

Supported Decision Making: A Rights-based Disability Concept and its Implications for Mental Health Law

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Piers Gooding

PhD candidate at the Centre for the Advancement of Law and Mental Health, Faculty of Law, Monash University, Australia.

Abstract: This article seeks to clarify the concept of supported decision making and to consider its major implications for mental health law. It draws on the UN Convention on the Rights of Persons with Disability as well as the broader literature on supported decision making in order to distinguish some of its conceptual features and to provide an overview of relevant debate. Emerging examples of supported decision making in legislation, policy, and programming are drawn upon to demonstrate the variety of measures that might constitute practical supported decision making in the mental health context.

Key words: supported decision making, mental health law, guardianship, capacity, United Nations Convention on the Rights of Persons with Disabilities, human rights.

Introduction

‘Supported decision making’ is an emerging concept in law that is taking on a need for practical application to assist people with decision-making support needs. As such, the concept has significant implications for mental health law. Although these implications remain opaque, the small but rapidly expanding body of literature on supported decision making can help illuminate them by i) highlighting the conceptual features of supported decision making, ii) highlighting key debates informing its development, and iii) highlighting the rising number of practical examples of supported decision making in the mental health context. The article argues that the notion of supported decision making has the potential to address persistent conceptual issues in mental health law. However, some tensions seem likely to persist, particularly in relation to the broader implications of the United Nations (UN) Convention on the Rights of Persons with Disabilities¹ (CRPD) for domestic law and policy. The article focuses particularly on mental health law in developed Western jurisdictions.

Supported decision making is advanced in international law in the CRPD as the preferred response when a person’s decision-making ability is brought into question due to impairment or disability.² This article will thus consider mental health through the lens of human rights and disability, acknowledging that tension remains between the medical model and the social model of disability.³ The term ‘persons with psychosocial disability’ is a term that has been broadly adopted by the international disability movement involved in drafting and negotiating the CRPD, and is used throughout this article to describe people diagnosed with mental illness, as well as those who identify as mental health consumers, survivors of psychiatry, ‘mad’ and so on. This cohort meets the CRPD’s definition of disability as ‘an evolving concept... (that) 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.’⁴

The first section of the article will define supported decision making by drawing on activity around the CRPD, as well as in certain Canadian legislation, which will also help highlight the significance of the concept to the mental health context. The second section will outline core concepts behind supported decision making in greater detail, including the following: providing an alternative to substituted decision making, distinguishing legal capacity from cognitive functioning, regarding autonomy as relational, respecting ‘dignity of risk’ alongside strengthened provision of support and protections against abuse and exploitation, and being based in developments around international human rights law. The third and final section includes a discussion about supported decision making

in the mental health context, specifically as a conceptual and practical bridge between ‘positive and negative rights’. It also discusses some of the tensions and objections that may arise at such a junction. The article will then conclude by asking how supported decision making might appear in practice, looking to practical examples at the intersection of law, policy, and programming.

1. Defining Supported Decision Making

The term ‘supported decision making’ is not specifically defined in the CRPD but an indication as to what it means is found in Article 12(2) and (3) which state:

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.⁵

The UN Committee on the Rights of Persons with Disability (CRPD Committee), which is mandated to interpret the CRPD, describes supported decision making in its publication, *Handbook for Parliamentarians*:⁶

Supported decision-making can take many forms. Those assisting a person may communicate the individual’s intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity... The individual is the decision maker; the support person(s) explain(s) the issues, when necessary, and interpret(s) the signs and preferences of the individual. Even when an individual with a disability requires total support, the support person(s) should enable the individual to exercise his/her legal capacity to the greatest extent possible, according to the wishes of the individual.⁷

The UN Office of the High Commissioner of Human Rights, in its thematic study on ‘enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities,’ defined supported decision making as simply, ‘the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal or legal matters.’⁸

Article 12(4) indicates the safeguards required for ‘all measure(s) that relates(s) to the exercise of legal capacity,’ which clearly encompasses supported decision making:

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity *respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.* The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.⁹

While there remains debate as to whether Article 12(4) tacitly endorses *substituted* decision making (a debate which shall be outlined in the next section), the safeguards provide a sense of the priorities in the support approach being advanced according to the terms of the CRPD.

Almost two decades before the CRPD came into power, supported decision making was codified into legislation in the reform of Canadian guardianship laws. Although the laws were developed to respond primarily to people with intellectual and cognitive disabilities, the statutes can here provide some guidance in defining supported decision making generally. Section 6(1) of *The Vulnerable Persons Living with a Disability Act* (Manitoba, C.C.S.M. c. V90) defines supported decision making as:

the process whereby a vulnerable person is enabled to make and communicate decisions with respect to personal care or his or her property and in which advice, support or assistance is provided to the vulnerable person by members of his or her support network.¹⁰

Similarly, Prince Edward Island enacted the *Supported Decision-Making and Adult Guardianship Act* 1997¹¹ which provides for a 'supported decision making agreement' for persons over 18, and British Columbia established 'representation agreements,' which provide for a contractual agreement between two or more adults to formalise a support relationship.¹² Under the 'representation agreement', the person deciding can appoint a person ('associate') to help him or her make various decisions to do with personal, health and financial matters. A patient in Prince Edward Island, for example, has the *right* to be assisted by an 'associate' when making health care decisions.¹³ However, the associate has no authority to make decisions *for* the supported individual. These earlier statutes provide useful guidance as to how legislative and policy structures of supported decision making might work to support people with psychosocial disability, as well as other groups, such as those with age-related disability, and so on.

In addition to helping define supported decision making, activity around the CRPD highlights the significance of the concept to laws (and policy) concerning people with psychosocial disabilities, including guardianship and mental health legislation. For example, the CRPD Committee, in its compliance review of Tunisia (the first such review), recommended that States Parties ‘review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to *replace regimes of substitute decision-making (with) supported decision-making.*’¹⁴ The CRPD Committee invited States Parties to create a new legislative and policy framework and implied that mental health laws be repealed. Specifically, it recommended that Tunisia ‘repeal legislative provisions which allow for the deprivation on the basis of disability, including a psychosocial or intellectual disability,’¹⁵ though it did not clarify how that might occur. The CRPD Committee’s position echoes a 2009 report by the Office of the High Commissioner of Human Rights (OHCHR), which called for the repeal of disability-specific legislation on the basis that it was unjustly discriminatory, and singled out mental health legislation as unfairly discriminatory against persons with a diagnosis of mental disorder. Regardless of whether states parties observe the CRPD Committee’s conclusions (a matter that will be addressed shortly) the comments here provide a sense of the potency attributed to the supported decision making idea in international law, and its implication for mental health law.

Supported Decision Making: Core Concepts

The application of supported decision making to mental health law, policy, and programming is relatively new, though its tenets can be found in existing mental health concepts such as the ‘recovery’ model of support.¹⁶ It is perhaps too early then to point to ‘best practice’ or any general legislation that meets the criteria for the CRPD Committee’s call for ‘regimes of supported decision making.’¹⁷ However, since the coming into power of the CRPD activity around supported decision making has gained a small but visible momentum in academic monographs,¹⁸ academic journal articles,¹⁹ in case law,²⁰ in regional courts and bodies,²¹ legislative reform activity,²² in the formation of centres and institutes,²³ in a growing body of ‘grey literature’,²⁴ the operation of conferences and symposia,²⁵ and in UN activity.²⁶ Out of this material some clear conceptual features can be identified, some of which are briefly summarised below.

a) Autonomy with Support

Supported decision making refers to processes whereby a person is provided with support, if he or she so chooses, to give expression to their wishes and preferences regarding a particular decision concerning him or herself.²⁷ At the heart of supported decision making then is the proposition that instead of delegating a person’s decision making power to another, the individual can be provided with necessary supports and accommodation to make and communicate decisions according to his or

her wishes.²⁸ This might consist of having family and friends to help the person understand information and communicate wishes, or any other situation where support would assist an individual to express and articulate a decision. In relation to healthcare (including mental healthcare) this would mean communicating information about healthcare decisions in appropriate ways, in providing a variety of options, and in understanding and respecting a person's choice.

Supported decision making is often contrasted with substituted decision making.²⁹ Substituted decision making occurs where someone is appointed to make decisions on another person's behalf, again, typically to provide for protection against abuse and exploitation by others, or potentially harmful actions by the individual themselves.³⁰ As a legal concept, substituted decision making in this context is most directly covered in guardianship, an intervention whose scope varies across the wide spectrum of substituted decision making laws within and between jurisdictions; from plenary style guardianship, to limited substituted decision making in specific matters, such as financial administration, medical treatment, housing, and compulsory intervention under mental health law, and so on³¹—a scope which makes it difficult to generalise. Despite this variation, the most significant legal point of difference would appear to be that with supported decision making the legal power to make the decision stays with the person.

However, the distinction between supported and substituted decision making is not always entirely clear. For example, if planning, advocacy, and communication supports are insufficient to ascertain a person's view, then representational support may be required in which there are some elements of substituted decision making. This may take the form of people who know the person well helping to provide a sense of who the person is, a sense of their identity, intentions and hopes, which can then form the basis for decisions. The above mentioned *Representation Agreement Act* in British Columbia, Canada, has formalised this type of support. A representation agreement under this Act can only occur where the supported person *appoints* his or her representative.³² A general aim of the representative arrangement is to ascertain a sense of the supported person's wishes and preferences, and to give expression to those wishes and preferences, rather than simply making decisions on their behalf. However, once the representative is appointed, the representation process appears to include moments of 'substituted judgment' where representatives must make a judgment about what the supported person would wish and prefer.

b) The Interdependence of Autonomy

In some senses, the degree to which representational support is seen to constitute supported decision making (rather than substitute decision making) may depend upon the way autonomy is conceptualised. At a philosophical level, the supported decision making approach would seem to emphasise the relational aspect of self, in which autonomy, or at least the enjoyment of autonomy, is

seen as an *interdependent* rather than *independent* phenomenon. This view challenges the traditional legal conception of autonomy and decision making as isolated, rationalistic and ‘purely’ independent.³³ Instead, the supported decision making approach advances a more realistic view of autonomy which acknowledges that individuals rely to a greater or lesser extent on others to help them make and give effect to decisions—from informal supporters such as family members and friends, to experts, such as accountants, medical doctors, and mechanics.³⁴ While the interdependent nature of autonomy and decision making is often more obvious for people with disabilities, and particularly those with decision making impairments, it is not seen to be anomalous to them. With respect to decision making, Robert Gordon frames it thus: ‘(s)ome people require more in the way of support and assistance than others, and with respect to more areas of decision-making than others; it is a matter of degree, rather than a case of absolutes.’³⁵ As such, the dynamic of interdependence varies depending on the context of the decision and on the individual’s level of reliance on others to inform his or her decision making. One obvious implication of this view of autonomy is the potential need for ‘supporters’ to be *legally* recognised as people who can assist, but not assume control over, a person’s decision making. This approach appears in legislation in some Canadian provinces, and was partly intended to indicate to third parties (such as banks, medical practitioners, and others) that the support persons have specific powers, such as being able to gather information for the supported person and assist in communicating their wishes.

Beyond this practical example, the broader ramifications of re-conceptualising autonomy toward a relational account of decision making in law are complex and beyond the scope of this article.³⁶ Nevertheless, it is worth noting that the idea of relational autonomy has ‘importantly shifted attention concerning autonomy to the social and interpersonal dynamics that shape its enjoyment, connecting ideas about autonomy with broader issues of social justice, recognition, and social practices.’³⁷

c) The ‘Dignity of Risk’

Another common theme in the supported decision making literature relates to the matter of risk-taking. Risk is viewed as an often crucial component of decision making that people with disabilities, particularly intellectual disabilities, can historically be seen to have been denied. The attribution of positive value to risk-taking seeks to remedy situations where people are placed under substituted decision making arrangements which may deny them the chance to learn decision making skills and access the inherent dignity of exercising choice, ostensibly for reasons of protection. From a legal perspective, according to Gordon, it is within the ambit of exercising choice – including the right to assume moral risks – that personhood is exercised and realised.³⁸ Where supported decision making is concerned, respecting the choices which may carry some risk is not a matter of turning away from persons with disability in risky situations and thus allowing people, in Darold Treffert’s famous

words, to ‘die with their rights on.’³⁹ Instead, supported decision making could only be said to occur in these instances, where adequate assistance and information was offered, and where the individual was assisted to become aware of his or her responsibilities and of the implications of his or her choice.

Risk can be further mitigated with safeguards to prevent people with disabilities being abused or exploited by others, abuse and exploitation which often motivate the protective impulse behind substituted decision making arrangements.⁴⁰ The Victorian Law Reform Commission recently undertook a review of Guardianship laws in Victoria, Australia, and promoted a transition to a supported decision making approach, which would ideally include the introduction of ‘a new public wrong of abusing, neglecting or exploiting a person with impaired decision-making ability... enforceable by civil penalty.’⁴¹ The law would function to ‘complement existing criminal laws... (to) be used where criminal proceedings would be unlikely to succeed or might not be appropriate.’⁴² In this sense, rather than directing the state’s protective impulse toward preventing the actions of the individual purportedly at risk, the emphasis turns to ensuring the provision of adequate information and assistance, as well as providing safeguards to punish perpetrators of abuse against those individuals.

In one sense, this aspect of supported decision making may challenge public and private institutions with a strong focus on risk-aversion (including mental health services). However, it may also be the case that clarifying ways that risk can be respected will provide institutions with more ‘room to move’ in providing support and assistance while also respecting a person’s sphere of freedom to exercise choice (knowing too, that mechanisms exist to punish perpetrators of abuse against the person). This may be legally useful for public officials who may feel restricted in the range of choice they can offer people, out of fear of liability in the case of terrible events occurring. This feature of supported decision making is addressed in a number of guides produced by the United Kingdom Department of Health, which contrast supported decision making explicitly with a culture of risk-aversion.⁴³ One describes the departments wider effort to ‘shift... the balance away from risk-aversion towards supported decision-making.’⁴⁴ In terms of broader law reform, the trend among governments to pursue a risk agenda may affect the extent to which this aspect of supported decision making comes into effect.

d) Legal Capacity and the UN CRPD

The UN CRPD enunciates a host of rights and principles which can assist in clarifying the concept of supported decision making further. Further, certain key debates around the CRPD can help contextualise the way in which supported decision making is being applied and developed. As noted, Article 12 is particularly relevant to psychosocial disability as it sets out the right of persons with disability to legal capacity and to the supports needed to exercise legal capacity on an equal basis with

others.⁴⁵ Other rights articulated in the CRPD can also assist in understanding supported decision making with reference to specific areas of life where decisions are made and legal capacity is exercised. These include accessible communication (Article 9), effective access to justice (Article 13), liberty of movement (Article 18), the right to choose where and with whom to live (Article 19), marriage and parenting rights and obligations (Article 23), health care decisions which should be on the basis of free and informed consent (Article 25) and the right to vote and participate in political and public life (Article 29). Article 16 provides for safeguards from exploitation, violence and abuse, and Article 5 provides guidance on principles of equality, non-discrimination, and reasonable accommodation. However, a person must be said to hold legal capacity in order to claim many of the rights listed above. Subsequently, as well as being central to the concept of supported decision making Article 12 is one of the more (if not the most) controversial articles of the CRPD.

The foremost question raised by Article 12 is simply, what is meant by “legal capacity”? Bernadette McSherry has observed that the concept of legal capacity has two constitutive elements: legal standing (a social and legal status as a person before the law) and legal agency (the ability to act within the legal framework), both of which are captured in Article 12 of the CRPD.⁴⁶ Typically, the assessment of whether or not a person lacks capacity has relied on cognitive testing, which is based on a determination of ‘mental incapacity’ (or ‘mental incompetence’, as it is often termed in North America). As such, *legal* capacity is often conflated with *mental* capacity. However, Article 12 of the CRPD indicates that the two concepts are not co-extensive. Hence a person who may fail a mental capacity test – as set out in, for example, the *Mental Capacity Act (England and Wales) 2005* – may still be able to exercise legal agency *if* they are given adequate supports to obtain and express their wishes and preferences.

Two questions then follow: what is meant by ‘*support* to exercise legal capacity’ and at what point can legal capacity be displaced? And it is these two questions, in relation to legal agency, that are the subject of much of the current debate.⁴⁷

At a minimum, it is generally agreed that the CRPD endorses a strong preference for supported decision making, particularly given that any reference to substituted decision making was dropped from the final text of Article 12 during the negotiation between states parties and civil society organisations.⁴⁸ This reading (which is by no means the only one, as shall be demonstrated shortly) would endorse the addition of supported decision making mechanisms to existing capacity-related laws. The declaration of two countries, Canada and Australia, provides an example of such an interpretation.⁴⁹ In the process of ratifying the CRPD both countries declared their interpretation of Article 12 as allowing for substituted decision making *as well as* supported decision making.⁵⁰ Dianne Chartres and John Brayley have proposed a model that would develop upon such an approach, which

they describe as a ‘stepped approach to supported decision making.’ The stepped approach would see a broader range of legal avenues made available if a person had impaired decision making ability.⁵¹ At one end of the spectrum would be autonomous decision making (entailing maximum self-determination and no unusual state intervention), followed by a range of supported decision making and representative measures, which would then be followed by a range of limited substitute decision making mechanisms. Finally, at the other extreme of the spectrum, the appointment of a public guardian would see the maximum level of care, protection, and state intervention. Regardless of where a person sat on the spectrum, efforts would be directed to assisting a person to exercise their legal capacity to the greatest extent possible and to move them back up the spectrum toward independence (again, where possible).

A second major reading of Article 12 goes a step further and argues that there is no point beyond which legal capacity is lost. This perspective would mark a complete break between the concepts of *legal* capacity and *mental* capacity. Substituted decision making under current guardianship and mental health law would thus be seen to contravene Article 12 and would continue to do so even if supported decision making mechanisms were ‘tacked on’ to existing arrangements. Accordingly, the positive obligation to provide ‘support to exercise legal capacity’ would occur when a person’s ability to make decisions is called into question or appears tentative (and even *absent*),⁵² at which point a support process would be initiated to maximise a person’s legal capacity. ‘Supported decision making,’ according to some proponents of this approach, then becomes something of a catchall term for a broad principle-based regime and not simply a specific mechanism on a spectrum with substituted decision making.⁵³ From this view, the focus would shift away completely from determining whether or not a person lacks capacity. Instead, efforts would be directed to identifying a person’s decision making impairments—but *only* as a means to identify the necessary support he or she requires to exercise legal capacity, supports that the state is then obliged to provide.⁵⁴

This second reading of Article 12 appears to be gaining ground, including in mental health law scholarship.⁵⁵ If it takes hold, according to Peter Bartlett, the mental health context would see a ‘significant shift in the legal landscape’⁵⁶ away from a focus on capacity-based tests for involuntary treatment, which has characterised progressive mental health law in recent years. Instead, focus would be directed to the evaluation of decision making abilities to determine a person’s support requirements. Such a shift appears to be advanced by the CRPD Committee in their compliance review of Tunisia, which again, expressed a position that the CRPD mandates States Parties to ‘replace substituted decision-making regimes by supported decision-making.’⁵⁷ Again, it is unclear precisely what is meant by a ‘supported decision making regime’ and whether this would include forms of substituted decision making (such as in the case of the representation agreement cited above) or whether such an arrangement would constitute an unlawful deprivation of legal capacity. As yet,

the CRPD Committee has not pointed to any legislative framework which captures this reading of Article 12.

Michael Bach and Lana Kerzner have produced a detailed proposal for legislation that they argue would comply with the terms of the CRPD and in accordance with the second reading.⁵⁸ In it they discard any notion of incapacity as it is understood in common law jurisprudence and propose a new test that is seemingly disability-neutral in assessing whether a person lacks legal capacity (or at least, *legal agency*). Such a scheme would see three main categories for decision making – autonomous, supported, and facilitated – to be accompanied by a corresponding level of legal oversight that spans from non-intervention, to the provision of support mechanisms designed to help develop decision making capabilities, to a form of limited substitute decision making, described as ‘facilitated decision making.’⁵⁹

The two divergent readings of Article 12 noted above – which in and of themselves contain considerable variation – add another layer of complexity to an already challenging and highly nuanced issue. The ongoing debate about Article 12 compounds the way in which the supported decision making concept resists being reduced to a uniform model and highlights its entwinement with broader debates around legal capacity and the CRPD.

2. Supported Decision Making and Mental Health Law

The conceptual features outlined in the previous section can help in examining the potential benefits and drawbacks of applying supported decision making to mental health law, and to the mental health context generally.

a. Potential Benefits

In general terms it can be said that supported decision making in the mental health law context shifts the debate away from ‘*freedom from* intervention’ toward ‘*access to* support to exercise legal capacity’. McSherry has argued that this shift characterises the CRPD’s implications for mental health law more generally, by bringing social, cultural, and economic rights – so-called second generation or ‘positive’ rights – into laws designed to protect the rights of persons with psychosocial disabilities.⁶⁰ In the past, human rights approaches to mental health law have focused on first-generation or ‘negative’ rights (*freedom from* state intervention to make one’s own decisions) and particularly ‘the rights to liberty and autonomy in relation to the involuntary commitment of individuals with very serious mental illnesses.’⁶¹ This libertarian emphasis, captured particularly in Larry Gostin’s concept of a ‘new legalism,’ sought to introduce procedural safeguards to regulate the control of psychiatrists and address the misuse of medical power. The legalistic approach also sought (albeit tentatively) to

provide for the right to treatment. Gerard Quinn has argued that this latter goal was perhaps the least successful of the ‘new legalism’ framework and led mental health debates into an ‘imprisoning logic’ and a breakdown of meaningful dialogue:

‘Some civil libertarians would hesitate to use an argument for a legal right to treatment (no matter how meritorious) lest the need for treatment might be used to justify an undue encroachment on liberty. Contrariwise, some professionals in the field who have the responsibility to deliver services, would hesitate to embrace liberty-enhancing arguments lest it interfere too much with their capacity to deliver a substantive right to treatment – with their professional prerogatives.’⁶²

The impasse fits with a common critique against ‘new legalism’ in mental health: it has typically struggled to provide substantive rights to persons with mental impairments in the form of access to healthcare. Jill Peay describes this as the ‘problematic nexus of mental health and law’ where the law has taken a historical role of restraining rather than facilitating access to services.⁶³ The International Disability Alliance have argued, in a broader critique of traditional capacity laws, that this narrow focus on civil and political liberties has often left people with disabilities in a ‘binary system of self-sufficiency versus enforced dependence.’⁶⁴ The supported decision making approach seeks to address this stark dichotomy by bridging ‘positive’ and ‘negative’ rights, by offering greater support to exercise autonomy (for example, by providing greater choice and information, establishing support persons, emphasising participatory healthcare, and so on) at the same time as maintaining freedom from intrusion on autonomy and liberty (for example, respecting choices).

By blending these two groups of rights (which are often misleadingly differentiated in the first place), supported decision making has the potential to address some longstanding issues in mental health law. According to Penelope Weller, the supported decision making concept can address the ‘imprisoning logic’ (to use Quinn’s term) by drawing together the two clashing set of rights – the right to health and the right to autonomy and liberty – under the principle of non-discrimination.⁶⁵ By drawing on the non-discrimination principle to expand the operation of the right to health (Article 25) and the right to equality before the law (Article 12) the CRPD effectively limits involuntary medical treatment through the requirement to develop supported rather than substitute decision making in health.⁶⁶ Thus, instead of focusing on the point at which a person is incapable of consenting to medical treatment, or the point at which a substitute decision maker is legally empowered, the emphasis shifts to identifying when a person who has some decision making impairment, or is at risk of losing the capacity to make decisions, should be provided with support. For individuals, this might mean identifying social isolation and providing a personal advocate, or perhaps working to facilitate an existing informal support network, or even establishing a new informal support network around them. On a larger scale,

in establishing policy and legislative conventions, the principle of equality and non-discrimination in mental health might mean challenging the meagre proportion of government spending on mental health compared to other health priorities,⁶⁷ or providing individuals with a greater ‘sphere of risk-taking’ where psychiatrists feel pressured by political risk agendas or limited options for alternative support arrangements. By emphasising state duties to provide goods to enhance autonomy and self-determination, rather than simply inviting non-interference, supported decision making emphasises areas of consensus among actors in the mental health context about the need for proactive measures of support. Within the wider basis of the CRPD this expands the purview of mental health justice beyond the vexing question of involuntary treatment to encompass the provision of substantive rights related to exercising legal capacity, including community living, rights to home and family, education, work and employment, and so on.

b. Potential Drawbacks

On the other hand, despite having the potential to transcend persistent issues in mental health law, the supported decision making concept also raises some significant tensions (i) when set against mental health legislation, and (ii) when applied to the mental health context more generally.

i) Possible Issues in Mental Health Law

One clear difficulty arises from the broader implications of the CRPD for mental health law. As noted the UN Office of the High Commission of Human Rights has expressed the view that mental health legislation is unjustly discriminatory against people with psychosocial disability because it systematically uses mental disorder as criteria to limit legal capacity,⁶⁸ a view echoed by the CRPD Committee. The proposition of applying supported decision making to mental health legislation is therefore problematic, given that principles of non-discrimination and equality that underpin supported decision making.⁶⁹ Particular sections of the CRPD will create ongoing challenges to the operation of mental health legislation: in particular, Article 14, as relates to detention (“the existence of a disability shall in no case justify a deprivation of liberty”);⁷⁰ Article 17, as relates to involuntary treatment (“(e)very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others”), and 25,⁷¹ and, again, Article 12, as relates to restrictions on legal capacity on the basis of a disability.⁷² The Australian government appeared to anticipate these tensions and included in its interpretative declaration the understanding that the CRPD allows for ‘compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards.’⁷³ Presumably, states parties wishing to comply with the terms of the CRPD will set about installing measures to assist people to exercise legal capacity across a range of legal and policy contexts. If McSherry and Wilson are correct in their estimation that mental health legislation appears unlikely to be repealed in

countries like the UK, Canada, and Australia, in the short-to-medium term,¹ then States Parties are likely to proceed with efforts to install supports to make decisions into mental health statutes, despite the tensions noted above.

Subsequently, it seems useful to ask whether the issues raised by supported decision making are fruitfully answered within the boundaries of a particular ‘field’ such as mental health law, a query that Terry Carney has posed in relation to elder law.⁷⁴ Carney argues that more universal frames may be preferable, such as the ‘equality’ principle, but is careful to emphasise that countries must design legal and policy frameworks in ways appropriate to their own legal apparatus and values, and according to ‘evidence-based assessments of competing legal or other policy instruments.’⁷⁵ Certainly, current debate around Article 12 has implications that go beyond the scope of mental health legislation, into other areas of law, such as criminal law, adult protection law, elder law, and so on. This is reflected in efforts to create supported decision making processes for people with psychosocial disabilities, which are beginning to occur both within and without the bounds of mental health legislation (as shall be highlighted in Section 3).

ii) Possible Issues in the Mental Health Context Generally

It is worth briefly considering the distinct challenges that arise with supported decision making in the mental health context more generally. After all, it is not entirely clear what it means to provide supported decision making to assist with the types of impairments associated with psychosocial disability, particularly in situations of emergency or extreme crisis. In Canada, representation agreements and supported decision making legislation were never intended for use during emergencies but rather, prior to problems and conflicts developing.⁷⁶ Indeed, supported decision making seems easier to imagine for people with intellectual and cognitive impairments as compared to people with mental impairments – including psychosis and other types of extreme mental stress – whose decision making abilities may fluctuate rapidly. The serious issue of suicide has also received scant attention in literature on supported decision making, an area which undoubtedly warrants close consideration.

Another general issue, which has only been touched on here, relates to the role of families, partners, friends, and other providers of informal support. This article has not addressed the very real concerns of families of persons requiring support who, as Quinn has rightly identified, will ask questions such as, ‘it is all very well to talk of the right to make one’s own mistakes and assume the dignity of risk – who will be around to pick up the inevitable pieces – service providers?’⁷⁷ And what will be the impact of legally formalising previously informal relationships?⁷⁸ How can the law best protect these informal relationships in ways that foster their continuation, yet provide appropriate support for individuals where crucial supports breakdown? How can the legal regulation of people’s intimate

lives be kept to an absolute minimum while still retaining effective safeguards against abuse? The perspectives of persons with lived experience of psychosocial disability, as well as formal and informal providers of a wide range of support – including peers, families, professionals, and so on – will provide useful insights into these concerns.

Before proceeding to the final section, which looks to examples of supported decision making in practice, this latter point requires special consideration. Supported decision making is an evolving concept whose development will seemingly be as participatory as the CRPD itself. Lord, Suozzi and Taylor have argued that ‘(t)he Convention – in its embrace of a highly participatory implementation framework in which civil society, national human rights institutions, and inter-governmental organizations can play roles – implicates a wide range of actors and thus embodies due process values much more so than many other international public health law processes.’⁷⁹ The CRPD explicitly directs that people with disabilities themselves ‘should have the opportunity to be *actively involved* in decision-making processes about policies and programmes, including those directly concerning them,’ and which includes the development of indicators, reporting, and evaluation.⁸⁰ ‘Active involvement’ in the practical political sense is ambiguous at this point, and will be a challenge for governments, disabled persons organisations, NGOs, professional bodies, and so on, in the ongoing development of supported decision making. But such participation appears crucial if the introduction of supported decision making, whether in mental health legislation or elsewhere, is to be effective and lasting. In this sense, it is perhaps fruitful to focus on establishing procedures to develop and research elements of a ‘supported decision making regime.’

3. Examples of Supported Decision Making in Practice

Indeed this is already beginning to occur. Current discussion about supported decision making among disabled peoples organisations, legal scholars, government officials, and other disability and human rights advocates, centres on the question of how supported decision making will be best formed into socio-legal conventions to ensure non-discrimination against people with psychosocial disability—whether in mental health legislation, in policy and programming, or elsewhere. The practical application of the supported decision making approach can reasonably span beyond narrow legislative reform, to include policy, programming, and other forms of extra-legal regulation, such as professional ethics guidelines.⁸¹ The application of supported decision making in the mental health context, according to Tina Minkowitz, ‘will require innovation and should draw on existing programs that may not have been understood as support in the exercise of legal capacity.’⁸² This could include ‘(p)eer support, recovery-based services, community support networks, and personal assistance, (which) may all help people with psychosocial disabilities in ways related to decision making or the exercise of legal capacity.’⁸³ The following examples are not exhaustive but are meant here to provide

a general overview of the range of possible supported decision making activities from around the world with relevance to the mental health context.

The formalisation of 'support networks' in Canadian guardianship law, mentioned above, is one example of legislative reform that could potentially be used to support persons with psychosocial disability. A support network is made up of a number of informal supporters (peers, family members, partners, and so on) being invited by the individual to support him/ her in making and communicating decisions.⁸⁴ The support network is meant to help with practical matters, such as understanding and communicating a person's wishes. The network also holds a crucial symbolic value. As Gordon has argued, the appointment of a support network is meant to affirm to everyone involved, that the person being supported is an equal and a peer—a subject with rights rather than an object of care and welfare.⁸⁵

Notwithstanding the concerns raised above about the tensions between supported decision making and mental health legislation, Weller has pointed to psychiatric advance directives (sometimes referred to as 'living wills') as a practical method for formalising supported decision making in mental health law.⁸⁶ She adds that these measures, which have been codified in mental health legislation most thoroughly in Scotland, would occur in ways that 'take account of varying mental health conditions and the specific institutional contexts in which mental health treatment is provided.'⁸⁷ Weller has described advanced directives as a practical step toward a broader 'culture of supported decision-making' in the mental health context.⁸⁸ Perhaps in a similar vein, Carney has argued that mental health tribunals in Australia could do more to appreciate the significance of the social networks of people who stand before tribunals.⁸⁹ By creating 'relational space' for tribunal adjudications, he argues, greater consideration could be given to the views of family, friends, and support people.

Outside of mental health legislation, a number of non-statutory measures to create supported decision making can also be found. The Office of the Public Advocate (OPA) of South Australia has considered the benefits and drawbacks of both statutory and non-statutory forms of supported decision making in its 'Supported decision making Practice Manual.'⁹⁰ In light of South Australia lacking supported decision making legislation, the OPA is presently trialling a *non-statutory* supported decision making program, which it describes as a 'process of setting up supported decision making agreements, and supporting the participants with those agreements.'⁹¹ The manual is an iterative document outlining the program, first published in June 2011, whose results are not fully available.⁹² The authors reported earlier that they will approach two pathways to non-statutory supported decision making:

(O)ne will test supported decision making as an alternative to guardianship (for people who might otherwise be subject to guardianship if they cannot be seen to make decisions for themselves) and the other, will test supported decision making as an early intervention strategy for people not yet under guardianship. The latter is an exciting element that might prevent problems occurring in the future, avoid the need for guardianship orders and facilitate age appropriate responses and skills in self determination. The project will investigate whether supported decision making serves as an effective alternative to substituted decision making and beyond this, what are the wider possible benefits of supported decision making? One hypothesis is that supported decision making will at the very least provide an effective alternative to substituted decision making, enabling people to avoid loss of their legal rights and/or government intervention. A second hypothesis is that as an outcome of supported decision making, people living with a disability will enjoy a range of other benefits related to community inclusion, and autonomy.⁹³

It is perhaps noteworthy that the OPA research comprises an interdisciplinary ‘Research Control Group’ which includes people with lived experience of disability, as well as a family carer, and whose experience ranges from ‘law, social work, psychology, medicine, nursing, disability service reform, guardianship, quality improvement, counselling and academic research.’⁹⁴

In its *Handbook for Parliamentarians*, the CRPD Committee recommended the ‘PO Skåne’ program in Sweden, as a supported decision making program specifically useful for persons with psychosocial disability.⁹⁵ This novel social-service and legal structure provides for a range of support relationships for people with impairments, as opposed to guardianship under a single relationship. Under the program, a legal mentor or personal ombudsman is judicially appointed to assist a person to make legal decisions.⁹⁶ The program also includes support persons described variously as ‘mentors’ (*god man*), ‘contact person’ (*kontakt*), trustees, and ‘escort persons’. Personal ombudsmen generally comprise trained social workers or lawyers who, along with the other aspects in the relationships, must be able to ‘argue effectively for the client’s rights in front of various authorities or in court,’ as required.⁹⁷

The Centre for the Human Rights of Users and Survivors of Psychiatry, an independent advocacy group primarily led by persons with psychosocial disability, has pointed to ‘Intentional Peer Support’ as a form of supported decision making.⁹⁸ Intentional Peer Support is designed to be applied both prior to but also during emergency decision making moments.⁹⁹ Intentional Peer Support explores models of social relations between people experiencing profound mental stress in ways that address patterns of power and authority on the exercise of individual agency. Research into programs such as

Intentional Peer Support may help advance a view of autonomy and decision making that is better suited to the practical activities of supported decision making for people with psychosocial disability.

On a related point, directing attention to mental health service models that reduce the use of involuntary treatment and detention may prove fruitful. Models of interest might include ‘Open Dialogues’, an approach pioneered in Finland wherein care decisions are made in the presence of the individual and their wider networks, even during severe psychosis.¹⁰⁰ Preliminary results of a two-year follow up found that a group of people with a first instance diagnosis of schizophrenia who used the approach ‘were hospitalized for fewer days, family meetings were organized more often and neuroleptic medication was used in fewer cases.’¹⁰¹ Reports also noted that participants experienced ‘fewer relapses and less residual psychotic symptoms and their employment status was better than in the (non-participating) Comparison group.’¹⁰² Another example might be ‘joint crisis plans’, a form of advance agreements trialled in England and developed in consultation with national service-user groups, including ‘detailed development work with service users in south London.’¹⁰³ Henderson, Flood, Leese, Thornicroft, Sutherby, and Szmukler conducted a study which found that the ‘use of joint crisis plans reduced compulsory admissions and treatment in patients with severe mental illness.’¹⁰⁴ Both the joint crisis plans program¹⁰⁵ and the Open Dialogues approach¹⁰⁶ are not uncontroversial. And yet such models offer useful starting points to develop and implement workable measures of supported decision making, which can be later reassessed against developments in the CRPD more generally.

The practice examples listed above can help identify practical measures to assess supported decision making, including indicators, benchmarks, impact assessments, budgetary analysis, and so on. Such measures would begin to clarify a legal and policy framework and could provide an operational tool for policy makers wishing to restructure their budgets and see available options. The examples also demonstrate the wide range of approaches under the general title of ‘supported decision making’, which include information supports, communicative and interpretative supports, goal setting and life planning tools such as person-centred planning, advocacy and more formal and administrative representational supports, relationship building supports, and so on.¹⁰⁷ In this sense, to prevent terms become so general as to confuse, it is perhaps useful to distinguish between supported decision making (which is a legal status where others are formally appointed to assist with decision making processes) and the more general *supports for decision making* (which would include the innumerable ways in which support can be provided; for example, in assistive decision-making tools). Research will be vital in testing the wide range of support approaches necessary to creating an overarching regime. In this sense, Carney may be right in arguing that ‘uniformity of approach may appeal to purists or academic commentators, (but) overlooks the need to accommodate local values, institutions and patterns of administration.’¹⁰⁸

Conclusion

In summary, supported decision making is a pragmatic and pluralistic approach whose increasing influence has the potential to redefine law, policy and programming in the mental health context. The small but rapidly expanding body of literature indicates that supported decision making is concerned with such things as:

- offering a conceptual and practical alternative to substituted decision making;
- protecting the right to autonomy with support appropriate to the individual in the context of exercising choice;
- autonomy being viewed as an *interdependent* rather than independent phenomenon;
- respecting the ‘dignity of risk’ balanced against access to information and support, and protections against abuse and exploitation;
- principles of equality and non-discrimination; and
- reflecting norms and developments (though contested) in international human rights law.

These key conceptual features have been outlined above and set against the changing legal and policy dynamics that continue to bring supported decision making to the fore of debate.

It would appear that supported decision making has the potential to address persistent issues in the field of mental health law, in particular, by offering an alternative route to providing substantive rights to people with impaired decision making associated with psychosocial disability. The mechanism to provide supports to exercise legal capacity may help transcend the traditional disjuncture caused by a narrow focus on political and civil rights in mental health law debates. It is true that ambiguities remain in the formulation of supported decision making, particularly in its application to the mental health context, and the concept is unlikely to address all persistent practical and conceptual issues around mental health law. However, there appears to be a significant consensus among a wide range of actors in the mental health context about many aspects of the approach. Efforts to implement the support approach continue in the development of legislation and policy,¹⁰⁹ as well as in the work of non-government actors, including among community-based service providers, informal and formal peer-support groups, within families, and so on. This ongoing endeavour will be influenced by – and will influence in turn – major debates related to the role of mental health laws under the CRPD, and the operation of supported decision making for persons with psychosocial disability. Where existing

practices in domestic law, policy, and programming are not yet conceived as supports for decision making, such practices could be identified and buttressed with state support. Equally important will be the creation of processes that facilitate active involvement of people with psychosocial disabilities and their supporters in processes to develop the support approach on both the small and large scale. After all, the success of any supported decision making law reform can only truly be measured 'on the ground' for those whose lives' it is meant to assist.

End.

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¹ Convention on the Rights of Persons with Disabilities 2007 A/RES/61/106 Annex I; see also, United Nations Committee on the Convention on the Rights of Persons with Disabilities 'Chapter Six: From provisions to practice: implementing the Convention, Legal Capacity and Supported Decision-Making' in *UN Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities* (Geneva, 2007) <<http://www.un.org/disabilities/default.asp?id=242>> accessed 2 February 2012.

² CRPD, s 12.

³ To summarise, the medical model of disability uses biomedical explanations which locate disability within the individual, in terms of pathology. By contrast, the social model that underpins the CRPD views disability as arising from the interaction between a person's impairment (physical or mental conditions which directly limit one's ability to enjoy a major life activity to a relatively normal degree) and the *external* physical and attitudinal barriers to his or her full and effective participation in society, on an equal basis with others. The distinction between impairment and disability is not always clear. The social context in which disability arises is always up for debate. Nonetheless, the social model of the CRPD was meant to provide an inclusive term which draws attention to external barriers to human flourishing rather than emphasising diagnostic categorisation, except so far as it is necessary to identify support requirements. Lord, Suozzi, and Taylor touch on the tension between the medical and social model in relation to the CRPD, arguing that it will 'inevitably lead to some challenges, as well as opportunities, when considering the broader implications of the CRPD for global health governance.' J Lord, D Suozzi & A Taylor 'Health; Human rights; International law (Legislative Comment) Lessons from the experience of U.N. Convention on the Rights of Persons with Disabilities: addressing the democratic deficit in global health governance' (2011) 38(3) *Journal of Law, Medicine and Ethics* 564.

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⁵ CRPD, s 12(2)(3).

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⁷ *ibid* 89.

⁸ UN General Assembly, OHCHR, Tenth session Agenda item 2, 'ANNUAL REPORT OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS AND REPORTS OF THE OFFICE OF THE HIGH COMMISSIONER AND THE SECRETARY-GENERAL: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities' Distr. GENERAL A/HRC/10/48 26 January 2009.

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¹⁴ UN Committee on the Rights of Persons with Disabilities 'Compliance Review: Tunisia', adopted 15 April 2011, CRPD/C/TUN/CO/1: 22 <www2.ohchr.org/SPdocs/CRPD/6thsession/CRPD-C-ESP-CO-1%20.doc> accessed 02 February 2012 (emphasis added).

¹⁵ *ibid*.

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¹⁷ UN Committee on the Rights of Persons with Disabilities (n14) 22.

¹⁸ B McSherry (ed.), *International Trends in Mental Health Laws* (Federation Press 2008); B McSherry & P Weller (eds.), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010); See also Mary Donnelly *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (CUP 2010).

¹⁹ N Devi, J Bickenbach & G Stucki, 'Moving towards substituted or supported decision-making? Article 12 of the Convention on the Rights of Persons with Disabilities' (2011) 5 *European Journal of Disability Rights* 249; A Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2007) 34(2) *Syracuse Journal of International Law* 563, 597; P Weller, 'Supported Decision-Making and the Achievement of Non-Discrimination: The Promise and Paradox of the Disabilities Convention' (2008) 26(2) *Law in Context* 85; A Kämpf, 'The disabilities convention and its consequences for mental health laws in Australia' (2008) 26(2) *Law in Context* 10; J Lord, D Suozzi & A Taylor (n3); A Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34(2) *Syracuse Journal of International Law* 429, 456–60.

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²² See for example, Victorian Law Reform Committee, 'Part 3: Supported Decision Making' in *The Guardianship Consultation Paper*, March 2011

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