD/C/GBR/CO/1, 3 October 2017 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/GBR/CO/1> accessed 16 December 2019.

¹⁷⁰ *ibid* para 34.

¹⁷¹ *ibid* para 35.

Committee therefore concluded that the English law fails to comply with Article 14 of the CRPD. This issue will be examined in the next chapter.

3.4.2.2 Statement and Guidelines

As mentioned above, the CRPD Committee has adopted a *Statement* and *Guidelines* on Article 14. In its *Statement*, the CRPD Committee emphasised the ‘absolute prohibition of detention on the basis of disability’ and that no exceptions are permitted under Article 14.¹⁷² It was however noted that existing practices and legislation of several States Parties – including mental health laws – justify deprivation of liberty on grounds of actual or perceived disability, combined with dangerousness to self or others, or other reasons. The *Statement* clarified that this is incompatible with Article 14, as interpreted by the CRPD Committee’s jurisprudence.¹⁷³

As regards the ‘alleged danger of persons for themselves or for others’ as grounds for allowing for detention of persons with disabilities, the CRPD Committee noted in its *Statement* that this contrary to Article 14 of the CRPD; Article 14 prohibits ‘the involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels’.¹⁷⁴

As already mentioned, the *Statement* was replaced in 2015 by *Guidelines*, which present the updated and more detailed understanding of the CRPD Committee’s view on Article 14. It should be noted that one of the reasons why the CRPD Committee published the *Guidelines*, was that the Human Rights Committee (HRC) had recently published its *General Comment on Article 9* of the International Covenant on Civil and Political Rights (ICCPR),¹⁷⁵ which protects the right to liberty and security of person, the equivalent of Article 14 of the CRPD.

Article 9(1) of the ICCPR provides that ‘no one shall be subjected to arbitrary arrest or detention’, and ‘no one shall be deprived of his liberty except on such

¹⁷² CRPD Committee, *Statement on Article 14* (n 158).

¹⁷³ *ibid.*

¹⁷⁴ *ibid.*

¹⁷⁵ HRC, *General Comment No. 35 on Article 9 (Liberty and Security of Person)*, UNDoc.CCPR/C/GC/35, 16 December 2014 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CCPR/C/GC/35> accessed 16 December 2019.

grounds and in accordance with such procedure as are established by law'. In its *General Comment*, the HRC stated that:

The existence of a disability shall not *in itself* justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others.¹⁷⁶

It is therefore clear that the HRC interprets Article 9 of the ICCPR as allowing for deprivation of liberty on the basis of disability, as long as it is also based on additional factors, namely protection from harm to the person or others. The HRC did suggest that 'States Parties should make available adequate community-based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement',¹⁷⁷ and noted that deprivation of liberty 'must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law',¹⁷⁸ but nevertheless its view was that disability can be grounds for depriving a person of their liberty.

The CRPD Committee was apparently concerned that the HRC Committee adopted that approach,¹⁷⁹ and wanted to clarify that this is not permitted under the CRPD. In its *Guidelines*, the CRPD Committee once again emphasised that Article 14 of the CRPD 'does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment'.¹⁸⁰ It also referred to the discussion on Article 14 during the CRPD negotiations, noting that the proposal to qualify the prohibition of deprivation of liberty on the basis of disability, by adding words such as 'solely' or 'exclusively', was considered and rejected.¹⁸¹ Therefore, the *Guidelines* make clear that Article 14(1)(b) does not

¹⁷⁶ *ibid* para 19 (emphasis added).

¹⁷⁷ *ibid*.

¹⁷⁸ *ibid*.

¹⁷⁹ CRPD Committee, *Guidelines on Article 14* (n 159) para 1.

¹⁸⁰ *ibid* para 6.

¹⁸¹ *ibid* para 7.

allow deprivation of liberty on the basis of disability, either alone or in conjunction with other factors, such as danger to self or others.¹⁸²

Furthermore, the CRPD Committee referred specifically to the ‘involuntary commitment in mental health institutions’; it stated that Article 14(1)(b) prohibits ‘involuntary commitment of persons with disabilities on health care grounds’, and that provisions that allow for involuntary commitment of persons with disabilities in mental health institutions should be repealed.¹⁸³

The *Guidelines* also discussed those factors that are commonly used as basis for depriving a person of their liberty, namely ‘perceived danger of persons to themselves or to others’ and ‘alleged need for care or treatment’. It was stated that using those factors, or any other factors tied to ‘impairment or health diagnosis’, as basis for involuntary detention of persons with disabilities is contrary to Article 14 of the CRPD.¹⁸⁴

As regards specifically the ‘perceived danger of persons to themselves or to others’ factor, which is frequently linked to mental disability, the *Guidelines* took the view that this should not be addressed through mental health laws. It was noted that ‘these laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial’, and are therefore incompatible with Article 14 as well as Article 13 of the CRPD, which protects the right to access to justice.¹⁸⁵ Instead, persons with disabilities should be treated as any person who breaches the ‘duty to do no harm’; that is through criminal and other laws that deal with this obligation.¹⁸⁶

Regarding the ‘alleged need for care or treatment’ factor, the *Guidelines* noted that decisions about treatment must be based on the person’s free and informed consent, and pointed out that one of the principles of the CRPD, namely the

¹⁸² *ibid.*

¹⁸³ *ibid* para 10.

¹⁸⁴ *ibid* para 13.

¹⁸⁵ *ibid* para 14.

¹⁸⁶ *ibid.*

‘freedom to make one’s own choices’,¹⁸⁷ includes the ‘freedom to take risks and make mistakes on an equal basis with others’.¹⁸⁸

Having considered the COs on States Parties reports, as well as the *Statement* and *Guidelines* adopted on Article 14 of the CRPD, it can be noted that the CRPD Committee interprets the right to liberty as absolutely prohibiting deprivation of liberty on the basis of disability, and takes the view that the use of factors such as ‘perceived danger of persons to themselves or to others’ and ‘alleged need for care or treatment’, or any other factors ‘tied to impairment or health diagnosis’, as basis for involuntary detention of persons with disabilities is contrary to Article 14 of the CRPD.

3.4.3 Justification of deprivation of liberty based on mental disability

As already mentioned, dangerousness to self or others and need for care or treatment are the most common factors that, combined with mental - or intellectual - disability, are used to justify deprivation of liberty. Several States Parties, including the UK, have in place mental health laws that allow for deprivation of liberty of persons with mental disabilities, on the grounds that they are in need of care or treatment, and/or they pose a risk of self-harm or harm to others.

Article 14 of the CRPD, as seen in the previous subsections, prohibits deprivation of liberty on the basis of disability, either alone or in combination with other factors. However, as stated by the CRPD Committee in its *Guidelines*, Article 14 ‘is, in essence, a non-discrimination provision’; it prohibits all disability-based discrimination in the exercise of the right to liberty.¹⁸⁹ Consequently, there is a ‘close interrelation’ between Article 14 and Article 5, which protects the right to equality and non-discrimination.¹⁹⁰ Deprivation of liberty on the basis of disability therefore constitutes discrimination; it is a form of differential

¹⁸⁷ CRPD, Art 3(a).

¹⁸⁸ CRPD Committee, *Guidelines on Article 14* (n 159) para 15.

¹⁸⁹ *ibid* para 4.

¹⁹⁰ *ibid* para 5.

treatment of persons with disabilities that denies or restricts their right to liberty.

Non-discrimination is one of the CRPD's general principles under Article 3(b), and discrimination on the basis of disability is prohibited under Article 5(2) of the CRPD. Furthermore, as the CRPD Committee states in its *General Comment on Equality and Non-Discrimination*,¹⁹¹ all substantive rights of the CRPD are linked to the principle of non-discrimination; the phrase 'on an equal basis with others', evoking non-discrimination, is repeatedly used in all the substantive rights of the CRPD.¹⁹² That includes Article 14, which affirms in paragraph 1(a) that persons with disabilities must enjoy the right to liberty 'on an equal basis with others'.

In considering the prohibition of discrimination on the basis of disability under the CRPD, it should be noted that some authors take the view that the CRPD allows for the possibility to justify differential treatment based on disability.¹⁹³ Anna Nilsson in particular suggests that 'the CRPD prohibition of discrimination includes the possibility to justify disability-related compulsory interventions'.¹⁹⁴ It should be mentioned that the HRC and other UN treaty bodies accept that differential treatment can be justified. In particular, the HRC states in its *General Comment on Non-discrimination* that:

[N]ot every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable

¹⁹¹ CRPD Committee, *General Comment No. 6 (2018) on Equality and Non-Discrimination*, UN Doc. CRPD/C/GC/6, 26 April 2018 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/GC/6> accessed 16 December 2019.

¹⁹² *ibid* para 7.

¹⁹³ See for example Wayne Martin and others, *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If not, What Next?* (The Essex Autonomy Project 2014) 6-8 <<https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-Position-Paper-FINAL.pdf>> accessed 16 December 2019; Anna Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective' (2014) 14 HRL Rev 459, 462-64. See also John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 Int JL & Psychiatry 70, 73.

¹⁹⁴ Nilsson (n 193) 462.

and objective and if the aim is to achieve a purpose which is legitimate under the Covenant.¹⁹⁵

Therefore, differential treatments can be justified if they pursue a legitimate aim, and are based on criteria that are 'reasonable and objective'.

It can be argued however that the CRPD does not accept this. Article 5 does not indicate that there is any possibility to justify discrimination based on disability. Neither does Article 14; in fact, Article 14 explicitly states that 'the existence of disability *shall in no case justify* a deprivation of liberty'.¹⁹⁶ Furthermore, the CRPD Committee in its own *General Comment on Equality and Non-Discrimination* makes no reference to the 'objective and reasonable' standard or any other circumstances that could possibly justify disability-based discrimination.

Nevertheless, it is worth considering what the 'objective and reasonable standard' entails, and its application to deprivation of liberty of persons with mental disabilities. Nilsson helpfully provides a full analysis of this standard, based on jurisprudence from the HRC and other UN treaty bodies.¹⁹⁷ Basically, as she explains, a law that provides for differential treatment will meet the 'objective and reasonable standard', if certain elements are satisfied. The first element is relevance; the law must be relevant to the - legitimate - aim pursued, and it must also explain why differential treatment is relevant to the aim. The second element is necessity; the law must be necessary to achieve the pursued aim. The third element is balancing, or proportionality in a strict sense; the positive effects of the law must outweigh the negative effects.

Nilsson, taking the view that the CRPD allows for the possibility to justify disability-based discrimination, applies the 'objective and reasonable standard'

¹⁹⁵ HRC, *General Comment 18 on Non-discrimination* (Thirty-seventh session, 1989), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI/GEN/1/Rev.1, 29 July 1994, para 13 <http://www.un.org/en/ga/search/view_doc.asp?symbol=HRI/GEN/1/Rev.1> accessed 16 December 2019.

¹⁹⁶ CRPD, Art 14(1)(b) (emphasis added).

¹⁹⁷ Nilsson (n 193) 464-68.

to detention of persons with mental disabilities under mental health laws.¹⁹⁸ As mentioned above, the most common factors or criteria used to justify deprivation of liberty of persons with mental disabilities are need for care or treatment and dangerousness to self or others. Protection of the person's health or safety and protection of the safety of others are therefore the aims pursued by mental health laws that allow for deprivation of liberty of persons with mental disabilities. There can be no doubt that those aims are legitimate, but whether detention of persons with mental disabilities under mental health laws satisfies the 'objective and reasonable standard', or not, is less clear. Those aims will be specifically discussed now, beginning with the need to protect the person's health.

3.4.3.1 Protection of person's health

As regards the relevance element of the 'objective and reasonable standard', it is unclear whether detention achieves the aim of protecting the person's health. Nilsson notes that, although some studies suggest that involuntary detention, combined with compulsory treatment, contributes to health improvement, other studies suggest that coercion affects treatment outcomes negatively. She mentions in particular that, according to studies conducted, most persons who were detained show health improvement at discharge, but this is unlikely to continue in the longer term, and also a substantial number of people reported that their treatment provided no benefits.¹⁹⁹ Georg Høyer also points out that coercion, or perceived coercion, can have a serious impact on the doctor-patient relationship and consequently treatment outcomes.²⁰⁰

Furthermore, it appears that no valid reasons exist for singling out persons with mental disabilities for involuntary detention and treatment. As Peter Bartlett states, 'societies do not generally detain people for treatment, except for people with mental disabilities'; there is no reason for this distinction, 'particularly in the

¹⁹⁸ *ibid* 468-83.

¹⁹⁹ *ibid* 470-71. See also Peter Bartlett, 'A Mental Disorder of a Kind or Degree Warranting Confinement: Examining Justifications for Psychiatric Detention' (2012) 16 *IJHR* 831, 834-35.

²⁰⁰ Georg Høyer, 'On the Justification for Civil Commitment' (2000) 101 *Acta Psychiatr Scand* 65, 65-66.

event that the individual understands the proposed treatment and does not want it'.²⁰¹ Genevra Richardson also notes that 'in most jurisdictions a competent patient is free to refuse treatment'.²⁰² Nilsson considers the negative impact that certain mental disabilities may have on decision-making skills, as a potential reason for singling out persons with mental disabilities; however, as she states, 'persons with psychosocial disabilities are not the only ones whose decision-making skills may be affected from time to time', and 'a condition's potential impact on a person's ability to understand and reason cannot be ascertained from its categorisation as cognitive, somatic or psychosocial'.²⁰³

As regards the necessity element of the 'objective and reasonable standard', Nilsson points out that involuntary detention of persons with mental disabilities cannot satisfy the standard, unless non-coercive or less restricting alternatives, such as community-based services, are insufficient to protect the person's health.²⁰⁴ Although research on those alternatives is still limited, she mentions that a number of them that have been reviewed were found to be 'equally effective in terms of therapeutic outcomes'.²⁰⁵ Eilionóir Flynn also refers to research that establishes that 'care and support can be provided by non-coercive means, even in situations of acute crisis and distress'.²⁰⁶

As regards finally the balancing element of the 'objective and reasonable standard', it seems that the positive effects, or benefits, to health gained through involuntary detention and treatment do not outweigh the negative effects, or costs, associated with compulsory treatment and the intrusion on the person's liberty and integrity. As Nilsson states, although non-intervention in cases where it is needed may lead to serious deterioration of health, the negative effects of

²⁰¹ Bartlett, 'A Mental Disorder of a Kind or Degree Warranting Confinement' (n 199) 840.

²⁰² Genevra Richardson, 'Balancing Autonomy and Risk: A Failure of Nerve in England and Wales?' (2007) 30 Int JL & Psychiatry 71, 72.

²⁰³ Nilsson (n 193) 472.

²⁰⁴ *ibid* 478.

²⁰⁵ *ibid* 479.

²⁰⁶ Eilionóir Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches' (2016) 22 International Journal of Mental Health and Capacity Law 75, 85. See also Piers Gooding and others, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (Melbourne Social Equity Institute 2018).

compulsory detention and treatment are significant.²⁰⁷ Bartlett points out that anti-psychotic medication and drugs have adverse effects, in some cases permanent, including obesity, diabetes, dizziness, tremors, dystonia and sexual dysfunction.²⁰⁸ He also notes that it appears that ‘a minority of people who are detained are grateful for the detention afterwards’, or think that their detention was justified.²⁰⁹

The balancing between the interest of protecting health on the one hand and the right to liberty and integrity on the other, especially considering how it is done within the mental health context compared to the general health context, seems problematic as well. In particular, Nilsson notes that within the health care context generally, great importance is attached to liberty and integrity, irrespective of negative health outcomes. This is not the case however when it comes to mental health treatment.²¹⁰ Richardson also notes that in the context of mental disorder, beneficence and paternalism are given more weight than patient autonomy, whereas in the context of physical disorder patient autonomy is favoured over beneficence and paternalism.²¹¹

3.4.3.2 Protection of person’s safety

Protection of the person’s safety is the second common aim that laws that allow for detention of persons with mental disabilities seek to achieve. In considering whether detention satisfies the relevance element of the ‘objective and reasonable standard’, it can be noted that it is not certainly an effective means to prevent self-harm or suicide. Nilsson states that detention facilitates treatment and discourages self-destructive behaviour; treatment however does not always have the desired results, which questions the effectiveness of detention.²¹² Sascha Callaghan, Christopher Ryan and Ian Kerridge also note that ‘in terms of

²⁰⁷ Nilsson (n 193) 480. See also Høyer (n 200) 68.

²⁰⁸ Peter Bartlett, “The Necessity Must Be Convincingly Shown to Exist”: Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983’ (2011) 19 Med L Rev 514, 517-18.

²⁰⁹ Bartlett, ‘A Mental Disorder of a Kind or Degree Warranting Confinement’ (n 199) 834. See also Høyer (n 200) 69.

²¹⁰ Nilsson (n 193) 481.

²¹¹ Richardson (n 202) 72.

²¹² Nilsson (n 193) 473.

effectiveness, it is not actually the case that simply admitting a person to a psychiatric unit negates the possibility that a person might suicide'.²¹³ They further refer to the difficulty in determining which persons are at high-risk of suicide.²¹⁴ Nilsson notes too that the effectiveness of detention is undermined by the fact that it is very difficult to predict who will actually engage in serious self-harm.²¹⁵

Furthermore, as Nilsson states, persons with mental disabilities are not the only ones who harm themselves; persons without mental disabilities harm themselves too, but they are not deprived of their liberty in order to be protected.²¹⁶ It appears therefore that no valid reasons exist for singling out persons with mental disabilities for involuntary detention in order to protect their safety and prevent them from self-harm.

As regards the necessity element of the 'objective and reasonable standard', it seems that alternatives to detention do exist that seem to be equally effective in preventing self-harm. Flynn mentions that non-coercive alternatives have been developed, which are often trauma-based approaches, including de-escalating crisis situations with peer support, counselling, talking therapies, family group conferencing, use of personal ombuds, circles of support and open dialogue,²¹⁷ and in fact states that literature demonstrates that those 'less invasive responses to the risk of suicide can be far more effective than approaches involving force or coercion'.²¹⁸

As regards the balancing element of the 'objective and reasonable standard', the benefit of protecting the person's safety through detention, like that of protecting health, does not seem to outweigh the intrusion on the right to liberty. Furthermore, the differential treatment of persons with mental disabilities seems problematic. As Bartlett and Nilsson point out, although

²¹³ Sascha Callaghan, Christopher Ryan and Ian Kerridge, 'Risk of Suicide is Insufficient Warrant for Coercive Treatment for Mental Illness' (2013) 36 Int JL & Psychiatry 374, 382.

²¹⁴ *ibid.*

²¹⁵ Nilsson (n 193) 474.

²¹⁶ *ibid* 474-75.

²¹⁷ Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms' (n 206) 96-97.

²¹⁸ *ibid* 96.

persons are generally allowed to take risks, even if that involves harmful or life-ending decisions, this is not the case for persons with mental disabilities; their freedom to take similar risks is restricted or denied, for no apparent reason.²¹⁹

3.4.3.3 Protection of safety of others

The third aim that laws that allow for detention of persons with mental disabilities commonly seek to achieve is protection of the safety of others. As Nilsson states, whether detention satisfies the relevance element of the ‘objective and reasonable standard’ depends on whether there is a link between mental disability and violence or increased risk of violence.²²⁰ This is a highly controversial issue that cannot be given any definite answers. Nilsson notes that the association of certain mental disabilities with other factors linked to increased risk of violence, such as substance abuse, antisocial personality traits and socio-economic factors, means that it is difficult to ascertain which ones, if any at all, cause violence.²²¹ She also notes that the same problems of prediction exist in the case of violence against others, as in the case of self-harm.²²²

Furthermore, singling out persons with mental disabilities for involuntary detention in order to protect public safety seems unreasonable. Studies show that there might be some statistical link between mental disability and violence against others, but, as Richardson states, ‘that does not single out mental disorder as in any way unique’.²²³ Richardson argues that ‘there is an even stronger statistical link between drug and alcohol abuse and violence to others, for example, or even between being young and male and driving dangerously’.²²⁴ Nilsson also states that ‘other factors, including gender, age, history of violent behaviour and substance abuse, have proven to be more closely associated with

²¹⁹ Bartlett, ‘A Mental Disorder of a Kind or Degree Warranting Confinement’ (n 199) 837; Nilsson (n 193) 481-82.

²²⁰ Nilsson (n 193) 475.

²²¹ *ibid* 475-76.

²²² *ibid* 476. See also Bartlett, ‘A Mental Disorder of a Kind or Degree Warranting Confinement’ (n 199) 838.

²²³ Richardson (n 202) 73.

²²⁴ *ibid*.

violence and better predictors of future aggression'.²²⁵ Bartlett notes that some studies do show that people with mental disabilities are 'slightly more dangerous than average', but as he states 'the difference is marginal; and the proportion of violence caused by people with mental disabilities is small'.²²⁶

As regards the necessity element of the 'objective and reasonable standard', it can be noted that it is uncertain whether voluntary alternatives to detention would be sufficiently effective in preventing violence against others.

As regards finally the balancing element of the 'objective and reasonable standard', it seems that, similarly to the benefits of protecting the person's health or safety, the benefit of protecting the safety of others through detention does not seem to outweigh the intrusion on the right to liberty. As Nilsson notes, laws generally do not provide for compulsory interventions, including involuntary detention, to prevent violent behaviour; therefore 'the individual's right to liberty and integrity is considered to outweigh the interest to prevent future acts of violence'.²²⁷ However, this does not seem to be the case for persons with mental disabilities. Bartlett notes that, although people are not generally detained based on future dangerousness, and the state can intervene only when criminal behaviour actually occurs, this approach, for no obvious reason, does not apply to preventive detention of persons with mental disabilities.²²⁸ Nilsson suggests that this is due to the increased risk of violence linked to certain mental disabilities. She points out however that there are other factors besides mental disability that indicate increased risk of violence too, several of those even predicting violence more accurately; these factors are nevertheless not used as grounds for preventive detention. As she states, 'it seems incoherent to authorise detention and treatment in some cases of increased risk and at the

²²⁵ Nilsson (n 193) 477.

²²⁶ Bartlett, 'A Mental Disorder of a Kind or Degree Warranting Confinement' (n 199) 837.

²²⁷ Nilsson (n 193) 482.

²²⁸ Bartlett, 'A Mental Disorder of a Kind or Degree Warranting Confinement' (n 199) 837.

same time prohibit preventive detention in other cases where the risk of violent behaviour appears to be even higher'.²²⁹

Having considered the application of the 'objective and reasonable standard' to deprivation of liberty on the basis of mental disability, differential treatment does not appear to be justified. Therefore, even if the CRPD does allow for the possibility to justify differential treatment based on disability - although arguably it does not - , it seems that deprivation of liberty on the basis of mental disability fails to satisfy the 'objective and reasonable standard', and therefore cannot be justified, provided that non-coercive alternatives are equally effective.

3.5 Conclusion

The focus of this chapter was on the CRPD, and particularly its definition of disability and the use of disability as a factor in deprivation of liberty. The chapter sought to determine, first, whether the CRPD adopts the British 'social model' approach to disability or not, and second, the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability.

Section two began with an overview of the CRPD. It was found in particular that it was necessary to have a specific convention for persons with disabilities, because, although existing human rights instruments in theory applied to them, in practice they had failed to sufficiently protect their rights. It was also found that the CRPD is based on a 'holistic approach' that incorporates social development, human rights and non-discrimination elements. It is a 'hybrid' convention, containing civil and political rights, as well as economic, social and cultural rights, and also combines substantive human rights with the principles of equality and non-discrimination. It was finally found that it imposes an obligation on States Parties to abolish any laws that discriminate against persons with disabilities.

Section three focused on the definition of disability under the CRPD, and considered whether it adopts the British 'social model' approach to disability or

²²⁹ Nilsson (n 193) 482-83.

not. Based on how disability is conceived in the text of the CRPD, and particularly the use of the words 'interaction' and 'hinders' in the definition, as well as the relevant discussion during the negotiations, it was found that the CRPD does not adopt the British 'social model' approach, but rather defines disability in a way similar to the ICF understanding.

Finally, section four considered the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability. Based on the relevant discussion that took place during the negotiations, it was found that disability cannot be used as a factor in deprivations of liberty, either alone or in combination with other factors.

This section also examined how the CRPD Committee interprets Article 14 of the CRPD, and its view on deprivation of liberty on the basis of disability. Based on the concluding observations on States Parties reports, and the Statement and Guidelines on Article 14, it was found that the CRPD Committee interprets the right to liberty as absolutely prohibiting deprivation of liberty on the basis of disability. It also takes the view that the use of factors such as 'perceived danger of persons to themselves or to others' and 'alleged need for care or treatment', or any other factors 'tied to impairment or health diagnosis', as basis for involuntary detention of persons with disabilities is contrary to Article 14 of the CRPD.

The final part of section four considered whether the CRPD allows for the possibility to justify deprivation of liberty based on mental disability. The view taken was that the CRPD does not allow for such possibility. Even assuming that it does, it was found that deprivation of liberty on the basis of mental disability fails to meet the 'objective and reasonable standard', and therefore cannot be justified, provided that non-coercive alternatives are equally effective.

Chapter 4 Deprivation of Liberty of Persons with Mental Disabilities under the English law

4.1 Introduction

The previous chapter focused on two issues in relation to the UN Convention on the Rights of Persons with Disabilities (CRPD),¹ namely the definition of disability, and the prohibition of deprivation of liberty on the basis of disability. Regarding the first issue, it was found that the CRPD does not adopt the British ‘social model’ approach, but rather defines disability in a way similar to the WHO’s International Classification of Functioning, Disability and Health (ICF)² understanding. As regards the second issue, it was found that, under the CRPD, disability cannot be used as a factor in deprivations of liberty, either alone or in combination with other factors.

This chapter is concerned with the latter issue, and seeks to situate it within the context of English mental health law. As mentioned in the previous chapter, States Parties, including the UK, are under the obligation to ensure that their laws and practices comply with the requirements of the CRPD. In particular, they are required to ensure the protection of the right of persons with mental disabilities under the CRPD not to be deprived of their liberty on the basis of their disability. The aim of this chapter is therefore to determine whether the English law complies with that requirement.

As a starting point, it should be noted that the English law on mental capacity and deprivation of liberty was reviewed by the Law Commission, and a *Final Report and Draft Bill*³ was published on 13 March 2017. Previously, a

¹ UN Convention on the Rights of Persons with Disabilities (CRPD), GA Res. 61/106, UN Doc. A/RES/61/106, 24 January 2007 <http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/61/106&Lang=E> accessed 16 December 2019.

² WHO, ICF, Res. WHA 54.21 (WHO 2001).

³ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) <http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf> accessed 16 December 2019.

*Consultation Paper*⁴ that contained their reform proposals was published on 7 July 2015, and an *Interim Statement*⁵ was published on 25 May 2016. The *Government's Final Response* to the Law Commission's report was published on 14 March 2018,⁶ and agreed in principle with the Law Commission's recommendations. The Mental Capacity (Amendment) Act 2019 (MCA(A) 2019) has now been passed that will replace the Deprivation of Liberty Safeguards (DoLS), contained in the Mental Capacity Act 2005 (MCA 2005), with a new scheme called the 'Liberty Protection Safeguards' (LPS). The proposals of the Law Commission and the relevant new provisions will be briefly discussed at the end, but the focus of this chapter will be on the DoLS, as those are still in force until at least Spring 2020.

Currently in England there are two statutes that include provisions in relation to the deprivation of liberty of persons with mental disabilities; the Mental Health Act 1983 (MHA 1983) and the Mental Capacity Act 2005 (MCA 2005), both as amended by the Mental Health Act 2007 (MHA 2007). The MHA 1983 allows for detention mainly under sections 2 and 3, and the MCA 2005 allows for detention under the Deprivation of Liberty Safeguards (DoLS) in Schedules A1 and 1A. It must be noted however that, although both statutes provide powers to deprive persons with mental disabilities of their liberty, they are very different pieces of legislation.

On the one hand, the MHA 1983 provides the legal framework for the compulsory admission and treatment of people in hospital for their mental disorder; the disorder must be of a nature or degree that justifies detention, either for their own health or safety or for the protection of others.

⁴ Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (Law Com CP No 222, 2015) <http://www.lawcom.gov.uk/wp-content/uploads/2015/07/cp222_mental_capacity.pdf> accessed 16 December 2019.

⁵ Law Commission, *Mental Capacity and Deprivation of Liberty: Interim Statement*, 25 May 2016 <http://www.lawcom.gov.uk/app/uploads/2016/06/mental_capacity_interim_statement.pdf> accessed 16 December 2019.

⁶ Department of Health and Social Care, *Final Government Response to the Law Commission's Review of Deprivation of Liberty Safeguards and Mental Capacity: Written statement - HCWS542*, 14 March 2018 <<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-03-14/HCWS542/>> accessed 16 December 2019.

On the other hand, the MCA 2005 provides the legal framework for making decisions, including those in relation to health and welfare matters, on behalf of people who lack the mental capacity to decide for themselves; they must lack the mental capacity to make a specific decision at a specific time, and decisions must be made in their best interests.

The DoLS in particular provide the legal framework for deprivation of liberty in hospitals and care homes of people who lack capacity to decide about accommodation for the purpose of being given care or treatment.

The following two sections will examine whether the MHA 1983 and the MCA 2005 comply with the obligation under Article 14(1)(b) of the CRPD to prohibit deprivation of liberty on the basis of mental disability. It is argued that both statutes fail to comply with that obligation.

4.2 Mental Health Act 1983

As already noted, the MHA 1983 provides the legal framework for the compulsory admission and treatment of people in hospital for their mental disorder.⁷ The main civil detaining⁸ powers under the MHA 1983 are found in sections 2 and 3, which allow for admission for assessment and admission for treatment respectively.

The power of admission provided for by section 2 allows for detention for up to 28 days for assessment of mental disorder or for assessment followed by treatment. Thus, persons detained under section 2 can also be given treatment without consent. Section 3 provides for admission for treatment and, pursuant to section 20(1), detention is allowed for up to six months; it may be renewed for six months, then for one year and so on for one year at a time.⁹ Detention under section 2 cannot be renewed; however, a person may then be placed on

⁷ For a detailed analysis of the process and procedures for detention under the MHA 1983, see the leading textbook in this area: Peter Bartlett and Ralph Sandland, *Mental Health Law: Policy and Practice* (4th edn, OUP 2014) 236-77. See also Peter Bartlett, 'Civil Confinement' in Lawrence Gostin and others (eds), *Principles of Mental Health Law and Policy* (OUP 2010) 413-72; Phil Fennell, *Mental Health: Law and Practice* (2nd edn, Jordan Publishing Ltd 2011) 201-10.

⁸ Civil detention refers to the detention of non-offender patients, also called 'civil patients'.

⁹ MHA 1983, ss 20(2)(a) and 20(2)(b).

detention under section 3. A person may be admitted for treatment without having first been detained under section 2. Also, there is a power under the MHA 1983 to admit and detain a person for assessment for up to 72 hours, in cases of emergency. In particular, section 4 provides for admission in case of 'urgent necessity', where compliance with the requirements of section 2 'would involve undesirable delay'.

In order to determine whether the law authorises detention on the basis of mental disability, it is essential to examine the substantive criteria for detention under sections 2 and 3.

Section 2(1) states that 'a patient may be admitted to a hospital and detained there', when an application for admission for assessment has been made that meets the requirements of section 2. The grounds for making the application are found in subsection (2):

(a) [The patient] is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) [the patient] ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

Therefore, there are three criteria for detention under section 2: first, presence of a mental disorder; second, detention must be warranted by the nature or degree of the mental disorder; third, detention must be justified in the interests of the person's own health or safety, or with a view to the protection of others.

Section 3(1) states that 'a patient may be admitted to a hospital and detained there', when an application for admission for treatment has been made that meets the requirements of section 3. The grounds for making the application are found in subsection (2):

(a) [The patient] is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and;

(d) appropriate medical treatment is available for him.

Therefore, there are five criteria for detention under section 3: first, presence of a mental disorder; second, it must be appropriate to receive medical treatment in hospital due to the nature or degree of the mental disorder; third, receiving medical treatment must be necessary for the person's own health or safety, or for the protection of others; fourth, detention must be the only available means for providing medical treatment; fifth, appropriate medical treatment must be available.

In considering the criteria provided for in sections 2 and 3, it can be noted that the triggering factor for the application of the MHA 1983 is the presence of a mental disorder. The MHA 1983 only applies to those who are suffering from mental disorders, and this is the only group of people who can be subjected to its compulsory powers. Regarding specifically detention, the presence of mental disorder is clearly required for admissions for assessment or treatment. It can therefore be argued that the MHA 1983 does authorise detention on the basis of mental disability.

Also, as the Act makes special regulations for intervention in the case of people with mental disabilities, including allowing their civil detention and therefore interfering with their right to liberty, it can be argued that it directly discriminates against them. As mentioned in the previous chapter, these restrictions upon liberty that are linked to mental disability violate the CRPD and are incompatible with its requirements. Article 5(2) requires States Parties to

prohibit all discrimination on the basis of disability,¹⁰ which is defined in Article 2 as:

[A]ny 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.

Also Article 14(1)(b) prohibits deprivations of liberty on the basis of disability and clearly states that ‘the existence of disability shall in no case justify a deprivation of liberty’. It has already been found that this includes detention that is not solely based on mental disorder or disability, but also on other grounds such as dangerousness to self or others, or health care grounds.

The MHA 1983 indeed uses these additional factors as justification for involuntary detention. As noted above, the criteria for detention require not only the presence of mental disorder, but also considerations relevant to the person’s own health or safety, or the protection of others. However, the inclusion of these other grounds does not suffice to ensure compliance with the CRPD. Since, and as long as, the presence of mental disorder is a requirement and forms part of the grounds for detention, the legal basis for detention under the MHA 1983 is, and will be, incompatible with the CRPD, and in particular contrary to Article 14.

Nevertheless, for the purpose of understanding the aims and objectives of the MHA 1983, and specifically the reasons why it authorises the involuntary detention of people with mental disorders, it is essential to examine the substantive criteria in more detail.

4.2.1 Criteria for detention

As noted above, the factors that need to be considered for detention under the MHA 1983 are found in sections 2 and 3. These are: The presence of mental

¹⁰ For the CRPD Committee’s interpretation of Article 5, see CRPD Committee, *General Comment No.6(2018)onEqualityandNonDiscrimination*, UNDoc.CRPD/C/GC/6, 26 April 2018 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/GC/6> accessed 16 December 2019.

disorder, the nature or degree of that mental disorder, the presence of risk to the person's health or safety or to other persons, alternatives to detention, and the availability of appropriate treatment.

4.2.1.1 Presence of mental disorder

The presence of mental disorder is the main requirement for detention under the MHA 1983. Unless a person is suffering from a mental disorder, it is legally impossible to be admitted for assessment or treatment. The current¹¹ definition of mental disorder in the MHA 1983 is 'any disorder or disability of the mind'.¹²

As a first point, it can be noted that this definition is very general; it does not give a specific explanation or further clarification of the meaning of mental disorder. This might seem to be confusing as regards the applicability of the MHA 1983. Some guidance is offered by the MHA 1983 Code of Practice (MHA CoP),¹³ which provides a list of mental conditions that could be included in the definition, such as affective disorders, schizophrenia, neurotic disorders, organic mental disorders and personality disorders.¹⁴ However, it is clearly stated that this is a non-exhaustive list, and, although it is emphasised that the determination of whether a person has a mental disorder for the purposes of the MHA 1983 should be made in accordance with 'good clinical practice and accepted standards' of what constitutes such a mental disorder,¹⁵ it seems that a significant degree of discretion is given to the relevant professionals in deciding whether that person should be detained under the MHA 1983. In fact, as stated in the *White Paper*¹⁶ that was produced during the most recent reform of the MHA 1983, the definition of mental disorder should be broad in order 'to ensure

¹¹ For a historical overview of the legal categorisation of mental disorder, see Andrew Forrester and others, 'The Evolution of Mental Disorder as a Legal Category in England and Wales' (2008) 19 *The Journal of Forensic Psychiatry & Psychology* 543.

¹² MHA 1983, s 1(2).

¹³ Department of Health, *MHA 1983: Code of Practice* (TSO 2015). Note that the MHA CoP provides statutory guidance to certain professionals, including registered medical practitioners, approved clinicians, and approved mental health professionals, on how they should carry out their functions under the MHA 1983. Although they do not have a legal duty to comply with the MHA CoP, they must have regard to it and departures could give rise to legal challenge.

¹⁴ *ibid* figure 1.

¹⁵ *ibid* para 2.4.

¹⁶ Department of Health, *Reforming the MHA: Part I - The New Legal Framework (White Paper, Cm 5016-I, 2000)*.

that the presence, or absence, of any one particular clinical condition does not limit the discretion of clinicians to consider whether a patient with mental disorder should be treated under compulsory powers'.¹⁷

Also, despite the general definition of mental disorder, section 1 of MHA 1983 specifically contains one exclusion and one qualification; it excludes dependence on alcohol or drugs from its scope,¹⁸ and for some specific sections of the MHA 1983, including section 3 – but not section 2 –, people with learning disabilities will only be considered to be suffering from a mental disorder if the disability is 'associated with abnormally aggressive or seriously irresponsible conduct'.¹⁹ Based on that, it can be argued that the MHA 1983 has a very wide scope of application; it seems that any mental disorder that is not explicitly excluded or qualified could come within its scope, which means that the compulsory powers of the MHA 1983 apply to a significantly large number of people.

It is worth noting that, prior to the MHA 2007 amendments,²⁰ there were four categories of mental disorder, namely 'mental illness', 'psychopathic disorder', 'mental impairment' and 'severe mental impairment'. These have now been removed from the MHA 1983, and the current definition of mental disorder does not distinguish between any categories. That might be problematic, because it could be seen as ignoring the different issues related to specific mental conditions, and suggesting that all mental conditions should be treated under the same compulsory powers.²¹

Furthermore, the removal of the categories has extended the scope of detention, and specifically detention under section 3. In particular, prior to the MHA 2007 amendments, although admission for assessment simply required a 'disorder or disability of the mind', a person could only be admitted for treatment under one of the four categories. Now, the MHA 1983 applies the broad definition of

¹⁷ *ibid* para 3.3.

¹⁸ MHA 1983, s 1(3).

¹⁹ MHA 1983, s 1(2A).

²⁰ For an analysis of the 2007 amendments to the criteria for detention in the MHA 1983, see Paul Bowen, *Blackstone's Guide to the MHA 2007* (OUP 2007) 33-56.

²¹ See Forrester (n 11) 554-55, 557.

mental disorder to both section 2 and section 3, and therefore allows for a wider scope of detention, as more people may be involuntarily admitted for treatment. A practical example of the effect of abolishing the categories, as given in the Explanatory Notes to the MHA 2007,²² is that section 3 now covers forms of personality disorder that were not previously covered. In particular, section 1(2) of the MHA 1983, before being amended, defined psychopathic disorder as ‘a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned’. That meant that those personality disorders that could not fall under this definition because they did not result in ‘abnormally aggressive or seriously irresponsible conduct’, and could not be considered to be ‘mental illness’, were not covered by section 3. By using a single broad definition of mental disorder, the MHA 1983 as amended has widened the scope of section 3 to cover all types of personality disorder, which now fall under ‘any disorder or disability of the mind’.²³

4.2.1.2 Nature or degree

The second factor that needs to be considered for detention under the MHA 1983 is the ‘nature and degree’ of the mental disorder. In particular, the mere presence of a mental disorder will not suffice; a person suffering from mental disorder cannot be admitted under sections 2 and 3 of the MHA 1983, unless that mental disorder is of such a nature or degree that justifies detention.

As established in *R v Mental Health Review Tribunal for the South Thames Region, ex p Smith*,²⁴ the words ‘nature’ and ‘degree’ are not interchangeable; they can be read disjunctively, and the relevant criterion will be satisfied if either – or both – meet the required standard for detention. The Reference Guide to the MHA 1983 (MHA RG), citing *Smith*, states that ‘nature’ refers to ‘the particular mental disorder from which the patient is suffering, its chronicity, its

²²Explanatory Notes to the MHA 2007 <http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpgaen_20070012_en.pdf> accessed 16 December 2019.

²³ *ibid* para 19.

²⁴ *R v Mental Health Review Tribunal for the South Thames Region, ex p Smith* (1998) 47 BMLR 104.

prognosis, and the patient's previous response to receiving treatment for the disorder', whereas 'degree' refers to 'the current manifestation of the patient's disorder'.²⁵ The same definitions are also used in the MHA CoP.²⁶

The distinction between 'nature' and 'degree' means that, where a mental disorder has not reached a sufficient degree for detention, or even where the person is not presenting with any symptoms at all, they might still be detained under the MHA 1983 on the basis of the nature of the mental disorder, if that mental disorder is chronic and will deteriorate if treatment is ceased, and the person has a history of relapse when stopped taking medication.

It should be noted that, although the definitions in the MHA CoP and the MHA RG clarify the meaning of 'nature' and 'degree', they do not specify what the required standard for detention is. Nor is that specified in the MHA 1983 itself; instead, as Peter Bartlett and Ralph Sandland point out, the language used in sections 2 and 3 is 'extraordinary flexib[le]' and allows for 'a very broad discretion'.²⁷ Thus, it is not clear what the nature or degree of a mental disorder must be in order to 'warrant' detention or 'make it appropriate' to receive medical treatment.

4.2.1.3 Presence of risk

The most important criterion for detention under the MHA 1983 is arguably the risk that the person poses to themselves or others. In particular, while the mental disorder criterion can be considered to be the triggering factor for, and the key determinant of, the application of the MHA 1983, the nature or degree criterion qualifies the mental disorder criterion, and the remaining criteria - least restrictive option and availability of treatment - can be considered to be safeguards or additional requirements, the risk criterion can be seen as

²⁵ Department of Health, *Reference Guide to the MHA 1983* (TSO 2015) para 8.3 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf> accessed 16 December 2019. Note that the purpose of the MHA RG is to provide statutory guidance and an explanation of the provisions of the MHA 1983, and should be read together with the MHA CoP.

²⁶ MHA CoP (n 13) para 14.6.

²⁷ Bartlett and Sandland (n 7) 253.

representing the justification of compulsory detention and also revealing the key policy goal of the MHA 1983, namely the protection of personal and public safety.²⁸

As a starting point, it can be noted that the risk criterion as the legal basis for compulsory detention of those with mental disorders reflects two traditional doctrines, namely the 'parens patriae' authority and the 'police power' of the State. The 'parens patriae' authority refers to the role of the State of caring for those who are unable to care for themselves, whereas the 'police power' refers to the role of the State of protecting its citizens from harm.²⁹ Thus, the former is based on the person's presumed mental incapacity to make their own decisions, and the latter is based on the person's presumed dangerousness.

It should be noted that the State uses its 'police power' primarily in the context of criminal law, for those who have engaged in criminal activity, where coercion is justified on grounds of blameworthiness and sanctions resulting to loss of liberty are imposed as punishment. This is not the case in the civil detention of persons with mental disorders, where the 'police power' is used to detain people who have not been convicted for, or even charged with, an offence. The punitive interest is therefore absent, and detention is instead imposed preventively on the basis of predicted dangerousness.

Preventive detention, however, is highly controversial, as there are significant concerns in relation to 'dangerousness'; first regarding the vagueness of the concept, but most importantly regarding the difficulties in accurately predicting

²⁸ Phil Fennell has repeatedly stated that the 'primary driver' of mental health legislation has always been 'risk management': see for example Philip Fennell, 'Reforming the Mental Health Act 1983: "Joined Up Compulsion"' (2001) 5 *Journal of Mental Health Law* 5, 5; Philip Fennell, 'Mental Health Law and Risk Management' in Keith Soothill, Paul Rogers and Mairead Dolan (eds), *Handbook of Forensic Mental Health* (2nd edn, Willan Publishing 2012) 267.

²⁹ On these doctrines, see Lawrence Custer, 'The Origins of the Doctrine of *Parens Patriae*' (1978) 27 *Emory LJ* 195; Saleem Shah, 'Legal and Mental Health System Interactions: Major Developments and Research Notes' (1981) 4 *Int JL & Psychiatry* 219, 221-22; Michael Cavadino, *Mental Health Law in Context: Doctor's Orders?* (Dartmouth Publishing 1989) 132; Eric Janus, 'Toward a Conceptual Framework for Assessing Police Power Commitment Legislation: A Critique of Schopp's and Winick's Explications of Legal Mental Illness' (1997) 76 *Neb L Rev* 1, 2-3; Robert Schopp, *Competence, Condemnation, and Commitment: An Integrated Theory of Mental Health Law* (American Psychological Association 2001) 17-20; Paul Appelbaum and Thomas Gutheil, *Clinical Handbook of Psychiatry & the Law* (4th edn, Lippincott Williams & Wilkins 2007) 41-42.

it. In fact, it would seem that not only it is impossible to predict *with certainty* that a person will engage in violent behaviour in the future, but also it is extremely difficult for such a prediction to be made even on the basis of *likelihood*.³⁰ Therefore, even if systematic tools for risk assessment are used, predictions of future violence are problematic in their reliability and validity, and the decision to detain is discretionary and largely depends on who is assessing the person with mental disorder.³¹ As Nicola Glover-Thomas states, 'risk is an open-ended construct' and a matter to be assessed and interpreted by decision-makers 'in accordance with their professional judgment and experience'.³²

Turning now to the MHA 1983, the risks to be considered for detention under sections 2 and 3 are risk to own health, risk to own safety and risk to others. In particular, it must be determined that, for admission for assessment, the person 'ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons'³³ or, for admission for treatment, 'it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment'.³⁴ It must therefore be considered whether the person with mental disorder presents a risk to self or others that justifies his or her detention.

As the MHA CoP states, people with mental disorders may need to be detained for their own safety, if for example they are at risk of self-harm or self-neglect, or their own health, if for example their disorder will deteriorate if they do not receive treatment.³⁵ However, even if they do not need to be detained for their

³⁰ See Saleem Shah, 'Some Interactions of Law and Mental Health in the Handling of Social Deviance' (1974) 23 Cath UL Rev 674, 704-06; Ferdinand Schoeman, 'On Incapacitating the Dangerous' (1979) 16 Am Phil Q 27, 28-30; Shah, 'Legal and Mental Health System Interactions' (n 29) 235-39; Stephen Morse, 'Blame and Danger: An Essay on Preventive Detention' (1996) 76 BUL Rev 113, 115-16; Michael Corrado, 'Punishment and the Wild Beast of Prey: The Problem of Preventive Detention' (1996) 86 J Crim L & Criminology 778, 792-94.

³¹ See Schoeman (n 30) 30; Bartlett, 'Civil Confinement' (n 7) 420.

³² Nicola Glover-Thomas, 'The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007' (2011) 19 Med L Rev 581, 584.

³³ MHA 1983, s 2(2)(b).

³⁴ *ibid* s 3(2)(c).

³⁵ MHA CoP (n 13) para 14.9.

own health or safety, detention may still be necessary for the protection of others, if they pose a risk of harm to other people.³⁶

It is important to emphasise that either of the above three factors - the person's health, his or her safety, and the protection of others - may be used to justify detention under the MHA 1983. Therefore, as Phil Fennell points out, there is no need for the person to pose a risk of harm to their own or other people's safety; even if they are not dangerous to themselves or others, the MHA 1983 allows for them to be detained, 'on "strong paternalist" grounds', solely in the interests of their own health.³⁷

The next issue to be considered is patient and public protection as the main priority of the MHA 1983; this is evident in the government publications during the reform process. First, regarding the principles that should underpin mental health legislation, the *Green Paper*³⁸ clearly disagreed with the approach adopted in the *Expert Committee's Report (Richardson Report)*.³⁹ In particular, the Expert Committee put a lot of emphasis on the principles of non-discrimination and patient autonomy. As stated in the *Richardson Report*, their approach was based on the 'fundamental desire' to treat mental ill health and physical ill health according to similar principles; as capable refusals of treatment for physical disorder must be respected, promotion of non-discrimination leads 'inevitably' to promotion of patient autonomy.⁴⁰ The Expert Committee's recommendations included the recognition of the principle that 'wherever possible the principles governing mental health care should be the same as those which govern physical health',⁴¹ and also that patient autonomy should be expressly stated in the Act as the guiding principle.⁴²

³⁶ *ibid* 14.10.

³⁷ Fennell, *Mental Health* (n 7) 202.

³⁸ Department of Health, *Reform of the MHA 1983: Proposals for Consultation (Green Paper, Cm 4480, 1999)*.

³⁹ Department of Health, *Report of the Expert Committee: Review of the Mental Health Act 1983 (Richardson report, 1999)*. The Expert Committee, chaired by Geneva Richardson, was established in 1998 with the task to advise on how mental health law should be reformed.

⁴⁰ *ibid* para 2.1.

⁴¹ *ibid* para 2.15.

⁴² *ibid* para 2.18.

However, as Geneva Richardson puts it, ‘the government was never convinced by the arguments of non-discrimination and patient autonomy’,⁴³ and the *Green Paper* refused to adopt these principles. Significant weight was given instead to patient and public safety, and the inclusion of the following principle was proposed: ‘the safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed’.⁴⁴ The *Green Paper* emphasised that the MHA 1983 is primarily concerned with *compulsory* care and treatment; autonomy could not be used as guiding principle, and informal consensual care would be supported ‘wherever this is consistent with the patient’s best interests and safety and the safety of the public’.⁴⁵

The *Green Paper* also disagreed with the Expert Committee’s recommendation regarding the criteria for compulsory powers, and particularly with the view that the person’s capacity to consent to care and treatment for mental disorder should be given a central role within mental health law. The *Richardson Report* recommended that compulsory powers could be used in the case of persons who lack the capacity to make treatment decisions, but in the case of persons who retain such capacity, a higher threshold of risk would be required; in particular, they could not be subject to compulsion, unless they pose a ‘substantial risk of serious harm’.⁴⁶

That recommendation was rejected by the *Green Paper*. In the government’s view, whether or not a person is capable of making their own decisions regarding care and treatment for mental disorder is irrelevant for the purposes of mental health law. Emphasis was placed once again on risk, and the *Green Paper* stated that what is ‘crucial’ to the decision on whether or not to use compulsory powers is ‘the *degree of risk* that patients with mental disorder pose, to themselves or

⁴³ Geneva Richardson, ‘Balancing Autonomy and Risk: A Failure of Nerve in England and Wales?’ (2007) 30 Int JL & Psychiatry 71, 75. See also Geneva Richardson, ‘Reforming Mental Health Laws: Principle or Pragmatism?’ (2001) 54 CLP 415, 424-25.

⁴⁴ Department of Health, *Green Paper* (n 38) ch 3, para 4.

⁴⁵ *ibid* ch 3, para 7.

⁴⁶ Department of Health, *Richardson report* (n 39) para 5.95.

others'.⁴⁷ It is therefore clear that the *Green Paper* disregarded the principles of non-discrimination and patient autonomy and prioritised instead the principle of reducing the risk of harm, although, as George Szmukler and Frank Holloway point out, left unexplained 'where this principle comes from and why it should be primary'.⁴⁸

The importance of risk continued to be emphasised in the *White Paper*, where it was stated that, while formal care and treatment should reflect the person's best interests, 'concerns of risk will always take precedence'.⁴⁹ Also, in their response (*Government Response*)⁵⁰ to the *Joint Scrutiny Committee's Report (JC Report)*,⁵¹ the government disagreed with the Joint Committee on what the purpose of mental health legislation should be. According to the *JC Report*, the primary purpose must be the improvement of services and safeguards and the reduction of the stigma of mental disorder.⁵² However, the *Government Response* firmly asserted that mental health legislation 'is not about improving services', but instead 'about the legal processes for bringing people under compulsion'.⁵³

It was also stated in the *Government Response* that the only way to overcome the stigma of mental illness is to bring people with mental disorders under compulsion, because otherwise the public will be concerned about the risk posed to public safety; therefore, compulsion is in the interests of those with mental disorders.⁵⁴ It can however be argued that bringing people with mental disorders under formal legal compulsion only adds to the stigma. Considering the interaction between law and society, the existence of specialist mental health legislation perpetuates the fear of mental health problems, and confirms the

⁴⁷ Department of Health, *Green Paper* (n 38) ch 5, para 6.

⁴⁸ George Szmukler and Frank Holloway, 'Reform of the Mental Health Act: Health or Safety?' (2000) 177 *The British Journal of Psychiatry* 196, 196.

⁴⁹ Department of Health, *White Paper* (n 16) para 2.16.

⁵⁰ Department of Health, *Government Response to the Report of the Joint Committee on the Draft Mental Health Bill (Government response, Cm 6624, 2005)*.

⁵¹ Joint Committee on the Draft Mental Health Bill, *Draft Mental Health Bill (JC report, HL Paper 79-I, HC 95-I, Session 2004-05)*.

⁵² *ibid* 5.

⁵³ Department of Health, *Government response* (n 50) 4.

⁵⁴ *ibid* 5.

assumption that persons with mental disorders pose a risk of harm and therefore need to be detained and treated with or without their consent.

Regarding the aims of the MHA 1983, although the *JC Report* accepted 'effective risk management and public protection' as an objective of mental health legislation and policy, it recommended that this 'must never be allowed to predominate as the primary objective of reform'.⁵⁵ The *Government Response* took the view that the correct balance was achieved between individual rights and protection from harm, and noted the introduction of safeguards that help ensure that patients' rights or liberty are not inappropriately affected by compulsory treatment.⁵⁶ Nevertheless, given the emphasis placed on risk, it seems questionable whether the right balance was indeed struck, and whether procedural safeguards suffice to protect individual rights.

Finally, the *JC Report* expressed concerns over the risk criterion for the use of compulsory powers. In particular, it recommended that both in cases where compulsion is necessary in the person's own interests and where it is necessary for the protection of others the criterion should be tightened, and the view taken was that in both cases it should require 'serious harm'.⁵⁷ Although the relevant recommendations were rejected by the *Government Response*,⁵⁸ it can be argued that, without such a requirement and in the absence of clarification of the risk criterion, combined with the broad definition of mental disorder and the lack of a mental capacity criterion, the scope of detention under the MHA 1983 is inappropriately wide.

As Rowena Daw argues, throughout the reform process the government 'remained obsessed with the "problem" of risk and the need to give clinicians every power they might need to contain it'.⁵⁹ Consequently, the MHA 1983 puts too much weight on prevention of harm at the expense of other interests,

⁵⁵ *JC report* (n 51) 15.

⁵⁶ Department of Health, *Government response* (n 50) 7.

⁵⁷ *JC report* (n 51) 44-47.

⁵⁸ Department of Health, *Government response* (n 50) 14.

⁵⁹ Rowena Daw, 'The Mental Health Act 2007 – The Defeat of an Ideal' (2007) 16 *Journal of Mental Health Law* 131, 132. See also Laura Davidson, 'Human Rights vs Public Protection: English Mental Health Law in Crisis?' (2002) 25 *Int JL & Psychiatry* 491, 494-95.

including respect for patient autonomy, non-discrimination and individual rights. Even more so, the fact that mental health policy was mostly informed by documents on homicides by persons with mental disorders and rarely by statistics on self-harm, as Fennell points out,⁶⁰ would appear to suggest that, despite the stated emphasis on protecting both the patient and the public, the MHA 1983 is in fact concerned primarily with public, rather than personal, safety.

4.2.1.4 **Least restrictive option**

The fourth condition that needs to be met for detention under section 3 of the MHA 1983 is that treatment 'cannot be provided unless [the person] is detained under this section'.⁶¹ Therefore, this criterion requires consideration of alternatives to detention that are less restrictive, and it must be determined that detention under section 3 is the only available means for providing treatment.

This requirement is based on the 'least restrictive option' principle, which is one of the guiding principles of the MHA 1983 included in the MHA CoP. In particular, the MHA CoP states that 'where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained',⁶² and that any restrictions imposed should be kept to the 'minimum necessary'.⁶³

Alternative ways of providing care and treatment, which might be less restrictive than detention under section 3, include, as mentioned in the MHA CoP, informal admission, treatment under the MCA 2005, the DoLS or a Court of Protection order in those cases where deprivation of liberty is necessary, management in the community and guardianship.⁶⁴

⁶⁰ Phil Fennell, 'Protection! Protection! Protection! Déjà Vu All Over Again. The Government Response to the Parliamentary Scrutiny Committee' (2005) 13 Journal of Mental Health Law 110, 115.

⁶¹ MHA 1983, s 3(2)(c).

⁶² MHA CoP (n 13) para 1.2.

⁶³ *ibid* para 1.5.

⁶⁴ *ibid* para 14.11.

4.2.1.5 Availability of appropriate medical treatment

For detention under section 3 of the MHA 1983, the fifth requirement is that 'appropriate medical treatment is available' for the person.⁶⁵ The 'appropriate treatment' test was introduced by the MHA 2007, and replaced the 'treatability' test, which previously applied to detention under section 3.

In particular, prior to the MHA 2007 amendments and the removal of the classifications of mental disorder, a person who had been classified as suffering from 'psychopathic disorder' or 'mental impairment' could not be detained under section 3, unless treatment was 'likely to alleviate or prevent a deterioration of his condition'.⁶⁶ Thus, therapeutic purpose was important to detention, and, if such treatment was not available, the person could not be detained because he or she was not 'treatable'. The removal of the 'treatability' test, as Bartlett notes, therefore appeared as intention to move away from a 'therapeutic model of confinement', to one which is based on 'social control and dangerousness'.⁶⁷ Nevertheless, the 'treatability' test posed significant problems as criterion for detention under section 3, mainly due to the difficulties in predicting whether the treatment would alleviate or prevent the deterioration of the person's condition.⁶⁸

As a result of the introduction of the 'appropriate treatment' test, the factor that needs to be considered for detention under section 3 is the availability of appropriate medical treatment for the person, rather than the availability of treatment that is likely to alleviate or prevent deterioration of their condition. It should also be noted that, since the classifications of mental disorder have been removed, the 'appropriate treatment' test now applies for 'any disorder or disability of the mind'.

The meaning of 'appropriate treatment' for a person with mental disorder is clarified in new section 3(4) of the MHA 1983, and refers to medical treatment

⁶⁵ MHA 1983, s 3(2)(d).

⁶⁶ *ibid* s 3(2)(b), repealed by the MHA 2007.

⁶⁷ Bartlett, 'Civil Confinement' (n 7) 424.

⁶⁸ Fennell, *Mental Health* (n 7) 85.

‘which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case’. ‘Other circumstances’ might include, as mentioned in the MHA CoP, the person’s physical health, their age, the location of the available treatment, implications for their family and social relationships or for their education or work, consequences of not receiving the treatment, and their views and wishes regarding treatment.⁶⁹

‘Medical treatment’ as defined in the MHA 1983 ‘includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care’.⁷⁰ Also, the new section 145(4) of the MHA 1983 states that medical treatment for mental disorder is ‘medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations’. Paul Bowen therefore suggests that the MHA 1983 as amended includes a new ‘treatability’ test.⁷¹ However, it is now only required that the medical treatment has the ‘purpose’ of alleviating, or preventing a worsening of mental disorder; it need not be ‘likely’ to achieve a beneficial effect. This is a significant distinction; as the MHA CoP states, ‘purpose is not the same as likelihood’, and a medical treatment may be included in the section 145(4) definition ‘even though it cannot be shown in advance that any particular effect is likely to be achieved’.⁷²

It should finally be noted that, as stated in the MHA CoP, it is always required that medical treatment is appropriate for the person with mental disorder and, although not required, ideally it should be ‘the most appropriate treatment available’.⁷³ It is however a requirement that the medical treatment is ‘actually available’ to the person, and ‘it is not sufficient that appropriate treatment could theoretically be provided’.⁷⁴

⁶⁹ MHA CoP (n 13) para 23.12.

⁷⁰ MHA 1983, s 145(1).

⁷¹ Bowen (n 20) 47.

⁷² MHA CoP (n 13) para 23.4.

⁷³ *ibid* para 23.13.

⁷⁴ *ibid* para 23.14.

Having examined the criteria for detention under the MHA 1983, it was found that great emphasis is placed on risk; personal and public safety is the primary concern of the MHA 1983. The presence of mental disorder, defined as ‘any disorder or disability of the mind’ is nevertheless the main requirement for detention under the MHA 1983. The inclusion of additional factors does not suffice to ensure compliance with the CRPD; as detention is clearly authorised on grounds of mental disorder, the MHA 1983 fails to comply with Article 14 that prohibits deprivation of liberty on the basis of mental disability.

It is important to note at this point that the Government recently commissioned an independent review into the MHA 1983. An *Interim Report*⁷⁵ was published in May 2018, and the *Final Report*⁷⁶ was published in December 2018. The *Final Report* acknowledges that it does not go as far as to recommend the full implementation of the CRPD, meaning the abolition of mental health legislation, as this in their opinion would result in no protections against exploitation and excessive detention,⁷⁷ and would prevent intervention that would stop persons from harming themselves or others.⁷⁸ However, it does state that both the place and the need for coercion need to be reduced, and steps should be taken to ‘ensure that detention is truly a last resort, foremost among which is providing more and better alternatives’.⁷⁹

The *Final Report* indeed makes some positive recommendations. Importantly, it recommends including principles in the MHA 1983, one of them being the ‘Least Restriction’ principle that would require using the compulsory powers in the

⁷⁵ Department of Health and Social Care, *The Independent Review of the MHA: Interim Report*(2018)<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703919/The_independent_Mental_Health_Act_review_interim_report_01_05_2018.pdf> accessed 16 December 2019.

⁷⁶ Department of Health and Social Care, *Modernising the MHA: Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the MHA 1983* (2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice_reducing_compulsion.pdf> accessed 16 December 2019.

⁷⁷ *ibid* 12-13.

⁷⁸ *ibid* 62.

⁷⁹ *ibid* 13.

least restrictive way, and always considering less restrictive alternatives.⁸⁰ The *Final Report* suggests that the Government should resource policy development looking into alternatives to detention, focusing on improving crisis and community-based mental health services that support people and prevent crisis or the escalation of crisis and accordingly the need for admission.⁸¹

Furthermore, regarding the criteria for detention, the *Final Report* states that currently they are vague, and allowing detention based on grounds that it is 'necessary for' or 'justified in the interests of' the person's health or safety or 'for the protection of others' 'sets the bar too low'. Detention should only be permitted in the most serious of cases; it should not be possible to allow it based on 'any vague notion of risk'. Instead, the likelihood and seriousness of harm must be substantial, and that must be backed up by evidence, in order for detention to be justified. The *Final Report* therefore recommends that the criteria for detention should be strengthened to require that 'there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person'.⁸²

Although the *Final Report* does not go as far as recommending the abolition of compulsory detention, and anything sort of elimination will fail to comply with the CRPD requirements, its proposals to reduce coercion in the mental health setting are certainly a step in the right direction.

The following section will now examine the DoLS requirements for deprivation of liberty, found in the MCA 2005, in order to determine whether they comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

4.3 Mental Capacity Act 2005

As already stated, the MCA 2005 provides the legal framework for making decisions, including those in relation to health and welfare matters, on behalf of people who lack the mental capacity to decide for themselves. It should be noted

⁸⁰ *ibid* 66.

⁸¹ *ibid* 104-06.

⁸² *ibid* 110-11.

at this point that it is beyond the scope of this thesis to examine the compatibility of the MCA 2005 as a substitute decision-making regime with the CRPD, and particularly with Article 12, which protects the right to equal recognition before the law and requires that persons with disabilities enjoy legal capacity⁸³ on an equal basis with others.⁸⁴ Instead, discussion will be focused specifically on deprivation of liberty.

Deprivation of liberty under the MCA 2005 is governed by the DoLS, contained in Schedules A1 and 1A and introduced by the MHA 2007. The MCA 2005 is supported by the MCA 2005 Code of Practice (MCA CoP),⁸⁵ and there is also a Code of Practice specifically for the DoLS (DoLS CoP).⁸⁶

Before examining the DoLS requirements, it would be useful to first examine how the MCA 2005 defines lack of capacity, as this is the triggering factor for its application.

4.3.1 Lack of mental capacity

As stated in the introduction, the MCA 2005 operates on the basis of mental incapacity, as opposed to the MHA 1983 that operates on the basis of mental disorder. It applies in particular to those who lack the mental capacity to make

⁸³ Note the distinction between ‘mental’ and ‘legal’ capacity. ‘Mental capacity’ refers to decision-making ability, whereas ‘legal capacity’ refers to the ability to be recognised as a person before the law and holder of rights (legal standing), and to the ability to exercise those rights and take actions that the law must recognise (legal agency): see Bernadette McSherry, ‘Legal Capacity under the Convention on the Rights of Persons with Disabilities’ (2012) 20 *Journal of Law and Medicine* 22, 23; Cliona de Bhailís and Eilionóir Flynn, ‘Recognising Legal Capacity: Commentary and Analysis of Article 12 CRPD’ (2017) 13 *International Journal of Law in Context* 6, 9-10.

⁸⁴ On this issue, which has been discussed extensively in the CRPD literature, and on the requirements of Article 12, see for example Genevra Richardson, ‘Mental Disabilities and the Law: From Substituted to Supported Decision-Making?’ (2012) 65 *CRP* 333; Eilionóir Flynn and Anna Arstein-Kerslake, ‘Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity’ (2014) 10 *International Journal of Law in Context* 81; Piers Gooding, ‘Navigating the “Flashing Amber Lights” of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns’ (2015) 15 *HRL Rev* 45; De Bhailís and Flynn (n 83). For the CRPD Committee’s interpretation of Article 12, see CRPD Committee, *General Comment No. 1 (2014) Article 12: Equal Recognition before the Law*, UN Doc. CRPD/C/GC/1, 19 May 2014 <http://www.un.org/en/ga/search/view_doc.asp?symbol=CRPD/C/GC/1> accessed 16 December 2019.

⁸⁵ Department for Constitutional Affairs, *MCA 2005 Code of Practice* (TSO 2007).

⁸⁶ Ministry of Justice, *MCA 2005: Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main MCA 2005 Code of Practice* (TSO 2008).

their own decisions, and is therefore relevant to persons with mental disabilities only if they also lack such mental capacity.⁸⁷

The MCA 2005 defines 'lack of capacity' on the basis of a 'diagnostic' and a 'functional' test.⁸⁸ Pursuant to section 2(1):

[A] person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Thus, the first criterion, known as the 'diagnostic test', is that the person has either 'an impairment of the mind or brain', or 'a disturbance in the functioning of the mind or brain'. According to the MCA CoP, this includes not only 'conditions associated with some forms of mental illness' and 'significant learning disabilities', but also 'dementia', 'the long-term effects of brain damage', 'physical or medical conditions that cause confusion, drowsiness or loss of consciousness', 'delirium', 'concussion following a head injury' and 'the symptoms of alcohol or drug use'.⁸⁹ Also, pursuant to section 2(2), the impairment or disturbance might be either permanent or temporary.

The second criterion, known as the 'functional test', is that the person is 'unable to make a decision for himself', as defined in section 3(1) of the MCA 2005. Inability to make decisions contains four elements. In particular, the person must be unable to do any of the following in relation to the decision that needs to be made; either 'understand', 'retain' or 'use or weigh' the relevant information, or 'communicate' that decision.

⁸⁷ For a detailed analysis of the MCA 2005, see Bartlett and Sandland (n 7) 162-200; specifically on the DoLS see Bartlett and Sandland (n 7) 201-35. See also Peter Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005* (2nd edn, OUP 2008) 95-120; Peter Bartlett, 'Informal Admissions and Deprivation of Liberty under the Mental Capacity Act 2005' in Lawrence Gostin and others (eds), *Principles of Mental Health Law and Policy* (OUP 2010) 385-412; Fennell, *Mental Health* (n 7) 174-201.

⁸⁸ See MHA CoP (n 13) para 13.18-13.19.

⁸⁹ MCA CoP (n 85) para 4.12. See also Explanatory Notes to the MCA 2005 para 22 <http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgaen_20050009_en.pdf> accessed 16 December 2019.

It is important to note that a ‘causative nexus’ must exist between the inability to make the decision and the impairment of, or disturbance in the functioning of, the mind or brain. That means that the person must be unable to make the decision *as a result* of the impairment or disturbance.⁹⁰

It should finally be noted that the phrases ‘in relation to a matter’ and ‘at the material time’ in section 2(1) indicate that mental capacity is assessed in relation to a specific decision that needs to be made at a specific time. Therefore, as a result of the impairment or disturbance, the person must be unable to make a *particular decision at the time it needs to be made*.⁹¹

It can be argued that the use of mental incapacity, as defined in the MCA 2005, as basis for making decisions on behalf of others is discriminatory against persons with disabilities. Section 2(1) *prima facie* appears to be neutral; however, it includes a diagnostic threshold for incapacity, which, although it does not use the word ‘disability’, it does make explicit reference to ‘impairment’. Furthermore, the functional test to determine capacity seems to have a disproportionate impact on persons with mental disabilities, as they are far more likely to have their decision-making skills questioned and assessed.⁹² This is also the view of the CRPD Committee, which stated in its *General Comment on Article 12* that the functional approach⁹³ is discriminatorily applied to people with disabilities.⁹⁴ It was also noted that whereas all persons with disabilities can be

⁹⁰ See *PC v City of York Council* [2013] EWCA Civ 478 [58]-[59].

⁹¹ See MCA CoP (n 85) para 4.4. See also Vivienne Ashley, *Briefing Document: MCA 2005 and MHA 1983* (Essex Autonomy Project 2011) 5 <<https://autonomy.essex.ac.uk/wp-content/uploads/2016/11/EAP-Briefing-Documents-MCA-MHA-v-2.pdf>> accessed 16 December 2019.

⁹² See Peter Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75 MLR 752, 762-63; Wayne Martin and others, *Achieving CRPD Compliance: Is the MCA of England and Wales Compatible with the UN CRPD? If not, What Next?* (The Essex Autonomy Project 2014) 16, 31-32 <<https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-Position-Paper-FINAL.pdf>> accessed 16 December 2019; Flynn and Arstein-Kerslake, ‘Legislating Personhood’ (n 84) 86-87.

⁹³ On the ‘functional’ approach and its difference from the ‘status’ and ‘outcome’ approaches, see Amita Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar of the Future?’ (2006–2007) 34 Syracuse Journal of International Law and Commerce 429, 431-33; Flynn and Arstein-Kerslake, ‘Legislating Personhood’ (n 84) 86-87.

⁹⁴ CRPD Committee, *General Comment No. 1* (n 84) para 15.

affected by substitute decision-making, this disproportionately affects persons with mental - and learning or intellectual - disabilities.⁹⁵

It is important to emphasise that the CRPD prohibits direct as well as indirect discrimination on the basis of disability; as already mentioned, the definition of discrimination in Article 2 refers to both the 'purpose' and the 'effect' of any distinction, exclusion or restriction. Therefore, laws that *prima facie* appear disability-neutral, but in practice have a disproportionate impact on persons with disabilities, are prohibited under the CRPD.⁹⁶

It should be mentioned that the functional approach and the use of mental incapacity as criterion for intervention has been supported by some authors, because it has been seen as a way to avoid discrimination against persons with mental disabilities. Notably, John Dawson and George Szmukler suggested in 2006 that mental health legislation is unnecessary and discriminatory, as it singles out mental disorder for involuntary treatment; therefore a new scheme should be introduced that, combining mental health and mental capacity legislation, would allow for non-consensual treatment of both 'mental' and 'physical' conditions, on the basis of 'decision-making incapacity'.⁹⁷

This 'Fusion Law' proposal was slightly modified in 2014.⁹⁸ The term 'decision-making incapacity' was replaced by the term 'impaired decision-making capability', and it was noted that this could be from 'any cause of a disturbance or impairment of mental functioning'.⁹⁹ It was also mentioned that the 'impaired decision-making capability' as criterion for involuntary treatment is based on a functional, rather than status, approach, because the impairment is not based on 'a diagnosis of a disorder or category of disability', but on 'the inability to carry

⁹⁵ *ibid* para 9.

⁹⁶ See CRPD Committee, *General Comment No. 6* (n 10) para 18.

⁹⁷ John Dawson and George Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *The British Journal of Psychiatry* 504. Their 'Fusion Law' proposal was published in 2010: George Szmukler, Rowena Daw and John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' (2010) 20 *Journal of Mental Health Law* 11.

⁹⁸ George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37 *Int JL & Psychiatry* 245.

⁹⁹ *ibid* 248.

out a specific task at a specific time'.¹⁰⁰ It was therefore suggested that, as the 'Fusion Law' uses a 'disability-neutral' criterion that applies to all persons, it complies with the CRPD prohibition of discrimination on the basis of disability.¹⁰¹

It can however be argued that the 'Fusion Law' does not in fact comply with the CRPD. Despite using a criterion that is facially neutral and does not explicitly refer to 'disability', it adopts a functional approach that would disproportionately affect persons with mental disabilities. That would amount to indirect discrimination on the basis of disability, which is, as seen above, prohibited under the CRPD.

Functional approaches to assessing mental capacity, as the ones adopted by the 'Fusion Law' and section 2(1) of the MCA 2005, are therefore inconsistent with the CRPD prohibition of discrimination on the basis of disability. It should be noted at this point that decision-making *in general* is based on mental incapacity, as defined in section 2(1) of the MCA 2005, but decisions that involve specifically deprivation of liberty are subject to additional requirements, set out by the DoLS.

The following subsection will now focus on deprivation of liberty on the basis of mental incapacity. First it will discuss how people how lack mental capacity were deprived of their liberty prior to the introduction of the DoLS, and then it will examine the requirements for deprivation of liberty under the DoLS and whether or not they comply with the CRPD prohibition of deprivation of liberty on the basis of disability.

4.3.2 Deprivation of Liberty Safeguards (DoLS)

4.3.2.1 Deprivation of liberty prior to the DoLS

As noted above, there is a wide range of decisions covered under the MCA 2005, including those in relation to property and affairs of the person who lacks capacity, as well as their health and personal welfare. Decisions relating to care or treatment are protected from liability under section 5 of the MCA 2005, which

¹⁰⁰ *ibid.*

¹⁰¹ *ibid* 249-50.

provides a general defence for carers who carry out such acts, provided that they reasonably believe, and reasonable steps have been taken to determine, that the person lacks capacity to consent to the act, and that the act is in the person's best interests.¹⁰² It should be noted however that section 6 of the MCA 2005 sets out certain limitations to the protection offered by section 5. In particular, the use of restraint, as defined in section 6(4), is not protected under section 5, unless the carer reasonably believes that the act is necessary to prevent harm to the person, as well as a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.¹⁰³

Importantly, prior to the MHA 2007 amendments, deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights (ECHR)¹⁰⁴ was also excluded from protection under section 5 of the MCA 2005.¹⁰⁵ Thus, the MCA 2005 as originally passed prohibited the deprivation of liberty of a person who lacks capacity; it could only be authorised by a personal welfare order of the Court of Protection under section 16(2)(a). It would be useful to briefly mention at this point the reason behind this prohibition.

First it must be noted that, prior to the enactment of the MCA 2005, the practice regarding those who lack capacity to consent to admission was based on the principle that, wherever possible, persons should be admitted informally, without resort to the powers of compulsion. Consequently, those who did not resist admission were being admitted informally, and detained, if necessary, under the common law 'doctrine of necessity', whereas those who refused being into hospital and presented a risk to self or others were being detained under the powers of compulsion in the MHA 1983.¹⁰⁶ However, for those who did not resist admission and were therefore admitted informally, this approach meant that they did not have the rights of review or any of the safeguards provided for

¹⁰² MCA 2005, s 5(1).

¹⁰³ *ibid* s 6.

¹⁰⁴ Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), signed 4 November 1950, CETS No 5 (entered into force 3 September 1953). Note that Convention rights have been incorporated into domestic law by the Human Rights Act 1998 (HRA 1998). Article 5 protects the right to liberty and security.

¹⁰⁵ MCA 2005, s 6(5), repealed by the MHA 2007.

¹⁰⁶ See Bowen (n 20) 148; Fennell, *Mental Health* (n 7) 152.

by the MHA 1983, as those were reserved only for persons detained under the MHA 1983. These persons were thus subject to 'de facto detention', because, although not formally detained, they were being deprived of their liberty.¹⁰⁷

The issue of 'de facto detention' was considered by the European Court of Human Rights (ECtHR) in the landmark case of *HL v the United Kingdom*.¹⁰⁸ The ECtHR held that the applicant, who had been admitted as an 'informal patient', was 'deprived of his liberty' within the meaning of Article 5(1) of the ECHR.¹⁰⁹ It was stated in particular that:

[T]he right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.¹¹⁰

Moreover, his detention, which was based on the common law doctrine of necessity, was not 'in accordance with a procedure prescribed by law' and 'lawful' within the meaning of Article 5(1)(e) of the ECHR; it was stated in particular that the 'absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1) of the Convention'.¹¹¹ Hence, the law regarding detention of people who lack mental capacity needed to be amended, in order to comply with the ruling of the ECtHR.

Although the Government wished to amend the law in response to *HL v the United Kingdom*, it was not possible to fully address the ECtHR's judgment before the passage of the MCA 2005. Therefore, the MCA 2005 as originally enacted took some account of the case, by including section 6(5), which provided that

¹⁰⁷ Fennell, *Mental Health* (n 7) 14.

¹⁰⁸ *HL v the United Kingdom* (2005) 40 EHRR 32.

¹⁰⁹ *ibid* para 94.

¹¹⁰ *ibid* para 90.

¹¹¹ *ibid* para 124.

there was no protection from liability for an act that amounted to deprivation of liberty of the person who lacks capacity.¹¹²

The issues raised by the judgment in *HL v the United Kingdom* were fully addressed when the MCA 2005 was amended by the MHA 2007, which introduced the procedure for depriving people who lack capacity of their liberty in hospitals or care homes, namely the DoLS, contained in Schedules A1 and 1A to the MCA 2005.

In particular, the MHA 2007 introduced section 4A to the MCA 2005, which provides that deprivation of liberty can now be authorised, but only in three specific situations. First, by a Court of Protection order under section 16(2)(a), as it was the case prior to the MHA 2007 amendments.¹¹³ It should be noted, however, that pursuant to new section 16A(1), added by the MHA 2007, the court may not authorise the deprivation of liberty of a person who is ‘ineligible’ to be detained. Second, deprivation of liberty can be authorised while a Court of Protection decision is sought, provided that it is necessary to give the person who lacks capacity life-sustaining treatment or to do a ‘vital act’ to prevent a serious deterioration in the person’s condition.¹¹⁴ Third, deprivation of liberty can be authorised by Schedule A1 that contains the DoLS, the new procedure for persons who lack capacity and are deprived of their liberty in hospitals or care homes, introduced by the MHA 2007 in response to *HL v United Kingdom*.

The DoLS requirements for deprivation of liberty will now be examined.

4.3.2.2 DoLS requirements for deprivation of liberty

As already mentioned, mental capacity is assessed under the MCA 2005 in relation to a specific decision that needs to be made at a specific time. The specific decision that relates to the DoLS is whether the person should be accommodated in a particular hospital or care home for the purpose of being

¹¹² Note that deprivation of liberty by a donee of a lasting power of attorney (LPA), and a deputy, was also prohibited, under sections 11(6) and 20(13) respectively, now repealed by the MHA 2007.

¹¹³ MCA 2005, s 4A(3).

¹¹⁴ *ibid* s4B.

given care or treatment. The DoLS, contained in Schedules A1 and 1A to the MCA 2005, establish the procedure and process that need to be followed for authorising deprivation of liberty, when the person lacks capacity to make that decision for themselves. It should be noted that the DoLS apply only to hospitals and care homes. Deprivations of liberty in other settings, such as private homes and supported living accommodation, must be approved by the Court of Protection. If the arrangements for the person who lacks capacity amount to deprivation of liberty, a DoLS authorisation must be granted. Schedule A1 provides two mechanisms; the 'standard authorisations' and the 'urgent authorisations'.

For a 'standard authorisation' to be obtained, the 'managing authority' of the hospital or care home must make the request to the relevant local authority, namely the 'supervisory body'.¹¹⁵ Schedule A1 provides that a person can be detained under a 'standard authorisation' for up to one year.¹¹⁶ Pursuant to paragraph 24, a 'standard authorisation' must be requested by the 'managing authority' when it appears that the person, whether already accommodated in the hospital or care home or not, is likely within the next 28 days to be a 'detained resident' and meets or will meet within the next 28 days all of the qualifying requirements. The 'supervisory body' has a duty to secure that assessors carry out assessments of whether the qualifying requirements are met.¹¹⁷

There are six qualifying requirements that must be met for a 'standard authorisation', set out in paragraph 12(1) of Schedule A1:

First, the 'age requirement', which is met if the person is over the age of 18 years.¹¹⁸

¹¹⁵ *ibid* Sch A1, paras 2, 21 and 22.

¹¹⁶ *ibid* Sch A1, paras 42(2) and 51(2).

¹¹⁷ *ibid* Sch A1, para 33.

¹¹⁸ *ibid* Sch A1, para 13. Note that the main provisions of the MCA 2005 apply to persons over the age of 16 years.

Second, the 'mental health requirement', which is met if the person 'is suffering from mental disorder', as defined in the MHA 1983, 'but disregarding any exclusion for persons with learning disability'.¹¹⁹ Therefore, the person must suffer from 'any disorder or disability of the mind';¹²⁰ including learning disability, but excluding dependence on alcohol or drugs.

Third, the 'mental capacity requirement', which is met when the person 'lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment'.¹²¹ Lack of capacity is determined by reference to sections 2 and 3 of the MCA 2005. Therefore, the person must be at the material time unable, 'because of an impairment of, or a disturbance in the functioning of, the mind or brain', to make the decision for themselves,¹²² thus to 'understand', 'retain' or 'use or weigh' the relevant information, or 'communicate' their decision.¹²³

Fourth, the 'best interests requirement', which is met if it is in the best interests of the person to be deprived of their liberty, and if deprivation of liberty is necessary in order to prevent harm to the person, and a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.¹²⁴ This requirement refers directly to section 4 of the MCA 2005, which provides the criteria for what is in a person's 'best interests'.

Fifth, the 'eligibility requirement', which is met if the person is not 'ineligible' to be deprived of their liberty under the MCA 2005; the question of whether the person is 'ineligible' is determined in accordance with Schedule 1A to the MCA 2005.¹²⁵ This requirement relates to the interface between the DoLS and the MHA 1983, and persons who suffer from a mental disorder, as defined in the MHA 1983, for which they require assessment or treatment, and also lack

¹¹⁹ *ibid* Sch A1, para 14(1).

¹²⁰ MHA 1983, s 1(2).

¹²¹ MCA 2005, Sch A1, para 15.

¹²² *ibid* s 2(1).

¹²³ *ibid* s 3(1).

¹²⁴ *ibid* Sch A1, para 16.

¹²⁵ *ibid* Sch A1, para 17.

capacity to make the relevant decision regarding accommodation and treatment in hospital. Schedule 1A to the MCA 2005 determines when a person is 'ineligible';¹²⁶ that depends on whether they are subject to the compulsory powers,¹²⁷ or 'within the scope',¹²⁸ of the MHA 1983. In the first case, the person is 'ineligible' to be deprived of their liberty under the DoLS if that would conflict with the MHA 1983 powers.¹²⁹ In the second case, the person is 'ineligible' if they object to admission or some, or all, of the mental health treatment, unless a donee of an LPA or a deputy has made a valid decision to consent.¹³⁰

Sixth, the 'no refusals requirement', which is met if the person has not made a valid advance decision refusing some, or all, of the relevant treatment, and also if the admission is not in conflict with a valid decision of a donee of an LPA or deputy.¹³¹

In considering the requirements that must be met for a person to be deprived of their liberty under the DoLS, it can be argued that the MCA 2005 does authorise deprivation of liberty on the basis of mental disability. The 'mental health requirement' is based on a finding of 'mental disorder', defined as 'any disorder or disability of the mind'. Mental disability is thus explicitly used as criterion for deprivation of liberty. That is clearly against the requirements of Article 14(1)(b) of the CRPD, which states that 'the existence of disability shall in no case justify a deprivation of liberty'. Therefore the MCA 2005, as the MHA 1983, fails to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

The following subsection will now briefly discuss the LPS, and consider whether or not this new scheme will be consistent with Article 14 of the CRPD.

¹²⁶ *ibid* Sch 1A, para 1.

¹²⁷ *ibid* Sch 1A, para 2(Cases A-D).

¹²⁸ *ibid* Sch 1A, para 2(Case E).

¹²⁹ *ibid* Sch 1A, paras 3-5.

¹³⁰ *ibid* Sch 1A, para 5.

¹³¹ *ibid* Sch A1, paras 18-20.

4.3.3 Liberty Protection Safeguards (LPS)

As mentioned above, the Law Commission recently reviewed the English law on mental capacity and deprivation of liberty. The *Final Report* proposed a replacement scheme for the DoLS, namely the LPS.¹³² The new scheme - based on, albeit modified, the Law Commission's proposal - is contained in Schedule AA1 of the MC(A)A 2019, which, when it comes into force, will replace Schedules A1 and 1A to the MCA 2005.

The LPS will continue to authorise deprivation of liberty. They will apply in particular to arrangements for care or treatment, which would give rise to a deprivation of liberty, in any setting, of persons who lack capacity to consent to those arrangements. Further to lack of capacity to consent, the two other conditions that must be met before arrangements can be authorised are that the person has a mental disorder, as defined in the MHA 1983, and that the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person.¹³³

Part 7 of Schedule AA1 maintains the current interface between the MCA 2005 and the MHA 1983, contrary to what was proposed by the Law Commission. In particular, the *Final Report* proposed that the LPS would not be used for hospital arrangements for assessment or treatment of mental disorder.¹³⁴ Therefore, persons with mental disabilities who lack capacity, either compliant or objecting, would be detained under the MHA 1983 for mental health assessment or treatment; the MCA 2005 would no longer apply to them. On the contrary, Part 7 provides that the use of the LPS will be excluded for persons who are detained in hospital under the MHA 1983, or who are objecting to a hospital admission for mental health assessment or treatment.

¹³² For an overview of the LPS, see Law Commission, *Mental Capacity and Deprivation of Liberty* (n 3) 49-51.

¹³³ MC(A)A 2019, Sch AA1, para 13.

¹³⁴ Those arrangements are called 'mental health arrangements'. However, hospital arrangements for treatment of a learning disability, where that disability is not associated with 'abnormally aggressive or seriously irresponsible conduct', are not excluded from the LPS.

The LPS use ‘mental disorder’, defined as ‘any disorder or disability of the mind’, as criterion for the authorisation of arrangements. Deprivation of liberty under the LPS will thus still be based on mental disability, as is currently under the DoLS. This is not permitted by Article 14 of the CRPD, and therefore the MCA 2005, as amended by the MC(A)A 2019, will still have fail to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

It is important to note that, regarding the authorisation conditions, instead of the person having a ‘mental disorder’, the Law Commission had proposed that they are of ‘unsound mind’ within the meaning of Article 5(1)(e) of the ECHR.

‘Unsoundness of mind’ is a broad term that covers people not only with mental disorder or disability, but also learning or intellectual disability and brain disorder. The *Final Report* suggested that it can also cover fluctuating capacity.¹³⁵ The use of ‘unsoundness of mind’ as basis for application of the LPS was considered the most appropriate approach for a number of reasons. First, it is broader than ‘mental disorder’, as defined in the MHA 1983, which is what is currently required for the DoLS ‘mental health requirement’ to be met; persons who do not have a ‘mental disorder’, but can nevertheless be considered ‘of unsound mind’,¹³⁶ would therefore be included.¹³⁷ At the same time, it is narrower than the diagnostic test of section 2(1) of the MCA 2005, which requires ‘an impairment of, or a disturbance in the functioning of, the mind or brain’; persons who are temporarily concussed or unconscious, or under the influence of alcohol or drugs, would therefore be excluded.¹³⁸

It should be noted that ‘unsoundness of mind’ is the term used in Article 5 of the ECHR. The *Final Report* decided to use the same term as basis for the application of the LPS, ‘in order to ensure that [they] have the same scope as the relevant provisions of Article 5’.¹³⁹ The ‘mental disorder’ criterion in the MHA 1983 and

¹³⁵ Law Commission, *Mental Capacity and Deprivation of Liberty* (n 3) para 9.50.

¹³⁶ For instance people in a persistent vegetative or minimally conscious state caused by concussion or brain injury, or people suffering from ‘locked-in’ syndrome.

¹³⁷ Law Commission, *Mental Capacity and Deprivation of Liberty* (n 3) para 9.16.

¹³⁸ *ibid* para 9.15.

¹³⁹ *ibid* paras 9.17, 9.19.

the ‘mental health requirement’ under the DoLS in the MCA 2005 are also used to ensure that deprivation of liberty will be within the bounds permitted by Article 5(1)(e) of the ECHR.

Article 5 of the ECHR protects the right to liberty and security of person. This is however a limited right; deprivation of liberty is prohibited, except in the circumstances exhaustively listed in the text of the Article. In particular, ‘unsoundness of mind’ constitutes such an exception, as Article 5(1)(e), allows for ‘the lawful detention of ... persons of unsound mind’. It should be noted that the meaning of ‘unsoundness of mind’ is not defined in the ECHR. As stated in *Winterwerp v the Netherlands*,¹⁴⁰ ‘this term is not one that can be given a definitive interpretation ... it is a term whose meaning is continually evolving ...’¹⁴¹ States Parties to the ECHR, including the UK, can therefore interpret ‘unsoundness of mind’ broadly.

As noted above, the Law Commission proposed that the LPS would apply to persons of ‘unsound mind’, in order to ensure compliance with Article 5(1)(e). Indeed, ensuring compliance with the ECHR seems to have been a primary concern of the *Final Report*. This is reasonable, given that the ECHR is part of the domestic law, since the enactment of the Human Rights Act 1998 (HRA 1998). However, authorisation of deprivation of liberty on the basis of ‘unsoundness of mind’, a term that is linked to disability - not only mental, but in any case disability -, is not permitted by Article 14 of the CRPD. Therefore, the MCA 2005 would still have failed to comply with the CRPD prohibition of deprivation of liberty on the basis of disability.

The *Final Report* itself recognised this incompatibility. It explicitly states that the LPS ‘are unlikely to comply with Article 14 of the CRPD’,¹⁴² but claims that ‘it is not on its face possible’ to comply with both Article 5 of the ECHR and Article 14 of the CRPD.¹⁴³ In particular, the Law Commission in its *Consultation Paper*¹⁴⁴

¹⁴⁰ *Winterwerp v the Netherlands* (1979-80) 2 EHRR 387.

¹⁴¹ *ibid* para 37.

¹⁴² Law Commission, *Mental Capacity and Deprivation of Liberty* (n 3) app B 1.15(1).

¹⁴³ *ibid*.

referred to a point made by Philip Fennell and Urfan Khaliq,¹⁴⁵ that is that Article 14(1)(b) 'appears to pose a direct challenge' to Article 5(1)(e) of the ECHR, which accepts that 'unsoundness of mind' can be a lawful ground for deprivation of liberty.¹⁴⁶ Accordingly, they state that 'there is a conflicting treaty obligation for those state parties to the CRPD who are also parties to the European Convention'.¹⁴⁷ In other words, it is suggested that these States Parties will necessarily be in breach of either their obligations under the ECHR, or under the CRPD, because, while the ECHR allows for deprivation of liberty on the basis of mental disability, the CRPD expressly prohibits it.

However, it can be argued that this point is mistaken. As Bartlett correctly notes, Article 5(1)(e) 'allows but does not require the detention of persons of unsound mind'.¹⁴⁸ Therefore, although the ECHR and the CRPD adopt different approaches in relation to the permitted grounds for deprivation of liberty, these are not necessarily in conflict. A State Party to both Conventions can comply with them both if it does not permit deprivation on liberty on the basis of mental disability, because the CRPD prohibits such deprivation, while under the ECHR it is allowed, but not required.

4.4 Conclusion

This chapter sought to determine whether the English law complies with the obligation under Article 14(1)(b) of the CRPD to prohibit deprivation of liberty on the basis of mental disability. The two statutes that include provisions in relation to the deprivation of liberty of persons with mental disabilities are the MHA 1983 and the MCA 2005, both as amended by the MHA 2007.

¹⁴⁴ Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (n 4) para 3.21.

¹⁴⁵ Phillip Fennell and Urfan Khaliq, 'Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law' (2011) 6 EHRLR 662.

¹⁴⁶ *ibid* 665.

¹⁴⁷ *ibid* 667.

¹⁴⁸ Peter Bartlett, 'A Mental Disorder of a Kind or Degree Warranting Confinement: Examining Justifications for Psychiatric Detention' (2012) 16 IJHR 831, 836. See also Eilionóir Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches' (2016) 22 International Journal of Mental Health and Capacity Law 75, 79.

Section two focused on the MHA 1983, which provides the legal framework for the compulsory admission and treatment of people in hospital for their mental disorder. There are five factors that need to be considered for detention under the MHA 1983, found in sections 2 and 3. These are: The presence of mental disorder, the nature or degree of that mental disorder, the presence of risk to the person's health or safety or to other persons, alternatives to detention, and the availability of appropriate treatment.

In considering these factors, it was found that the presence of mental disorder, defined as 'any disorder or disability of the mind', is the main requirement for detention under the MHA 1983. Unless a person is suffering from a mental disorder, it is legally impossible to be admitted for assessment or treatment. Notwithstanding the inclusion of safeguards and additional factors as justification for involuntary detention, the MHA 1983 clearly authorises detention on grounds of mental disorder, and therefore is not compliant with Article 14 of the CRPD that prohibits deprivation of liberty on the basis of mental disability.

Section three focused on the MCA 2005, which provides the legal framework for making decisions on behalf of people who lack the mental capacity to decide for themselves. 'Lack of capacity' is the triggering factor for its application, defined on the basis of a 'diagnostic' and a 'functional' test. Importantly, a person cannot be found to lack mental capacity, unless they have an impairment of, or disturbance in the functioning of, the mind or brain that causes the inability to make the decision. Decisions that involve specifically deprivation of liberty are subject to requirements set out by the DoLS, contained in Schedules A1 and 1A to the MCA 2005. The DoLS in particular provide the legal framework for deprivation of liberty in hospitals and care homes of people who lack capacity to decide about accommodation for the purpose of being given care or treatment.

In considering the DoLS requirements, it was found that deprivation of liberty can only be authorised if the person who lacks capacity is suffering from a mental disorder, as defined in the MHA 1983. Since the MCA 2005 authorises

deprivation of liberty on the basis of mental disability, it fails to comply with Article 14 of the CRPD.

The final part of section three considered the new replacement scheme for the DoLS, namely the LPS, contained in Schedule AA1 of the MC(A)A 2019. The LPS will authorise deprivation of liberty on the basis of 'mental disorder, defined as 'any disorder or disability of the mind'. This is not permitted by Article 14 of the CRPD, and therefore it was found that the MCA 2005, as amended by the MC(A)A 2019, will still fail to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

Chapter 5 Conclusion

The purpose of this conclusion is to provide a summary of the findings of the thesis and concluding remarks, as well as identify potential directions for future research.

The thesis focused on the UN Convention on the Rights of Persons of Disabilities (CRPD), and sought to determine two main issues. First, whether the CRPD adopts the British 'social model' approach to disability, or rather defines disability in a way which is closer to WHO's International Classification of Functioning, Disability and Health (ICF) conceptualisation. Second, whether the English law, in particular the Mental Health Act 1983 (MHA 1983) and the Mental Capacity Act 2005 (MCA 2005), complies with the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of mental disability.

With regard to the first issue, based on the examination of the British 'social model' approach, the ICF conceptualisation and the definition of disability in the CRPD, it was found that the CRPD defines disability in a way which is closer to the ICF conceptualisation. With regard to the second issue, based on the examination of Article 14 of the CRPD, the MHA 1983 and the MCA 2005, it was found that the English law fails to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

In brief, the British 'social model' approach and the ICF conceptualisation were examined in chapter two, the CRPD definition of disability and the CRPD prohibition of deprivation of liberty on the basis of mental disability were examined in chapter three, and the MHA 1983 and the MCA 2005 were examined in chapter four.

Chapter two began by assessing the adequacy of the most commonly known social approach to disability, namely the British 'social model of disability'. This understanding rejects the view that disability is an individual and medical problem caused by impairment, and rather suggests that disability is a form of social oppression, caused by social barriers that exclude people with

impairments from participation in society. It was found that, although the British 'social model' approach correctly recognises the social and environmental factors that are relevant to the experience of disability, it fails to accurately describe it, most importantly because of the distinction it makes between impairment and disability and the denial of any causal link between them. The medical aspect of disability is thus ignored, while the role of social and environmental factors is over-emphasised.

It was then suggested that disability is more adequately described in balanced approaches that recognise the various factors that are relevant to this experience, without reducing it to only some of them. Disability is not simply functional limitation due to impairment; neither is it merely a socially created disadvantage for people with impairments. Balanced approaches understand the complexity of disability and, by integrating medical and social understandings, describe the experience of disability accurately.

The most adequate framework for understanding disability was found to be provided for by the ICF. Adopting a balanced, 'biopsychosocial' approach to disability, it correctly understands it as multi-dimensional and interactive. Disability is conceptualised as the experience of a wide range of problems in functioning, including impairments, limitations in performing activities and restrictions in participating in life situations; this experience is seen as arising out of the complex interaction between a health condition, personal factors and barriers in the physical and social environment.

Both the British 'social model' approach and the ICF conceptualisation of disability were finally examined within the mental health context. It was found that a relationship exists between mental health and disability. People with serious mental health problems experience long-term disabling effects in their lives; their situation can therefore be related to that of people with physical or sensory impairments.

The British 'social model' of disability was found to be relevant to people with mental health problems, although a potential application would require some

changes in order for specific difficulties to be covered and addressed. It was however suggested that, since disability is not accurately described in the British 'social model', it would not be desirable to understand the experience of people with mental health problems in accordance with this approach.

It was finally examined how the disability associated specifically with mental health conditions is conceptualised in the ICF, which is regarded as offering the most adequate understanding of disability. It was found that the ICF correctly avoids distinguishing between mental and physical conditions and understands difficulties in functioning, namely the experience of disability, irrespective of the underlying health condition.

Chapter three focused on the CRPD, and particularly its definition of disability and the use of disability as a factor in deprivation of liberty. The chapter sought to determine, first, whether the CRPD adopts the British 'social model' approach to disability or not, and second, the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability.

Section two began with an overview of the CRPD. It was found in particular that it was necessary to have a specific convention for persons with disabilities, because, although existing human rights instruments in theory applied to them, in practice they had failed to sufficiently protect their rights. It was also found that the CRPD is based on a 'holistic approach' that incorporates social development, human rights and non-discrimination elements. It is a 'hybrid' convention, containing civil and political rights, as well as economic, social and cultural rights, and also combines substantive human rights with the principles of equality and non-discrimination. It was finally found that it imposes an obligation on States Parties to abolish any laws that discriminate against persons with disabilities.

Section three focused on the definition of disability under the CRPD, and considered whether it adopts the British 'social model' approach to disability or not. Based on how disability is conceived in the text of the CRPD, and particularly the use of the words 'interaction' and 'hinders' in the definition, as well as the

relevant discussion during the negotiations, it was found that the CRPD does not adopt the British 'social model' approach, but rather defines disability in a way similar to the ICF understanding.

Finally, section four considered the meaning of the prohibition under Article 14 of the CRPD of deprivation of liberty on the basis of disability. Based on the relevant discussion that took place during the negotiations, it was found that disability cannot be used as a factor in deprivations of liberty, either alone or in combination with other factors.

This section also examined how the CRPD Committee interprets Article 14 of the CRPD, and its view on deprivation of liberty on the basis of disability. Based on the concluding observations on States Parties reports, and the Statement and Guidelines on Article 14, it was found that the CRPD Committee interprets the right to liberty as absolutely prohibiting deprivation of liberty on the basis of disability. It also takes the view that the use of factors such as 'perceived danger of persons to themselves or to others' and 'alleged need for care or treatment', or any other factors 'tied to impairment or health diagnosis', as basis for involuntary detention of persons with disabilities is contrary to Article 14 of the CRPD.

The final part of section four considered whether the CRPD allows for the possibility to justify deprivation of liberty based on mental disability. The view taken was that the CRPD does not allow for such possibility. Even assuming that it does, it was found that deprivation of liberty on the basis of mental disability fails to meet the 'objective and reasonable standard', and therefore cannot be justified, provided that non-coercive alternatives are equally effective.

Chapter four sought to determine whether the English law complies with the obligation under Article 14(1)(b) of the CRPD to prohibit deprivation of liberty on the basis of mental disability. The two statutes that include provisions in relation to the deprivation of liberty of persons with mental disabilities are the MHA 1983 and the MCA 2005, both as amended by the MHA 2007.

Section two focused on the MHA 1983, which provides the legal framework for the compulsory admission and treatment of people in hospital for their mental disorder. There are five factors that need to be considered for detention under the MHA 1983, found in sections 2 and 3. These are: The presence of mental disorder, the nature or degree of that mental disorder, the presence of risk to the person's health or safety or to other persons, alternatives to detention, and the availability of appropriate treatment.

In considering these factors, it was found that the presence of mental disorder, defined as 'any disorder or disability of the mind', is the main requirement for detention under the MHA 1983. Unless a person is suffering from a mental disorder, it is legally impossible to be admitted for assessment or treatment. Notwithstanding the inclusion of safeguards and additional factors as justification for involuntary detention, the MHA 1983 clearly authorises detention on grounds of mental disorder, and therefore is not compliant with Article 14 of the CRPD that prohibits deprivation of liberty on the basis of mental disability.

Section three focused on the MCA 2005, which provides the legal framework for making decisions on behalf of people who lack the mental capacity to decide for themselves. 'Lack of capacity' is the triggering factor for its application, defined on the basis of a 'diagnostic' and a 'functional' test. Importantly, a person cannot be found to lack mental capacity, unless they have an impairment of, or disturbance in the functioning of, the mind or brain that causes the inability to make the decision. Decisions that involve specifically deprivation of liberty are subject to requirements set out by the Deprivation of Liberty Safeguards (DoLS), contained in Schedules A1 and 1A to the MCA 2005. The DoLS in particular provide the legal framework for deprivation of liberty in hospitals and care homes of people who lack capacity to decide about accommodation for the purpose of being given care or treatment.

In considering the DoLS requirements, it was found that deprivation of liberty can only be authorised if the person who lacks capacity is suffering from a

mental disorder, as defined in the MHA 1983. Since the MCA 2005 authorises deprivation of liberty on the basis of mental disability, it fails to comply with Article 14 of the CRPD.

The final part of section three considered the new replacement scheme for the DoLS, namely the 'Liberty Protection Safeguards' (LPS), contained in Schedule AA1 of the MC(A)A 2019. The LPS will authorise deprivation of liberty on the basis of 'mental disorder, defined as 'any disorder or disability of the mind'. This is not permitted by Article 14 of the CRPD, and therefore it was found that the MCA 2005, as amended by the MC(A)A 2019, will still fail to comply with the CRPD prohibition of deprivation of liberty on the basis of mental disability.

Based on the above findings, the following concluding remarks can be made.

Article 14 of the CRPD requires a radical shift in how persons with mental disabilities are treated, by absolutely prohibiting deprivation of liberty on the basis of disability. This stems from the way the concept of disability is understood in the CRPD, and particularly the view that barriers in the social environment play a significant role in preventing people with disabilities from participating in society on an equal basis with others and causing disability. Laws that allow persons to be deprived of their liberty on the basis of their mental disability are seen as such a barrier to social inclusion that needs to be removed.

However, although the CRPD views disability from a social perspective that points to society's failure to include persons with disabilities, it does not adopt a strong 'social model' approach. Instead, by adopting a 'biopsychosocial' approach, it also recognises the impact that impairment has to the experience of disability. That means that the CRPD does not deny that persons with mental disabilities may face difficulties due to impairment; although deprivation of liberty on the basis of disability is not permitted, the CRPD does not ignore their health needs. It is not suggested that persons with mental disabilities who may need care and support are to be abandoned. Quite the opposite in fact, considering that Article 25 protects the right of persons with disabilities to health and requires States Parties to ensure that they have access to health services

that are specific to their needs. However, it explicitly states in paragraph (d) that care should be provided ‘on the basis of free and informed consent’. It is therefore not a matter of *whether* care and support should be provided, but of *how* it is provided.

The CRPD requires that persons with mental disabilities enjoy their human rights, including the right to liberty, on an equal basis with others, without discrimination on the basis of disability. At the same time, it is an undeniable reality that persons with mental disabilities experience difficulties that do make a difference and may impact their health and safety negatively, often with severe consequences. The question is whether deprivation of liberty is an effective way to improve health and/or prevent harm, and whether the care and support needed by persons with mental disabilities can be provided by alternative non-coercive measures. It is unclear at this point whether deprivation of liberty is an effective means to protect health and safety; in some cases it does contribute to health improvement and prevents harm, but in other cases it is a traumatic experience that negatively affects treatment outcomes. It is therefore the effectiveness of non-coercive alternatives that determines whether deprivation of liberty can be avoided.

Several studies indicate that non-coercive alternatives to deprivation of liberty can be equally effective in many cases, but research on those alternatives is currently limited, as is their development. Focus should be on investing in and improving the provision of non-coercive mental health services, and ensuring that they are appropriate and accessible to persons with mental disabilities. Creating a system that is based on offering various non-coercive forms of support tailored to the specific needs and circumstances of each person can help address mental health difficulties at an early stage and prevent reaching the point where the only option is the use of coercion. The need to develop those alternatives is in line with the approach to disability adopted by the CRPD, which (in part) locates the problem of disability in society’s failure to respond to it appropriately. If non-coercive alternatives to deprivation of liberty can be equally effective, and the State and society fail to provide them, denying equal

enjoyment of the right to liberty to persons with mental disabilities cannot be justified.

Future research in this area should focus on exploring the development and effectiveness of non-coercive community based mental health alternatives. Importantly, the main concern and point of difficulty is how to address the 'hard cases', where the person is engaging in behaviour that is likely to result in serious harm. The CRPD seeks to change the way in which persons with mental disabilities are treated; that is, to replace involuntary detention with non-coercive measures that address health needs and difficulties through various forms of support. Ideally, under a system that is based on support, trust and communication between the person and mental health professionals and services, it will be possible to avoid reaching extreme situations. However, prohibiting compulsory interventions and abolishing laws that allow for deprivation of liberty, while no effective alternatives are in place to respond to emergency situations where there is imminent risk of serious harm, would not be acceptable. In those cases, limited interventions may be permitted for the shortest possible time until the immediate risk is removed, while working on reducing the number of hard cases and developing effective alternatives.

The use of compulsory interventions should be extremely limited, and for the purpose of addressing the problem of hard cases that may not be possible to address otherwise. Nevertheless, the compulsory powers of the MHA 1983 and the MCA 2005 are not reserved for hard cases. Instead, deprivation of liberty is based on broad criteria, which means that there is a significant number of persons that could potentially be subject to compulsion. This is unnecessary and does not appear to be justified. The situations where there are no effective alternatives to deprivation of liberty should be exceptional, and laws that allow for compulsory interventions should be limited to those hard cases where there is imminent risk of serious harm that is impossible to be addressed by non-coercive means of support.

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