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Canada Should Retain Its Reservation on the United Nation's Convention on the Rights of Persons with Disabilities

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Abstract

The United Nations adopted the Convention on the Rights of Persons with Disabilities (CRPD) in 2006. When Canada ratified the CRPD, it reserved the right to continue using substitute decision making schemes even if the CRPD was 'interpreted as requiring their elimination'. This was a prescient decision because the CRPD Committee, which is tasked with overseeing the interpretation and implementation of the CRPD, subsequently opined that all legislation supporting substitute decision making schemes contravene the CRPD and must be revoked. The CRPD Committee insists that every person can make decisions with sufficient support and that if a person lacks capacity to make a decision, we must rely on their 'will and preferences'. Many international legal scholars have called this interpretation unrealistic. We agree and, in this article, describe how this unrealistic approach would result in extensive harm and suffering for people with severe cognitive or psychotic disorders. The reader should also be aware that the CRPD Committee also calls for the elimination of all mental health acts and the United Nations Commissioner for Human Rights for the abandonment of the not criminally responsible (NCR) defence.

Abrégé

Les Nations Unies ont adopté la Convention relative aux droits des personnes handicapées (CDPH) en 2006. Quand le Canada a ratifié la CDPH il a réservé le droit de continuer d'utiliser les mécanismes substituts de prise de décision, même si la CDPH était « interprétée en exiger l'élimination ». Ce fut une décision visionnaire parce que le Comité de la CDPH, qui est responsable de superviser l'interprétation et la mise en œuvre de la CDPH, a subséquemment décidé que toute loi qui soutenait les mécanismes substituts de prise de décision contrevenait à la CDPH et devait être révoquée. Le Comité de la CDPH affirme que toute personne peut prendre des décisions si elle est suffisamment soutenue et que si une personne n'a pas la capacité de prendre une décision, nous devons respecter sa « volonté et ses préférences ». Nombre de juristes internationaux ont estimé cette interprétation irréaliste. Nous acquiesçons et dans cet article, nous décrivons comment cette approche irréaliste se traduirait par des dommages importants pour les personnes souffrant de graves troubles cognitifs ou psychotiques. Le lecteur devrait aussi être conscient que le Comité de la CDPH demande également l'élimination de toutes les lois sur la santé mentale, et que le Haut-Commissaire des Nations Unies aux droits de l'homme réclame l'abandon de la défense de non-responsabilité criminelle (NRC).

Keywords

ethics, forensic psychiatry, healthcare policy, medicolegal issues

In 2006, the United Nations General Assembly formally adopted the Convention on the Rights of Persons with Disabilities (CRPD), the primary purpose of which 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'.[1] The CRPD represents the result of decades of advocacy from the disability rights movement. Given the obligations that countries hold when signing an international convention, the development of the CRPD was characterized by vigorous debates and negotiations. As of October 2017, a total of 175 countries, including Canada, had ratified the

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convention.[2] By advancing the rights and dignity of people with disabilities, the CRPD has the potential to further the full inclusion of all citizens in society irrespective of the presence of a disability.

When Canada ratified the convention in 2010, it did so with the following reservation:

'To the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards'.[3]

Several Canadian organizations, including the Law Commission of Ontario,[4] the Council of Canadians with Disabilities,[5] and the Canadian Association of Community Living,[5] have called on the Federal Government to abandon this reservation.

We believe that the principles outlined in the CRPD are supported by Canadian psychiatrists who are committed to upholding patients' rights, including appropriate procedural safeguards.[6] However, psychiatrists should be aware that the CRPD Committee demands an interpretation of the CRPD that would have negative consequences for many of our patients. We anticipate that Canadian psychiatrists, and others concerned about the well-being of patients, will encourage the Federal Government to maintain its reservation when they appreciate the consequences of dropping it.

We will first briefly review the background to the development and implementation of the CRPD before considering Canada's reservation. Several countries including Australia and the United Kingdom have, like Canada, ratified the CRPD with reservations. The drafting of the CRPD was a contentious process[7] reflecting sharply different views on balancing rights. The language in parts of the convention is vague, which may reflect a failure to resolve these different perspectives.[7] After adopting the CRPD, the United Nations established the Committee on the Rights of Persons with Disabilities (hereafter, the 'Committee') to interpret the convention and oversee its implementation. This Committee has adopted a highly contentious approach to the interpretation of the CRPD, which includes the position that 'committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders' contravene the convention and must be eliminated.[8] Moreover, the High Commissioner for Human Rights, who oversees the United Nations human rights efforts, has asserted that any consideration of mental capacity in criminal law, such as the 'not criminally responsible (NCR)' defence, also contravenes the convention and must be eliminated.[9] The consequences of these interpretations, which would likely include increased rates of incarceration of people with mental illnesses and their execution in jurisdictions that retain the death penalty, will be obvious to psychiatrists and we believe to the Canadian Government. Therefore, in this article, we will limit our analysis to Canada's reservation as it relates to the use of substitute decision making.

The Committee interpreted the CRPD to mean all individuals have a legal capacity to make decisions and that laws based on the concept of incapacity are incompatible with the CRPD.[10] The Committee went on to insist that because substitute decision making provisions have effect after a finding of incapacity, they are in contravention with the CRPD and must be replaced with supported decision making schemes.[8] Recently, the Committee confirmed these interpretations after reviewing Canada's report on its implementation of the CRPD.[11] The Committee specifically recommended that Canada 'withdraw its reservation to article 12 (. . .) that allows for the deprivation of legal capacity of persons with disabilities'.[11]

Let us pause to distinguish substitute decision making from supported decision making. Substitute decision making occurs after a person has been assessed as lacking the capacity to make a specific type of decision. The substitute decision maker, who is identified under a jurisdiction's law, then makes a decision that is in the person's best interest. However, in some jurisdictions, the substitute decision maker may be constrained by the need to respect advance directives or wishes that the individual previously expressed when capable. In contrast, in supported decision making, the person is assumed to have the capacity to make decisions and is supported by '. . . a network of friends, family, or other allies who help the person with disabilities make and express his or her decisions'.[12]

Supported decision making is not a new concept. Physicians incorporate elements of supported decision making when obtaining informed consent in certain situations. For example, it is common in Canada to encounter people who speak neither of our 2 official languages and need the assistance of an interpreter to understand the information required to make an informed decision. Similarly, people who are deaf may need to be provided with written material on a treatment and, possibly, also engage in discussion using sign language before making a treatment decision. A similar approach may be required to obtain valid consent from a person who has a mild to moderate intellectually disability. Such an individual may be capable of understanding the information needed to decide if that information is presented: slowly, repeatedly, in simple language, using pictures, by a trusted individual, or by using some combination of these techniques. These types of support can assist a person to exercise autonomy and promote personal dignity.

The question is what to do when, despite appropriate support, a person is unable to understand the information necessary to make a decision or is unable to appreciate the consequences of a decision even with appropriate support? In Canada, a person identified in provincial or territorial legislation makes the decision for such an incapable person. Canadian jurisdictions vary as to who is designated as the substitute decision maker (most often a relative) and what rules the substitute decision maker must follow in making decisions.[13] For example, in Ontario, the substitute decision maker must abide by any advance directives or prior capable

wishes of the person that are relevant to the decision at hand. If there is no such directive, the substitute decision maker must make a decision that is in the patient's best interest but, in doing so, must take into consideration the values and beliefs the person had when capable and the patient's current incapable wishes.

The Committee has stated that substitute decision making cannot be used even when an incapable person is unable to make a decision with support. The Committee indicates that in, such a situation, decisions 'must be based on the will and preferences of the person, not on what is perceived as being in his or her objective best interests'.[10] Following the 'will and preferences' of the person would prohibit the administration of any treatment that a person did not want, even if the treatment was required to preserve life. This would mean that a person with dementia who was resisting the administration of insulin could not be treated or that a patient with psychosis who is involuntarily hospitalized could not be given antipsychotic medications if he or she refused. Leaving involuntarily hospitalized patients untreated has been shown to result in a multitude of problems, including assaults on other patients, staff and visitors; suicides; unnecessary deprivation of liberty; blocking of scarce inpatient beds; increased system costs; and decreased staff morale.[13,14]

The Committee does not clarify who will determine a person's will and preferences in this situation. Will it be a relative, a friend, or some new state appointed person? Will it be one person or several people? What happens if 2 supporters disagree on the nature of the will and preferences? Who will fund these supporters? Who will oversee the supported decisions to ensure that they are free from conflict of interest or flagrant coercion? How would they be appealed and by whom? We are unaware of any country that has adopted an exclusively supported decision making approach as demanded by the CRPD Committee. Most of the limited research on supported decision making has been conducted on populations with intellectual disability or with dementia as opposed to those with mental illness.[15] Thus, we have little information about which patients with mental illness can benefit and what problems might arise. In view of these unanswered questions and the likelihood of severe negative consequences for some of the most vulnerable individuals in our society, it is remarkable that several groups have demanded that the Federal Government abandon Canada's current capacity-based substitute decision making schemes, which have generally served patients and their families well and which are backed by an extensive body of case law.

As we have noted, the proposal to repeal all substitute decision making schemes is just part of a broader set of contentious interpretations by the Committee that would end civil commitment and the NCR defence. Several international law scholars have concluded that the Committee's interpretations are unrealistic.[7,16,17] We agree and echo Dawson's observation that '... the Committee's approach reveals a famous weakness of rights discourse — its non-consequential character'.[16]

Before abandoning substitute decision making, we would need detailed proposals about how supported decision making would work in specific situations and not the current vague generalisations. Such a major policy change must be informed by research, which examines important outcome measures of pilot schemes of supported decisions, such as the duration of involuntary hospitalization, the level of severity of symptoms, aggressive incidents, criminal conviction, imprisonment, and mortality rates, including suicide. Unless it can be shown that supported decision making schemes can protect the interests of people with severe cognitive and psychotic illnesses, Canada should stoutly resist calls to drop its reservation and should continue to use its current substitute decision making arrangements.

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