

4 Negotiating capacity

Legally constructed entitlement and protection

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Introduction

In *R v I (D)* (2008), the Crown alleged that the complainant, a 23-year-old woman with the mental age of a three to six-year-old, had been repeatedly sexually assaulted by her mother's partner during the four years that he lived in the home. The Crown sought to call the complainant to testify about the alleged assaults. After a *voir dire* (a hearing held in the absence of the jury) the trial judge (*R v I (D)* 2008) found that she lacked capacity to testify because she had failed to show that she understood the duty to speak the truth. In a separate *voir dire*, the trial judge also excluded out-of-court statements made by the complainant to the police and her teacher on the grounds that the statements were unreliable and would compromise the accused's right to a fair trial. While the remainder of the evidence raised some serious suspicions about the accused's conduct, the case collapsed and the accused was acquitted. The Ontario Court of Appeal affirmed this result (*R v I (D)* 2010).

In an appeal to the Supreme Court of Canada, a majority of the court (six justices to three) set aside the acquittal and a new trial was ordered, based on the argument that the complainant, an adult with 'mental handicaps' (sic), could testify, that questioning her required consideration and accommodation of her particular needs, and that 'questions should be phrased patiently in a clear, simple manner' (2012: para 78). The majority also noted that preventing a witness from testifying could have significant consequences, preventing the truth from being told and making it impossible to prosecute crimes committed against members of a historically vulnerable population. The majority interpreted section 16 of the Canada Evidence Act 1985 to mean that a witness with mental disabilities who cannot understand the nature of an oath is still competent to testify in court if she can communicate the evidence and promise to tell the truth (2012: para 74).

This case demonstrates an assumption that often operates in law and more generally: legal capacity is presumed for individuals who are not labelled as disabled, while capacity must be negotiated by those with intellectual, significant psycho-social and communication disabilities. These individuals are presumed to lack legal and decision-making capacity and consequently

must negotiate their capacity to access justice, select appropriate support and care, and choose treatment or care protocols. As Genevra Richardson (2011: 146) has argued: '[s]pecialised legislation commonly provides for the involuntary treatment of people with mental disorder of the required severity and rarely stipulates that lack of capacity must be established before any such powers are used'. The consequences are important: presumptions about disability often lead to a failure to recognise individual capacity to exercise entitlements to choice, autonomy, equality and participation – key rights that are guaranteed by international treaties and state law. Determining incapacity based only on a person's status as a disabled person, or on functional incapacity based on impairment, shifts the burden of proof onto individuals to show they have the capacity to exercise their right to autonomy.

Commonly, values of beneficence and social protection outweigh the rights to exercise autonomy and equality and the expectation of reasonable accommodation. These rights are limited by presumptions about risk and the complexity of decisions of which persons with intellectual and psychosocial disabilities are presumed capable. The element of choice, which is essential to exercising rights, is proscribed by the way in which capacity and incapacity have been determined in law. Involuntary treatment and substitute decision-making have therefore become commonplace in medicine and personal care, limiting legal entitlement for persons with complex and multiple needs.

This chapter explores international treaties and guarantees of rights that affect the exercise of legal capacity. It addresses a number of critical areas at the intersection of legal capacity and individuals with multiple and complex needs. In particular, it focuses on domestic law in Colombia and Canada in order to assess how each of those countries have recently addressed issues of competence and incompetence in complex decision-making cases and the limitations on the exercise of legal capacity. Colombia and Canada have been selected because they represent two distinct legal systems: common law (with the exception of Quebec in Canada) and civil law, and because both have progressive courts that have made advances in human rights. This chapter will examine how Colombia and Canada justify limitations on the rights of persons with complex and multiple needs, including reliance on the rationales of protecting the public (including harm to self and others), entitlement to services and protection of individual rights.

The chapter addresses ideas that have become so dominant that they are often assumed to be 'natural', rather than constructed. The normative standards in law to establish, first of all, incapacity and, secondly, appropriate treatment options, act as inherent barriers to the exercise of rights and dignity by persons with disabilities, which mandates respecting their choices and preferences. The chapter will analyse the implied and explicit rationales for beneficence and social protection within the limits of law and the ways in which capacity is negotiated (that is, the conditions for involuntary treatments or for not extending legal capacity) using historical precedents,

legislative frameworks and case law. Both Colombia and Canada have attempted to address issues of competency in dealing with persons with disabilities, providing a useful basis for comparative analysis and a helpful perspective on how to construct entitlements and protections in a way that respects rights and choice within a framework of respecting difference and diversity.

After exploring the current Colombian and Canadian laws, the chapter will outline and assess the potential that supported decision-making presents for recognising fundamental rights. Finally, whether and to what extent the requirement to ensure reasonable accommodation could entail a positive obligation to facilitate supported decision-making for persons with psycho-social and intellectual disabilities who need and want it will be considered.

Conceptual issues

The acceptance of difference is fundamental to being able to exercise rights. Building social justice and rights into the social order mandates taking into account difference and recognising social diversity and social choice. The realisation of rights depends on more than the formal recognition of rights – it requires the promotion of autonomy through economic, social, cultural and civil and political environments, as well as the access and support that individuals need in order to exercise those rights. This also requires consideration of the barriers that impede the exercise of those rights, including unequal and implied presumptions about the capacity of a person.

The first issue is the social presumptions underlying the construction of incapacity, or competing conceptions of capacity. The early grounding of capacity in notions of intellect and rationality (or capacity to reason) provided an apolitical scientific (Goddard 1914; Binet 1915) foundation for the legal system's ideology underpinning incapacity and incompetence of persons with significant disabilities. Historically, rational capacity and intellect have provided the basis for legal competence. For individuals with an unknown or presumed limited capacity, risk to self or others has been used as a legitimate justification for imposing legal incapacity.

Successive eugenicists have provided 'scientific' justifications for restrictions that found their way into statute; all were based on widely held assumptions about the unchangeable nature of intellectual ability (Goddard and Spencer 1882; Goddard 1912). Social controls, such as the determination of incompetence and restrictions on activity, were needed to ensure that capitalist society could operate efficiently (Evans and Waites 1981). Partially grounded in the history of scientific positivism and biological determinism, as well as the conceptualisation of an 'efficient' society, individuals were classified as mentally incompetent and innate ability was viewed as uni-dimensional, leading to a binary legal assessment of incompetence versus competence.

This one-dimensional characterisation has rationalised the perceived need for society to protect itself from persons with significant disabilities. It has also served to justify measures adopted to protect individuals with disabilities from harm because of their inability to participate in socially accepted ways (for example, medical treatment, admission to an institution, testimony in court, marriage and parenthood) and in economic transactions (for example, managing property, entering into a contract and making a will). It has enabled legislation regarding mental competence to presuppose unilinear innate ability (Evans and Waites 1981; Faber 1968; Gould 1981). This has led to the attribution of the status of incapacity based on functional capacity – that is, if an individual has a specific impairment, or once an individual has been identified with a particular functional incapacity, he or she is presumed to lack capacity.

This scientific justification of legal disempowerment to exercise the right to autonomy and equality needs to be recognised in order to develop new models for decision-making that acknowledge the span of capacity and the types of decisions that need to be made by individuals who are legally categorised as incompetent.

A second conceptual issue that needs to be addressed is that of choice. Choice, or autonomy, is arguably an essential element to quality of life. Amartya Sen (1995, 1999) and Martha Nussbaum (2006) have argued that quality of life should be measured in terms of actual available opportunities and the ability (based on either structural or individual constraints or freedoms) an individual has in exercising choice over his or her state of being.

The illusion of the isolated self and the conception of the autonomous thinking self have led to a narrow and limiting perception of the individual, and have restricted a broader exploration of capacity as a flexible notion.

Capacity has been addressed in many ways. Some authors have questioned the binary legal assessment of capacity and incapacity. In some cases, where capacity is considered to be present, law and legal arguments have concentrated on defining it. However, disability is not the same as incapacity. The presumption of incapacity for all persons with psychosocial disabilities or intellectual disabilities is based on a paternalistic approach that views persons with disabilities as needing care and charity.

Individuals who are deemed capable of making autonomous choices will have their decisions respected. Decisions made in the absence of capacity will not be recognised as autonomous choices in law. Many countries have laws or processes for determining capacity and then for determining who makes the decision if an individual is unable to make autonomous choices. The flaw in this kind of model is that, while it recognises autonomy, there is little incentive to assess how decisions are made or how support could be provided for decision-making, and it presumes that capacity is static over time in those functional areas. In other words, it does not meet a more expansive reading of Article 12 of the Convention on the Rights of Persons with Disabilities 2006 (CRPD), as we explain below.

Legal capacity under international rights guarantees

The United Nations adopted the CRPD in 2006, and supported decision-making has since gained acceptance as the preferred decision-making model within the disability movement and the legal community who work in this field. Colombia and Canada have ratified the CRPD and assumed obligations to implement the rights it sets out. International human rights law and the values reflected therein can and should assist in informing the interpretation of domestic law and courts' understanding and judgment. Article 12.2 of the CRPD states that 'States parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life', and Article 12.3 states that 'States parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Colombia ratified the CRPD without reservations, but Canada has declared that, to the extent that Article 12 may be interpreted as requiring the elimination of all substitute decision-making, Canada reserves the right to continue to use substitute decision-making in appropriate circumstances (Devi et al 2011).

The legitimisation of supported decision-making related to disability is an underlying principle of the CRPD and, in Article 3 (general principles), the rights that may have been provided for those with disabilities but were often ignored under other treaties are clearly set out. The CRPD also opens up areas of affirmative choice for persons with disabilities. The key principles of Article 3 include:

- (a) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- (b) non-discrimination
- (c) full and effective participation and inclusion in society
- (d) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- (e) equality of opportunity
- (f) accessibility.

Importantly, Article 12(2) of the CRPD recognises the equal entitlement to legal capacity and Article 12(3) recognises the potential need for supported decision-making, thus proscribing the legitimisation of coercion in decision-making. The right to autonomous decision-making is clearly recognised, although the qualification in Article 12(4) of the CRPD is potentially troublesome, with its reference to setting up a mechanism for 'proportional and tailored [exemptions] to prevent abuse' – a phrase that is left open-ended.

Article 12 of the CRPD provides a framework for recognising the legal capacity of persons with disabilities, and the principles for operationalising it. A framework for a new legal construction can be developed using the six principles listed as the baselines against which involuntary treatment can be

measured, along with the specific guarantees of legal capacity provided in Article 12 of the CRPD. The CRPD in this way addresses both the subjugation of persons to a limitation of legal capacity through legal standards or procedures for depriving them of legal capacity, compulsory treatment or forced institutionalisation or hospitalisation (see for example Article 17 (respect for physical and mental integrity), Article 25(d) (free and informed consent in health care), Article 5 (reasonable accommodation) and Article 14 (liberty)) and the extension of supportive measures that respect the autonomy, integrity and equality of persons with disabilities.

Other international agreements also support this right of legal capacity or specifically prohibit denying entitlement, although they are more categorical. These include the International Covenant on Civil and Political Rights (ICCPR), which guarantees the right to be recognised as a person before the law (Article 16) and to be equal before the law (Article 26). In General Comment 8 of the ICCPR (UN Office of the High Commissioner for Human Rights 1982), the Human Rights Committee held that Article 9 applies to deprivations of liberty owing to mental illness, including in criminal cases and detention in a private facility. General Comment 21 (UN Office of the High Commissioner for Human Rights 1992) makes it clear that this applies to psychiatric hospitals, and particularly prohibits subjecting persons who are deprived of their liberty to any medical or scientific experimentation.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) incorporates the right to the highest attainable standard of mental and physical health. The ICESCR includes two elements: the first specifies access to goods and services, and that health services are available, accessible, acceptable and of good quality. The second specifies the right to be free from interference, including non-consensual medical treatment and experimentation. However, the ICESCR exempts coercive treatment of mental illness subject to the conditions of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991 (MI Principles). The MI Principles, while not formally binding, have also been influential in issues concerning capacity. They are significantly more limiting than the CRPD in presuming that 'mental illness' may lead to incapacity and, consequently, they provide for the appointment of a personal representative. Generally, the goal of the MI Principles is to protect individuals from coercion in decision-making and to structure provisions to ensure the protection of their interests, but they do not address the exercise of affirmative or supported decision-making. Thus, they do not relieve the need for individuals to negotiate capacity to make decisions and exercise rights; nor do they provide guidelines for supported decision-making. They state:

Principle 1(6): Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be

made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel.

Principle 1(7): Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interest.

Principle 9(4): The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

However, the MI Principles have been extensively criticised with respect to informed consent on the basis that they are paternalistic, provide only a minimum standard of protection and have substantive limitations (Rosenthal and Rubenstein 1993–94; Gendreau 1997; Jones 2005; Dhir 2005; Hunt and Mesquita 2006).

In addressing 'mental' disability, the Special Rapporteur on the Right to Health (United Nations Commission on Human Rights 2005) criticised human rights violations concerning intellectual disability, persons in segregated service settings and residential institutions. The Special Rapporteur (United Nations Commission on Human Rights 2005: para 15) singled out the administration of treatment to psychiatric patients without their informed consent:

People once thought incapable of making decisions for themselves have shattered stereotypes by showing that they are capable of living independently if provided with appropriate legal protections and supportive services. Moreover, many people once thought permanently or inherently limited by a diagnosis of major mental illness have demonstrated that full recovery is possible.

A number of authors have concluded that legal capacity is at the core of all other rights, making it fundamental to the exercise of rights for persons with disabilities. As the Ontario Law Commission working paper by Michael Bach and Lana Kerzner argues (2010: 30) citing Tina Minkowitz: '[t]he language of Article 12 represents a shift from the traditional dualistic model of [mental] capacity versus [mental] incapacity and is viewed as an equality-based approach to legal capacity'. It has been recognised as a major breakthrough in view of the many prevailing legal systems that are based on determinations of mental incapacity and guardianship/substitute decision-making regimes.

This chapter turns now to the challenges entailed in negotiating capacity at the national level, by considering how Colombia and Canada have approached these issues. Have legislators examined affirmative choice for persons with disabilities? How is it possible to restrict substitute decision-making or the making of decisions on another's behalf? What social and legal conditions would allow this to occur?

Negotiating legal capacity in Colombia

The tension between a strong codification tradition and a progressive constitutional order

Colombia serves as an interesting case study for analysing how capacity is negotiated, and the challenges and opportunities faced by persons with disabilities at the local level when promoting the implementation of international human rights norms. Colombia's legal reforms frequently serve as models for other countries in the region. Recently, the right to legal capacity for persons with intellectual and psycho-social disabilities has been widely discussed in Colombia and, among other developments, the Colombian Congress recently adopted a major reform to the Civil Code concerning legal capacity (Law 1306 of 2009). Disability organisations have publicly demanded supported decision-making alternatives for persons with intellectual and psycho-social disabilities (Asdown Colombia and FundaMental Colombia 2010), and some constitutional challenges are currently underway against several provisions of the new law (Universidad de los Andes 2011).

The Colombian case is interesting because it reveals a tension that is not uncommon in other countries – the co-existence of two legal traditions: one conservative, based on legal formalism and another more progressive tradition that uses different means to try to guarantee human rights at the local level (see Restrepo-Saldarriaga 2011: 4–7; Cepeda-Espinosa 2004: 179, describing the tension of legal traditions in Latin America). In Colombia, this tension is exemplified by the contrast between the power of the Codes, which were written in the 19th century and the progressive constitution, which was enacted in 1991 and is defended by an activist constitutional court.

This section will illustrate this tension and highlight the importance of acknowledging it when devising strategies to implement the CRPD at the local level. Legal capacity under Colombian law is mainly regulated under the Civil Code, which informs the interpretation of all other related norms. Thus, judges refer to the Civil Code when faced with problems of interpretation or with situations that are not governed by other legislative areas. Special emphasis is placed on the meaning of the Code for the Latin American legal tradition and how it has served to exclude groups of people from the enjoyment of fundamental rights. This section will then go on to contrast the existing statutory law with the provisions of the constitution and the jurisprudence of the Colombian Constitutional Court regarding legal capacity and consent to treatment. Although most of the cases presented are not related to persons with disabilities, they illustrate how Constitutional Court decides issues of autonomy and decision-making in complex cases. Finally, this section will explore how the Colombian Constitutional Court has addressed matters of support in decision-making and clarify how these relate to the concepts of equality and reasonable accommodation.

Legal capacity and consent to treatment under Colombian statutory law

A common feature of the Latin American legal tradition is the adoption of the Codes in the 19th century. In particular, the French Code, known as the Code Napoléon, provided many of the core concepts and methodologies of private law in Latin America (Mirrow 2004). The codification of private law was one consequence of the struggle for independence in the region, meeting the need of those who framed the law to have clear legal rules that promoted national identity and a formal equality of all citizens. The Code encompassed the ideals of liberal thinkers of the time and depicted the individual as a rational independent being. Any individual who did not conform to this depiction was treated by the Code as an 'outsider' with limited recognition as a citizen.

The definition of legal capacity used in the Colombian Civil Code of 1887 is a good example of how the codification of private law ended up excluding individuals from the recognition and guarantee of their rights. With respect to the right to legal capacity, the original drafting of the Civil Code was as follows:

Article 1503. Presumption of capacity: Every person is legally capable, except those that the law declares incapable.

Article 1504. Absolute and relative incapability: Are deemed absolutely incapable the insane, the prepubescent and the deaf and mute, who cannot be implied in writing.

Their actions do not produce any obligations, not even natural obligations, and do not admit support bond.

Are also unable, adult minors who have not obtained authorisation, the spendthrift under interdiction to administer their own affairs, married women and legal entities. But the inability of these four classes of people is not absolute and their actions may have value in certain circumstances and under certain respects prescribed by law (Law 57 of 1887).

These articles about capacity were based on two legal institutions in Roman law: the Marital Potestas (*Potestad Marital*) and the Patria Potestas (*Patria Potestad*). The first relates to the body of rights that the law confers on the husband over the person and property of his wife. The second concerns the group of rights that the law grants parents over their children. These legal institutions were justified by the presumption of incapacity of some individuals to dispose freely of their persons and their property, under the assumption that they were not responsible for their acts. Protection of the person and of society was the central argument for justifying the figure of potestas (authority).

In the case of persons with disabilities, presumed by the Code to be absolutely incapable, the result was (and still is) the declaration of nullity of all their acts and contracts. In general, after a person has been judicially declared interdict, this presumption makes it impossible for him or her to exercise or participate in basic decisions, such as the decision to sign a working contract, to marry, to have children or to decide a place of residence. According to the law, a guardian or a curator should make those decisions on the individual's behalf (see Colombian Civil Code 1887, Articles 428 and 432). The law also commonly allows for guardians to obtain judicial permission to sterilise persons with disabilities, to subject them to medical procedures or to force them to be institutionalised. The derogatory terms with which the Code refers to persons with disabilities illustrate the lack of recognition and the denial of dignity: until very recently, civil legislation used the terms 'furious, mad', 'fools', 'imbeciles, idiots' and persons with 'raving madness' to refer to persons with disabilities (see for example Colombian Civil Code 1887: Articles 140, 545, 554).

Some reforms were eventually made to the original drafting of the Code. Mainly, these changes eliminated restrictions on women's legal capacity from the Colombian legal system. Among other legal reforms, Law 1328, enacted in 1932, granted civil status to women, allowing them to manage and dispose of their property. Decree 2820, enacted in 1974, abolished the marital potestas.

In contrast to the achievements of women, reforms to the Civil Code and other provisions regarding legal capacity of persons with disabilities were almost non-existent in the 20th century. Market interests helped boost reforms with regard to women's legal capacity (Velásquez 1989), but the same logic did not apply to persons with disabilities.

Some reforms have taken place in recent years. In 2003, the constitutional court declared several of the derogatory terms with which the Code referred to persons with disabilities to be partially unconstitutional (Corte Constitucional: Decision C-478/03). In its judgment, the Court devoted several pages to explain how those terms reflected the 'lexicon of the medical profession' at the time of the enactment of the Code Napoléon. For the court, to sustain such an 'archaic terminology' with respect to persons with disabilities would amount to promoting prejudice against them and to denying their inherent dignity. However, unfortunately, the Court also affirmed the extreme importance of guardianships and curatorship in protecting persons with a disability, despite the fact that they 'impose a severe restriction on the exercise of patrimonial rights, and in general, of their civil capacity' (Corte Constitucional 2003: Decision C-478/03).

In 2009, the Civil Code underwent a major reform related to issues of legal capacity. Law 1306, '[B]y which norms for the protection of people with mental disabilities are dictated and norms for legal representation of incapable emancipated persons are established', amended more than 100 articles of the Civil Code concerning legal capacity. Among other reforms, the Law

introduced substantive changes to the process of interdiction, appointment of tutors and institutionalisation of persons with disabilities in psychiatric facilities.

Although Law 1306 has had some positive outcomes compared with the original drafting of the Code, it continues to reinforce the Roman civil tradition according to which the main goal of a system of legal capacity is the protection of property and the security of legal transactions, rather than the promotion of independence, equality and participation of persons with disability in all respects of social life. Law 1306 also portrays a suffering being and reinforces an ideal of normality, which has been used frequently to restrict minority rights (see for example Law 1306 of 2009: Articles 1–2).

Finally, in its overall impact, the Law is far removed from the intent of the CRPD with respect to legal capacity. Rather than presuming the capacity of persons with disability, it operates under a model of incapacity, assuming that some individuals, because of their disability, are incapable of making decisions by themselves. For example, the Law makes an unfortunate classification between what it calls ‘persons with absolute disabilities’ and ‘persons with relative disabilities’. The first, according to the Law, would be those persons ‘suffering from a severe or deep affection or pathology regarding learning, behavior or mental deterioration’ (Law 1306 of 2009: Article 17). The second would be those with ‘behavioral deficiencies, wasteful administration conduct, or business immaturity who may put their property under risk’ (Law 1306 of 2009: Article 32). Furthermore Law 1306, instead of implementing supported decision-making mechanisms to allow individuals to live independently and to be self-determining, is concerned mainly with amending the interdiction process and the appointment of guardians (Articles 16–18). As opposed to prohibiting involuntary institutionalisation, the Law continues to permit it if a ‘medical expert’ considers it to be ‘necessary for the health and therapeutic treatment of the person or to protect the general public’s safety and peace’ (Articles 20–24). Moreover, Law 1306 establishes a public registry of persons who have been interdicted – that is, whose legal capacity has been fully removed (Article 19), in clear violation of the right to privacy and the right to equality, among other rights. In summary, this Law exemplifies the importance of clarifying the core concepts with respect to legal capacity, as advanced by international instruments such as the CRPD.

Legal capacity and consent to treatment under the jurisprudence of the Colombian Constitutional Court

Although Law 1306 is an example of an unfortunate outcome of recent legal capacity reform, the Colombian legal system can also provide important insights about ways to move forward in recognising legal capacity and encouraging supported decision-making for persons with disabilities. A progressive transformation has evolved since the Constitution of 1991, especially in the doctrine of the Colombian Constitutional Court. The Court,

which is known as one of the most activist courts worldwide (Landau 2010), 'has embraced the protection of fundamental rights as its driving force behind its institutional role. The protection of human dignity, freedom, substantive equality and solidarity has become a primary agenda, allowing disadvantaged social groups to seek judicial redress' (Restrepo-Saldarriaga 2011: 7).

The jurisprudence of the Court regarding autonomy and consent to treatment provides interesting precedents to ensure that persons with intellectual and psychosocial disabilities can exercise their legal capacity. As in Canada, the general rule is the right of patients to decide freely about medical treatment. The Court has placed important emphasis on the fact that consent to treatment must be informed and free. Thus, a person has the right to receive all the information necessary to be able to appreciate the consequences of a particular medical treatment. Several cases involving adults refusing medical treatments have led the Court to reinforce its jurisprudence with respect to autonomy. In one case, an adult woman refused chemotherapy for her diagnosed cancer. In Decision T-492/93, the Court denied the *tutela*, holding that under the 'right to free development of personality' (Article 16), a person is entitled to decide for him/herself if he/she wants to receive treatment. This was a short and uncontroversial ruling, but served as a foundation for future jurisprudence in more complex cases dealing with decision-making.

For example, in 1994 the court declared as unconstitutional a legal provision which criminalised the possession and use of narcotic drugs, and which imposed penalties such as arrest and mandatory psychiatric treatment (Corte Constitucional 1994: Decision C-221/94). The Court ruled that the right to free development of an individual's personality can only be constitutionally restricted when it affects others, and struck down the criminalisation of the possession and use of drugs. It noted that if the state wants to reduce drug consumption, it should use education, rather than criminalisation, to avoid compromising personal autonomy. In this decision, the court (Corte Constitucional 1994: Decision C-221/94) emphatically rejected forced treatment and institutionalisation as an attack on human dignity:

With the excuse of treatment of certain behaviors that are deemed deviant or assimilated to diseases, hides a ferocious State's repressive power. It is a power even more censurable when it is presented as a paternal attitude (almost a loving one) against the dissident. Seclusion in psychiatric facilities or similar measures is, since a long time ago, an abominable mechanism used by totalitarian regimes to 'cure' the unorthodox

Furthermore, the Court (Corte Constitucional 1994: Decision C-221/94) explicitly referred to persons with disabilities, arguing that institutionalisation of these individuals should be also an act of free will, rather than imposed:

the protection of the persons with 'physical, sensory and psychical' disabilities referred to in Article 47 of the Charter, must be understood as an

obligation of the State in favor of those who, being in one of those situations, request it; thus creating an advantageous situation for them, who have then, the *power* to require such assistance and *not the obligation* to stand decisions of the State against their autonomy. The State, the Court insists, cannot regard itself as the owner of the will and life of individuals. (emphasis added)

These legal cases also highlighted other important issues. First, they clearly showed that vague considerations about the protection of public interest and society no longer trump the exercise of autonomy. The High Tribunal ruled that it is not reasonable to limit an individual's autonomy under the sole argument that she or he might endanger others or engage in undesirable actions or behaviours. The Court stated that, within the Colombian legal system, 'a person cannot be punished for what she or he presumably will do but for what she or he does' (Corte Constitucional 1994: Decision C-221/94). Secondly, the Court ruled that, although understandable, suffering or fear among family members is not a reasonable rationale for significantly limiting the possibilities of decision-making. Thirdly, the Court ruled 'that it is not legitimate for the state to interfere in a citizen's decision to harm him or herself' (Cepeda-Espinosa 2004: 579). As controversial as this decision might be, it challenges the overprotective rationales of most legal capacity regimes.

The Colombian Court has also ruled that the state may not fulfil its duty to protect life by disregarding an individual's autonomy and dignity. In a 1997 ruling (Corte Constitucional 1997: Decision C-239/97) the Court decriminalised euthanasia when it is performed on a terminally ill patient who has expressly and freely requested assistance to die. According to the Court, from a pluralist perspective, the assertion of an absolute duty to live is not sustainable, because life must not be understood as merely tenable, but instead as life with dignity. Therefore, the state should respect the informed consent of a patient who wishes to die a dignified death.

The 1997 ruling illustrates how the right to live (Article 11) is not only about survival: it is also about living a life with dignity. For the court to deny a person the possibility of a meaningful existence, or the ability to decide what is 'good' or 'bad' violates not only personal liberty, but also the right to live. The Court acknowledged that a person with a terminal illness could be in a state of great vulnerability, so it mandated that some protective measures should be taken to ensure that the individual provides free and informed consent. The important issue here is the court's ruling that protective measures should not include denying the possibility of the individual making decisions.

Several other cases deal with the issue of involuntary treatment. For example, the Court has addressed the issue of whether or not minors can make decisions by themselves concerning medical treatment. The Court has ruled that, in these cases, the fiction of age as a criterion for consent established by the Civil Code is not applicable. These cases illustrate how the Court's

jurisprudence emphasises autonomy with respect to medical treatment, even going so far as to disregard traditional rules established by the Civil Code about legal capacity. In all of these cases, the Court placed a strong emphasis on informing and supporting individuals to make free and informed decisions.

However, when confronted with cases dealing with decision-making possibilities for persons with intellectual or psycho-social disabilities, the Court has not applied these rules consistently. Most of these cases have relied on civil law provisions regarding legal capacity for persons with disability, without noting that these rules may interfere with the exercise of autonomy rights (see for example Corte Constitucional: Decisions T-560A/07, C-478/03, T-507/07, T-867/08). The Court seems to favour the idea that ensuring human rights for persons with disabilities requires overprotection. This is evident even in the court's continual references to persons with disabilities as being extremely vulnerable and in need of protection. Moreover, in contrast to its approach in other cases in which medical opinions are only one of several aspects of determining decision-making capacity (for example, in the hermaphrodite case Decision T-585/2000, the court relied on evidence from a multi-disciplinary group), the court regards a medical diagnosis as sufficient if the person in question has an intellectual or a psycho-social disability.

One exception, however, should be highlighted. A 2002 case (Corte Constitucional 2002: Decision T-850/02) involved the sexual and reproductive autonomy of a woman with a 'slight mental disability' who had expressed the desire to become a mother on several occasions. Through a *tutela* action, her mother had requested public health officials to sterilise her to prevent pregnancy. Although a psychiatric expert testified that the petitioner's daughter lacked the capacity fully to understand the responsibilities stemming from motherhood, the Constitutional Court saw this testimony as introducing the possibility that her capacity could be enhanced with appropriate information and support. Instead of ordering the sterilisation, the Court ordered the daughter's healthcare provider to enrol her in a special comprehensive educational programme in accordance with her capacities and needs, providing her with appropriate education for an individual with her intellectual capacity to enable the autonomous and responsible exercise of her sexuality and maternity.

Supported decision-making as an alternative to negotiating capacity: the Colombian experience

Some of the cases discussed above illustrate how the Colombian Constitutional Court has regarded support to be an important element in guaranteeing an individual's autonomy and dignity. In addition to the cases dealing with autonomy, several decisions regarding the equality clause (Colombian Constitution: Article 13) provide a solid framework for supported decision-making for persons with disability. 'Support' is closely linked with the

concept of 'reasonable accommodation'. The Colombian Constitution imposes on the state not only negative duties (to abstain from arbitrarily discriminating), but also positive obligations to adopt the measures necessary to guarantee conditions of substantial equality. Paragraphs 2 and 3 of Article 13 state:

The State shall promote conditions for the guarantee of a real and effective equality and shall adopt actions in favor of groups that have been discriminated or marginalized.

The State shall provide special protection to those people that due to their economic physical or mental status are in vulnerable circumstances and will punish any abuse or mistreatment perpetrated against them.

Under the equality provision, the Court has ruled that the state has a positive obligation to take measures to remove barriers that impede persons with disabilities from being able to exercise their rights as others do. For the Court, lack of compliance with this obligation is equivalent to a form of arbitrary discrimination and, to this end, it has ordered reasonable accommodations on several occasions to guarantee that a person with disability can exercise his or her rights. For example:

- The Court demanded that the state provide interpreters to guarantee the right to education for minors with hearing disabilities (Corte Constitucional 2011: Decision T- 051/2011).
- The Court guaranteed the right to vote for persons with visual disabilities by ordering the state to provide ballots in Braille (Corte Constitucional 2003: Decision T-487/03).
- In 2007, the Court ordered City Hall to provide ramps in its historical building, to guarantee persons with a physical disability the right to work (Corte Constitucional 2003: Decision T-576/03).
- In one of the most relevant cases concerning the right to health, the Court ruled that the health system must provide free transportation for persons with disabilities, when needed, to guarantee access to medical treatment (Corte Constitucional 2008: Decision T-760/08).

In short, reasonable accommodation, which is a form of support, has been at the centre of the court's equality jurisprudence.

It is important to note that, contrary to the jurisprudence of Canadian courts, the Colombian Constitutional Court does not resort to distinctions between positive or negative rights in order to intervene. Especially in cases concerning substantive equality and socio-economic rights, the Colombian Constitutional Court has expressly stated that this distinction is irrelevant with regard to whether the Court should intervene to guarantee rights (see for example Corte Constitucional 2008: Decision T-760/08).

Beyond negotiation: supported decision-making gaining recognition in Colombia

A number of issues need to be addressed in the Colombian context to ensure supported decision-making gains recognition. The challenge is devising strategies for replacing the ideas put forward in the 19th century, so that it is possible to achieve the aims expressed in recent international instruments such as the CRPD. In the Colombian context, the increasing importance of constitutional case law and the progressive constitutional court could help introduce new paradigms into the legal system. However, the Court also needs to understand what the 'paradigm shift' is all about. One important way to do this is to show the Court that its jurisprudence already encompasses the core ideas of the CRPD and other international instruments that encourage the recognition of decision-making abilities among persons with intellectual and psycho-social disabilities. Disability organisations are preparing a *constitutional public action* against several provisions of the 2009 Law 1306, which will provide an interesting opportunity to move the court's jurisprudence a step closer to guaranteeing autonomy, equality and dignity for all.

Legal capacity and consent to treatment in Canada

In Canada, persons with intellectual and psycho-social disabilities have faced pervasive and persistent marginalisation and exclusion. Yet human rights legislation and, more recently, constitutionally protected equality rights promise otherwise. We focus on decision-making about health care to examine the reality that people with serious psycho-social and intellectual disabilities face despite these protections.

Justice Cardozo has stated that '[e]very human being of adult years and sound mind has the right to determine what shall be done with his own body' (*Schloendorff v Society of New York Hospital* 1914: 93). This precept has guided Canadian judicial decisions about medical decision-making and treatment for decades. It gives substance to the respect for bodily integrity and autonomy that is basic to common law, and is now reflected in the Canadian Charter of Rights and Freedoms (Charter). It finds expression in the legal presumption that prevails in common law and has frequently been codified in statute: all adults are presumed capable of making decisions about treatment, and healthcare providers are required to obtain informed consent prior to treatment (*Reibl v Hughes* 1980; in Ontario, see for example section 4 of the Health Care Consent Act 1996). Persons with intellectual and psycho-social disabilities have been recognised as rights holders too. In *Fleming v Reid*, the Ontario Court of Appeal held that statutory provisions in the provincial Mental Health Act, which deprived involuntary patients of any right to have their previously competent decisions about psychiatric treatment even considered in a later period of incompetence, breached the patients' constitutional right

to security of the person under section 7 of the Charter. The court stated in *Fleming v Reid* (1991: 88; see also *Rodriguez v British Columbia (Attorney General)* 1993: 587–89):

The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s.7. Indeed, in my view the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.

The law recognises that individuals can be decisionally capable for some purposes but not for others – for example, a person might be able to decide to marry or to testify in legal proceedings but not to give instructions to a lawyer or make a will (see for example *Calvert (Litigation Guardian of) v Calvert* (1997); *R v DAI* (2012)). Capacity can come and go over time, and can vary depending on the complexity of the decision.

Negotiating legal capacity in Canada

With respect to medical treatment, the legal test for capacity requires that the person be able to understand the information relevant to making a decision about the treatment, and be able to appreciate the reasonably foreseeable consequences of a decision or lack of decision (see for example Ontario's Health Care Consent Act 1996 section 4). However, the law's strong support for an individual's right to autonomy in the healthcare context is dependent on his or her legal capacity to accept or reject a treatment. In *Fleming v Reid*, the applicants' *prior* wishes about treatment *expressed when they were still considered competent* had to be taken into account, rather than their views when they could no longer meet that legal test. This poses considerable risk for individuals with disabilities. Often, 'even people with disabilities who do not have diminished levels of capacity are ... inaccurately perceived to be not mentally capable' (Kerzner 2006: 338, quoting Kaiser in Downie and Caulfield 1999) merely because of their disability. David Weisstub (1990: 116) has noted that '... the tendency to conflate mental illness with lack of capacity ... occurs to an even greater extent when involuntary commitment is involved ...'. Thus, persons with psycho-social disabilities who face involuntary commitment and/or involuntary treatment must often face formidable barriers to assert their right to decide what treatment they will accept.

In assessing the current state of Canadian mental health law generally, Kaiser has argued (2009: 143) persuasively that, contrary to what might have

been expected after the passage of the Charter and with increasing recognition of the harmful effects of segregation and stigma:

... the early twenty-first century substantive legislative regime emerges as more paternalistic and interventionist than its predecessors of the previous three decades. While offering some modest procedural protections, there are virtually no guarantees of supports and services to minimise the risk of disabling crises and to maximise the likelihood of optimal social functioning ... The typical mental health statute evinces almost complete silence on human rights protections, equality rights and discrimination, health promotion, crisis prevention and positive rights to supports and services based upon a broad conception of health determinants.

The challenges facing people with psycho-social disabilities wanting to decide for themselves about treatment were at the fore in the Supreme Court of Canada's decision in *Starson v Swayze* (2003). The following facts are taken from the Supreme Court judgment and from Sheila Wildeman's overview of this case (2012: 257). Starson had been charged, tried and found not criminally responsible by reason of mental disorder for uttering threats in the course of an altercation at his rented premises. The Ontario Review Board (the body that supervises persons deemed not criminally responsible under the Criminal Code) determined that he would remain involuntarily in a psychiatric hospital, subject to the board's mandatory annual reviews. Starson had a history of frequent involuntary hospitalisation and treatment and, during the same period, a record of notable accomplishments in theoretical physics, despite a lack of formal training in that discipline. Starson's psychiatrists proposed treatment with anti-psychotics, anti-anxiety medications and mood stabilisers, which Starson refused, although he was willing to continue psychotherapy. When his treating psychiatrist concluded he was not decisionally capable, (meaning that, under Ontario law, a substitute decision-maker would decide for him whether to consent to or refuse this treatment), Starson challenged this determination before the Consent and Capacity Board (CCB). He argued that psychiatric medications had not been helpful in the past and would not be helpful in the future, asserting that they had been 'the most horrible experiences of [his] life' (*Starson v Swayze* 2003: para 98) and left him unable to continue his work in physics and struggling even to communicate. He would not characterise his condition as mental illness, although he did acknowledge he had some mental problems.

Starson was unsuccessful initially, but appealed further to the Divisional Court, where he succeeded in having the CCB's decision overturned. His physician's appeal to the Ontario Court of Appeal and then to the Supreme Court of Canada was unsuccessful. A majority of the Supreme Court concluded that the CCB had erred by substituting its own view of Starson's best interests, rather than first determining whether he met the statutory test of decisional capacity and could make the decision for himself. The court

concluded (*Starson v Swayze* 2003: para 79) that the evidence established that Starson was able to understand and appreciate information relevant to deciding about the proposed treatment and the possible consequences:

A patient is not required to describe his mental condition as an ‘illness’, or to otherwise characterize the condition in negative terms. Nor is the patient required to agree with the psychiatrist’s opinion regarding the cause of that condition. Nonetheless, if the patient’s condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.

While this decision generated considerable controversy, others have canvassed those issues extensively, and they will not be addressed further in this chapter (Wildeman 2012: n 71; McSherry 2008b; *Starson v Pearce* 2009).

The law with respect to whether involuntary patients capable of making treatment decisions can refuse treatment varies across Canada. Peter Carver (2011: 357–58; see also Wildeman 2012: 256–57) has identified four general approaches to consent to treatment:

- (a) a right to refuse treatment (Ontario)
- (b) no right to refuse treatment (British Columbia)
- (c) a right to refuse, subject to a ‘best interests’ override (Alberta, Manitoba) and
- (d) excluding capable individuals from committal (Saskatchewan, Nova Scotia).

Treatment for purposes unrelated to the person’s mental disorder is subject to the generally applicable rules regarding consent to treatment: consent is required, either from the patient, or if he or she lacks decisional capacity with respect to that treatment, from a substitute decision-maker (Carver 2011: 364).

Supported decision-making as an alternative to negotiated capacity: the Canadian experience

In *Starson v Swayze* (2003), the court had to determine whether Starson was decisionally capable; the question of supported decision-making did not arise. However, supported decision-making is beginning to gain recognition in legislation in several Canadian jurisdictions. Nandini Devi and colleagues (2011: 254–55) have noted that the supported decision-making model:

... is predicated on the basic principle that all people are autonomous beings who develop and maintain capacity as they engage in the process

of their own decision-making even if at some level support is needed. ... In the supported decision-making paradigm, the individual receives support from a trusted individual, network of individuals or entity to make personal, financial and legal decisions that must be followed by third parties such as financial institutions, business, health professionals and service providers.

Although supported decision-making is rarely the subject of judicial consideration, courts have recognised its utility in assisting individuals to exercise capacity. For example, in *Re Koch*, a woman with multiple sclerosis challenged her assessors' determination that she lacked capacity to manage her own financial affairs, and to decide whether to continue to live independently or in a care facility (*Re Koch* 1997). These assessors had become involved at the insistence of the woman's husband, from whom she was separated and engaged in litigation. As the presiding judge remarked, '... in the vernacular, her cry is "my husband had me committed!"' (*Re Koch* 1997: 485). Justice Quinn concluded the assessors had been unfair in conducting their assessments, and the evidence did not support their conclusion that she lacked capacity. He added: 'It is to be remembered that mental capacity exists if the appellant is able to carry out her decisions with the help of others', referencing the services and supports available to her in the building where she lived, which was operated by a community-based rehabilitation and advocacy charity for people with physical disabilities (*Re Koch* 1997: 513).

British Columbia's Representation Agreement Act 1996 provides an example of legislation recognising supported decision-making: adults can enter into a 'representation agreement' with trusted persons or support services, and authorise them either (i) to help the individual make decisions about personal care, routine financial management, health care and other listed matters; or (ii) to make those decisions on behalf of the individual. This agreement does not require the individual to have 'legal capacity' in the conventional sense. Factors taken into account in determining capability to make such an agreement include: whether the person communicates a desire to have the representative help to make, in fact make or stop making decisions; whether the person demonstrates choices or preferences and can express feelings of approval or disapproval of others; whether the person has a relationship with the representative characterised by trust; and whether the person is aware that making or changing the agreement can affect the representative's role in decision-making. Other British Columbia statutes also incorporate provisions related to assisted decision-making. Section 2 of the Adult Guardianship Act 1996, for example, states that guardianship should not be sought or granted unless alternatives, such as providing support and assistance, have been attempted or carefully considered (see also for example the Health Care (Consent) and Care Facility (Admission) Act 1996).

In Manitoba, the Vulnerable Persons Living with a Mental Disability Act 1993 is meant to protect the rights of 'vulnerable persons', including any

adult who lives with a mental disability and requires assistance with basic needs of personal care or property management. While the legislation promotes supported decision-making over substitute decision-making, it does so for a limited class of persons. Section 1 defines 'mental disability' solely in terms of intellectual disability, and excludes 'mental disorders', limiting the statute's reach. Section 6(2) states that '[s]upported decision-making by a vulnerable person with members of his or her support network should be respected and recognized as an important means of enhancing the self-determination, independence and dignity of a vulnerable person'. Section 6(1) 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'.

Manitoba Family Services and Labour (2012) describes the role of a support network as including involvement in individual planning; supporting the person making choices and decisions; helping the person understand, communicate and carry out functions he or she may not be able to do alone; and linking the person to a larger community to strengthen the circle of support. Prince Edward Island and the Yukon also have legislation that provides for assistance in decision-making, the former with respect to health care and the latter more generally (Consent to Treatment and Health Care Directives Act 1988 (PEI); Adult Protection and Decision-Making Act 2003 (Yukon)).

In contrast, substitute decision-making, which is the norm in much guardianship law, allows others to make decisions on behalf of a person who cannot meet the legal test for decisional capacity. Leslie Salzman (2010: 165) has noted that '[w]hen it comes to the obligation to assist persons with a diminished ability to make decisions ... we generally accept the notion of supplanting, rather than assisting, the decision-making process'. While there has been some openness to supported decision-making, substitute decision-making remains the prevalent model in Canada.

Robert Gordon (2000: 65) has argued that '... the concept simply recognizes the way in which most adults function in their everyday lives' (see also Bach and Kerzner 2010; Devi et al 2011). Rather than accepting the sharp distinction drawn in law between those who meet the legal test for decisional capacity and those who do not, they emphasise that many individuals seek help with decisions – from family, friends, lawyers, physicians, accountants, mechanics and others. Thus, they stress our similarities as decision-makers, rather than our differences, and argue that needing assistance should not automatically disqualify an individual as an autonomous decision-maker. Instead, appropriate supports must be made available, enabling the person concerned to retain power and authority.

The provision of appropriate supports is consistent with obligations under human rights legislation and the Canadian Charter. Individuals have a right to access services (including health care) without discrimination on the basis

of disability. They have a right to equality before and under the law, and to the equal protection and benefit of the law, without discrimination because of disability. As rights holders, they are entitled to reasonable accommodation so they can exercise those rights. Further, as Gwen Brodsky, Shelagh Day and Yvonne Peters (2012: 9) pointed out in their recent analysis of developments in human rights and Charter jurisprudence, *Accommodation in the 21st Century*, the Supreme Court of Canada's decisions in *British Columbia (Public Service Employee Relations Commission) v British Columbia Government Service Employees' Union* (1999) (*Meiorin*) and *British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights)* (1999) (*Grismer*) have made it clear that the duty to accommodate is not limited to '... a duty only to make individual after-the-fact exceptions', but extends to changing the standards employed from the outset (see also Pothier 1999–2001; Schucher 2000: 338). Speaking about employment-related discrimination on the basis of gender in *Meiorin* (1999: para 68), Chief Justice McLachlin stated:

To the extent that a standard unnecessarily fails to reflect the differences among individuals, it runs afoul of the prohibitions contained in the various human rights statutes and must be replaced. The standard itself is required to provide for individual accommodation, if reasonably possible.

The court's reasoning was not limited to employment: *Grismer* was a case of discrimination on the basis of disability in the criteria used to determine eligibility for a driving licence, and the court took the same analytical approach. Brodsky, Day and Peters (2012: 10) have concluded that '[a]ccommodation is not only tinkering, for individuals; it is systemic. It is not only after the fact, it is proactive'. This understanding of reasonable accommodation meshes well with frameworks that would enable supported decision-making.

Beyond negotiating: supported decision-making gaining recognition

Consistent with the decisions in *Meiorin* and *Grismer*, when negotiating capacity it is important to broaden the standard for determining capacity to accommodate persons with disabilities. More particularly, we argue there is an obligation to ensure reasonable accommodation to enable persons with psycho-social and intellectual disabilities to exercise their capacity to make decisions. Such accommodation could include forms of supported decision-making that the individual concerned needs and wants (see examples in Bach and Kerzner 2010: 24). This may entail imposing positive obligations on the state or on service providers, to ensure needed supports are made available.

Canadian courts have been notably reluctant to recognise that the state may be subject to positive obligations to remedy a breach of individuals' constitutional rights. The Supreme Court of Canada's decision in *Eldridge v*

British Columbia (Attorney General) (1997) is a rare exception, one which arose in the context of disability (see also *Canadian Association of the Deaf v Canada* (2006) regarding access to government by people with impaired hearing). The court concluded that, in refusing to fund sign language interpreters to allow individuals with hearing impairments to communicate effectively with physicians when receiving publicly insured health services (a benefit to which all Canadians are entitled by law), hospitals and the provincial public health insurance plan had discriminated on the basis of disability and breached the Charter right to equality. In reality, the Supreme Court of Canada's judgment has not been widely implemented in practice (Flood and Chen 2010: 494). The more common judicial response to claims that the state is constitutionally obligated to take positive steps to avoid breaching citizens' Charter rights is evident in the Supreme Court of Canada's decision in *Gosselin v Quebec (Attorney General)* (2002), a challenge to the Quebec government's decision to reduce welfare payments to younger recipients unless they participated in approved training programmes. The court concluded that the state had not breached individuals' rights to life, liberty and security of the person under section 7 of the Charter, or their equality rights under section 15, even though it had reduced the welfare payments in question to levels grossly inadequate to support life. The court declined to interfere with the government's decision, essentially holding that whether or not welfare recipients received sufficient support to survive was a policy decision for the government to make, and not a matter of positive obligation on the state.

Human rights legislation and statute-based human rights protections, however, have often provided the basis for imposing positive obligations. For example, in *Council of Canadians with Disabilities v Via Rail Canada Inc.* (2007), the Supreme Court of Canada confirmed that service providers must utilise inclusive standards in designing services, such that Via Rail had to ensure the rail cars it had purchased secondhand met accessibility standards for passengers with mobility restrictions.

Relying on this decision and others, Gwen Brodsky, Shelagh Day and Yvonne Peters (2012: 43) argue that '[i]f access to an institution or service is fundamental to the equality of people with disabilities and the sought-after accommodation is integral to it, denial of the accommodation should be understood as prima facie discrimination'. Deciding about how to live one's life certainly fits this description, making retaining decision-making power and authority vital to achieving equality, and triggering the obligation to provide reasonable accommodation tailored to an individual's circumstances.

Recognising the duty of the state and service providers to provide reasonable accommodation could serve as a counterweight to courts' reluctance to impose positive obligations on the state. As Justice Sopinka noted in *Eaton v Brant County Board of Education* (1997: para 67):

Exclusion from the mainstream of society results from the construction of a society based solely on 'mainstream' attributes to which disabled

persons will never be able to gain access ... Rather, it is the failure to make reasonable accommodation, to fine-tune society so that its structures and assumptions do not result in the relegation and banishment of disabled persons from participation, which results in discrimination against them ... It is recognition of the actual characteristics, and reasonable accommodation of these characteristics which is the central purpose of s.15(1) in relation to disability.

Arguments that an expansive understanding of 'reasonable accommodation' is needed to enable decision-making by persons with psycho-social and intellectual disabilities will probably be met with the response that, because of 'real differences', these individuals cannot make their own decisions, whether about treatment or other matters. In other words, borrowing from language used in *Eaton*, the 'true characteristics of this group' preclude them from this role, and require instead that others assume authority over their lives. Tied to this will be arguments that the courts' *parens patriae* powers mean the judiciary has an obligation to protect those who are not able to care for themselves. However, this kind of blanket conclusion, made without seriously considering how supports could enhance individuals' ability to understand, appreciate and make decisions, falls short of meeting the requirements of human rights law. Considerations of reasonable accommodation must be built into the standard from the outset. With regard to the courts' *parens patriae* responsibilities, its powers are meant to protect persons who are not decisionally capable (Peppin 1989–90: 65). If supports can enable a person to meet that threshold, then the court's jurisdiction would not be triggered.

Conclusions

Concerns about the context and content of a decision-making model will, and should, persist. Supported decision-making can easily slide into substituted decision-making, such that an individual's decision is effectively made by his or her support network instead of by the person concerned. The individual may also be vulnerable to exploitation and abuse. Further, supported decision-making could be imposed too readily and applied to individuals who do not need it, thereby subjecting them to unjustified intrusion.

Historically, some classes of people have had to negotiate their legal capacity. Some issues, such as those related to involuntary treatment, are constructed in law and then individually negotiated. Although some groups have made progress in affirming their decisional capacity, others, particularly persons with psycho-social and intellectual disabilities, have faced greater barriers in asserting their rights to legal capacity. The CRPD is a step forward in this respect, in that it presents an interpretation of decision-making that is not categorical but can be supported.

Framed within questions that arise at the interface of medical treatment, legal protection and community care, this chapter has argued that dignity,

equality, non-discrimination, autonomy and inclusion are inherent to every individual, whatever his or her condition. Within these parameters, individuals are presumed to have the legal capacity to act or to make their own decisions. The need for support or accommodation should be proportional to a person's capability and the nature of the disability should determine what support or supports need to be provided. The effectiveness of support provided (an outcome measure) should determine whether the support is adequate and appropriate. Every individual's dignity, equality and decision-making capacity must be recognised, along with an acknowledgement that the latter may vary under different circumstances and over time.

The challenge now is to implement the CRPD domestically. Here, we have focused on two countries to explore some of the local challenges faced by persons with disabilities in gaining recognition of their legal capacity. Canadian and Colombian courts both take human rights seriously, but the cases from both countries demonstrate entrenched and grounded notions of substituted decision-making, and reveal the presumptions about persons with disabilities that have led to legal constructions of (in)capacity. To remove these legal blinkers, we need to rethink capacity, beginning with a presumption of ability with support. The concept of support needs to be central, rather than individual ability; the idea of reasonable accommodation is a first step. In any case, the legal framing of support needs to be addressed. An expansive model of supported decision-making in the context of reasonable accommodation will draw on concepts of equality that fall outside the traditional notion of equal treatment, and beyond the neoliberal notion of equal opportunity to recognise equal outcome (Rioux and Valentine 2006: 47–69; Rioux 2003: 287–317).