

In debate

The UK Government should withdraw from the Convention on the Rights of Persons with Disabilities

Paul Gosney/Peter Bartlett

Summary

Many psychiatrists in the UK may be surprised to find that the Government ratified a convention ten years ago that suggests compulsory mental health treatment be prohibited. The Convention on the Rights of Persons with Disabilities is arguably the most important legal instrument that no one in psychiatry ever discusses, but if moved from ratification to enforcement it would have enormous effect on day-to-day practice. Here, Dr Paul Gosney argues that the convention if enforced would be damaging for the people it aims to protect, whereas Professor Peter Bartlett defends it as a necessary challenge to the inequalities in our current system.

Declaration of interest

P.G.: None/P.B.: None.

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Disabilities; CRPD; Convention on the Rights of Persons with Disabilities; mental illness; equality and human rights.

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For

The Convention on the Rights of Persons with Disabilities (CRPD) is a United Nations Treaty that was established with the purpose of ensuring that people with disabilities had access to all human rights. It came into force in 2008 and the UK ratified the Convention in 2009. The CRPD together with General Comment One (GC1), which is the Committee On The Rights Of Persons With Disabilities' interpretation of the Convention, commit our Government to a position that forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (Article 17); freedom from torture (Article 15); and freedom from violence, exploitation and abuse (Article 16).¹ Specifically, in the 2017 report by the Committee on the UK they recommended that the UK, 'Repeal legislation and practices that authorize non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment'.²

I argue that this approach is incoherent and that the Convention should be revised to include the possibility of treating without consent those who lack capacity or the UK should withdraw from the Convention.

The writers of the Convention had considerable problems with defining disability, but their definition as it pertains to this debate is 'long-term...mental, intellectual...impairments which in interaction with various barriers may hinder...full and effective participation in society on an equal basis with others'.³ No mention of mental illness is made in the Convention or GC1, instead it is recast as psychosocial disability. There is no definition of what long-term means. Szmulker *et al.* make the point that many mental health conditions result in 'potentially short-term impairments – often reversible with treatment'.⁴ If the paradigm case of mental illness – schizophrenia – is not considered a long-term psychosocial disability by the advocates of the Convention approach, then we can probably all go home. As it stands, the implication of the Convention then is that no patient with schizophrenia can ever be admitted to hospital nor treated without their consent,

including in crisis situations.¹ It is to be noted that there is a window for the treatment of people with 'short-term' mental impairments, although why it would be acceptable to force treatment on such people and not those with schizophrenia is not explained in the Convention.

The recently completed, Final Report of the Independent Review of the Mental Health Act 1983 discusses the CRPD extensively and comes to the conclusion that the Committee's interpretation of the Convention 'goes too far'.⁵ It is not apparent from the report what an appropriate interpretation would be, although clearly that was not in the terms of reference. The report is clear that adopting the Committee's view would require fundamental changes to the Mental Health Act and to the Mental Capacity Act, but believes that this is not necessary to secure greater rights for patients.

A proposed solution to the problem of how to retain the possibility of coercive treatment and be compliant with the CRPD is to use substitute decision-making through the assessment of a person's decision-making capability. At least eight countries, including several European countries, Australia and Canada, issued reservations on signing the Convention in which they stated they would keep 'substitute decision-making procedures' in place. However, we need to be clear that the aim of the Convention is to end compulsory treatment of people with mental illness for any reason, and so attempts to smuggle compulsory treatment back in by those countries, using mental capacity or decision-making capability have been rebuffed.¹ GC1 explicitly rules out this approach by asserting that the assessment of mental capacity is flawed and is just another way of discriminating against those with disability because it 'presumes to be able to accurately access the inner workings of the mind'.¹ Leaving aside the lack of quoted evidence for this assertion, it is arguably an attack on the whole projects of psychology and psychiatry, which seek to understand the minds of individuals.

The easiest superficial way of making the Mental Capacity Act compliant with the CRPD would be to remove the part of the test that deals with 'an impairment of, or a disturbance in the functioning of, the mind or brain',⁶ because on the surface that would appear to remove discrimination based on physical or mental health status. But as Professor Bartlett has pointed out elsewhere, this would just

be another way of discriminating against those with disabilities,⁷ because the lack of mental capacity itself can be viewed as a disability, and so we would be guilty again of smuggling discrimination in through the backdoor.

The Committee's approach seems to view mental illness in a static manner, i.e. that its presentation does not vary with time. However, an illness like schizophrenia can vary profoundly: at times a person may need few or no supports to enjoy legal capacity whereas at others it is hard and arguably impossible for the person to have legal capacity. It is this failure to recognise the fluctuating course of mental illness that underpins the failure of the Committee's approach. The fluctuating nature is important because mental illness can impair autonomy, or, to put this another way, there are some people for whom the only way of maximising their autonomy is through treatment with medication, and there is a subset of this group for whom their autonomy is so impaired by mental illness that compelled treatment can be justified, if only to increase their autonomy.

I argue that the CRPD is potentially in conflict with the European Convention on Human Rights (ECHR) as case law has demonstrated that member states have a positive duty to protect life. This includes prevention of suicide where there was a known 'real and immediate risk'.⁸ Although relevant cases brought before the European Court of Human Rights have only dealt with people that are institutionalised, if the Convention were to be fully observed then it is not too much of a stretch to imagine the relative of a person with mental illness who had taken their own life after not being detained to hospital bringing a case before the Court. The best we could offer in such circumstances would have been voluntary admission or community services, but if these were refused by the patient then we could do nothing. This not only appears inhumane, but under the current legal regime it may leave the member state of the assessing psychiatrist open to a case under Article 2 of the ECHR.

Finally, I want to consider the position of the mentally disordered offender. The Committee is clear in wanting to sweep away insanity defences and instead have everyone treated in the same way.⁹ This would lead to something of a paradox; however, under normal circumstances a person must form the intent of the criminal act (among other things) to be found guilty of it, but it would be difficult to argue that all psychotic offenders were able to form intent. The answer would either be to find people in this category not guilty or guilty without forming intent. The former would lead to an increase in danger to the general public, whereas the latter would necessitate a radical haul of our legal system and potential discrimination against those with mental disorders.¹⁰

What does the committee imagine goes in the place of forced treatment? Non-medical treatment centres!¹ At times it feels as though we are being cast as caught in a medical or psychiatric ideology, that our opposition to these parts of the Convention is because we lack sufficient imagination to see what the world would be like in the absence of forced treatment. Given that my position is from within psychiatry, maybe I am indeed caught in an ideological view, but in my daily clinical work I often assess people who are unwell, present high risks to themselves and are refusing help. The decision to detain such people is not taken lightly or by one individual, and this reassures me that these decisions are reasonable and ethical.

One can laud the aims of the Convention insofar as they promote the rights of people with mental illness. However, some of the articles and their interpretation could do radical damage to mental health patients by bringing back the pre-antipsychotics era. Much of modern psychiatric practice feels like we are trying to rescue people from damaged lives. If one of our tools is going to be taken away, then there needs to be a corresponding commitment from society to do better by all its members.

In conclusion, the CRPD and its interpretations must be altered to allow compulsory treatment for people suffering mental illness or where there are mental sequelae of physical illness by mental capacity test, or the UK Government should withdraw. To do anything else is to undermine the Government, the ECHR and the UN and, more importantly, because of the deadlock caused by ratifying the Convention without the intention to act on it, the progress of the rights of people with mental illness in the UK is inhibited.

Paul Gosney

Against

The CRPD came into effect in 2008. Britain has signed and ratified the Convention and its optional protocol, so it applies here. As Dr Gosney has noted, interpretations by the CRPD Committee (the United Nations body charged with the CRPD's implementation) and a number of commentators have proposed fundamental changes to the ways structure laws relating to mental disability (including psychosocial disability – people with mental health problems – and intellectual disability): our reliance on legal capacity and our laws relating to detention and compulsion are said to be in violation of the CRPD if they rely, in whole or in part, on an individual's disability.¹ That pretty much puts paid to mental health law and mental capacity law as we know it.

Unsurprisingly, this has proven controversial,^{10,11} but the Committee's approach has to be understood in terms of the CRPD as a whole, why it was thought necessary and what it is meant to achieve. It grew from an international consensus that systems of human rights that have developed since the Second World War were not delivering human rights to people with disabilities. Regarding people with mental disabilities, this will not be news to readers of this Journal. We are most comfortable thinking of these as 'foreign' problems, and the information gathered by the United Nations Subcommittee for the Prevention of Torture (<https://www.ohchr.org/EN/HRBodies/OPCAT/Pages/Documents.aspx>), the European Committee for the Prevention of Torture (CPT) (<https://www.coe.int/en/web/cpt/states>), Validity (formerly the Mental Disability Advocacy Centre; <https://validity.ngo/>) and Disability Rights International (<https://www.driadvocacy.org/media-gallery/our-reports-publications/>) provide pointed reminders of problems abroad.

However, a glance at UK data reinforces that we have little here to be complacent about. Detention rates are rising, particularly from the Black and minority ethnic community.¹² Our policies regarding seclusion, segregation and restraint, our use of police cells to hold people pending admission and our safeguards to compulsory treatment have recently been criticised by the CPT.¹³ A 2018 Care Quality Commission report found evidence of patient involvement in development of less than one-third of care plans.¹² We talk a good game about community living, but that same report found discharge planning in less than a quarter of care plans. For those in the community, a study by the Equality and Human Rights Commission notes that the absence of support makes housing providers reluctant to house people with mental disabilities.¹⁴ Only 53% of people aged 25 to 54 years with mental health problems are in employment, a figure which falls to roughly 31% when coupled with another illness, and those who do work earn 23% less than non-disabled people.¹⁵ These statistics become more pronounced for people with more severe disabilities: in 2009, only 3.4% of people on the Care Programme Approach were employed more than 16 hours per week, despite close to 90% of people with mental health conditions wanting to work.¹⁶ Confirming what we already knew, the fierce and adverse effects of austerity on people with disabilities (including mental disabilities) has been criticised by four separate

United Nations reports in the past 5 years.^{17–20} The most recent notes that nearly half of the households in poverty in the UK include persons with disabilities.¹⁸

These inequalities have been with us for so long that they feel somehow natural. They are not. They are the result of policy choices relating to issues such as employment, social welfare, housing and health. Anyone who has seen people with mental health problems denied employment (or discouraged to apply for employment because their benefits will be put at risk) or denied benefits or decent housing has seen those policy choices in action. Also damaging is the more passive exclusion of people from daily activities and social spaces, either because supports are not in place to facilitate social involvement, or because environments are not conducive to their involvement or because of stigma – the implicit or explicit message that people with mental disabilities are not really wanted.

A number of comments need to be made about the policy choices that underpin these outcomes. First, they are choices: they have not always existed, growing instead out of theories of governance and society founded in the 19th century. I am not proposing that we attempt to revert to a mythic 18th-century idyll, but we do need to recognise that things can be different. Second, the policy choices have characterised people with mental disabilities as appropriately the subjects of control and social exclusion. Sometimes that has been literal (closed asylum wards, for example), and sometimes it has been more symbolic or notional (such as marginalisation in the community). Often, it has been done with the best of intentions. The human rights law that arose after the Second World War accepted this overall approach, allowing control of people with mental disabilities so long as appropriate legal processes were in place, for example the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), Article 5(1)(e). This leads to the third and overarching point: these policy choices have bequeathed us a world in which people with mental disabilities are second-class citizens.

That is what the CRPD is designed to challenge. It is an attempt to hit the reset button. It envisages a world where people with disabilities do get to enjoy the human rights, life chances and aspirations taken for granted by the rest of us: it wants people with disabilities to have full and equal citizenship. It includes provisions relating to the full array of social as well as political rights, many of which readers of this Journal will find laudable. It is not anti-state or libertarian in outlook – indeed, it relies on direct intervention by government, legislative and administrative structures for its implementation – but it does recast the role of the state from controller or manager of people with disabilities to service provider and supporter. It does not deny the reality of disability and its effects. Rather, the expectation is that the state will work with disabled persons and their representative organisations to develop services that disabled people want; however, as is the case with other citizens, services are to be offered, not imposed. In the CRPD vision, people with disabilities get to make the same choices as the rest of us. That is, I suspect, a vision that will chime with the sympathies of the readers of this journal, and therefore does lead to a conclusion on the motion: no, the UK should not withdraw from the CRPD.

It is in that context that the CRPD Committee's critique of psychiatric compulsion must be read. The current law is certainly an inheritance from the past. Can any of us seriously suggest that if we were starting with a blank page, we would design anything like the sort of system we have now? The interpretation of the Committee is not an abandonment of people with mental disabilities, rather, it is a demand that support be provided to people with mental disabilities, to access services appropriate to their needs and that they are prepared to accept. This is certainly a significant departure from the legal structure we have now, but it is also

similar to how we provide other medical services. If we are looking to a model of equal citizenship, that would be a mark in its favour.

The Committee is meant to engage in a 'productive dialogue' with States Parties to the Convention, so there is room for debate of the positions it has expressed. That does need to occur, however, in the context of the problem, universally acknowledged, that the CRPD was introduced to address: human rights are not getting through to people with disabilities. This means that the way forward cannot simply be a reaffirmation of what has come before; we have been trying that for 70 years and it has not produced the desired results. Simply negative criticism of the Committee approach is of limited help because without proposing an alternative, it risks becoming little more than an affirmation of the status quo.

I suspect that most readers of this Journal will be sympathetic to that overall project (although perhaps more skittish when it comes to reforms to compulsion based on mental disability). Psychiatrists and other mental health professionals have, after all, been at the forefront of the fight against stigma and the fight for better implementation of the right to health. Individually and at an organisational level, criticisms have been made of reductions in community services, social welfare policies and availability of good social housing. I suspect that few readers of this Journal would defend the status quo, either abroad or in the UK, as a vision for the future.

The Committee has provided one set of proposals to bring about change. For critics of that position, simply repeating the old mantras that have not provided adequate results in the past is not enough: the CRPD arose because those models have not delivered. The challenge instead is to develop a positive alternative. It must of course reflect the wording of the CRPD itself. That includes involving people with mental disabilities and their organisations in developing solutions. However, importantly, the alternative must articulate the legal and cultural shift that will create the meaningful life choices, provide the human rights and ensure the full citizenship for people with mental disabilities that the rest of us take for granted.

Peter Bartlett

For: rebuttal

Professor Bartlett makes many good and important points about discrimination against those with disabilities, both globally and in the UK. It would be unreasonable to oppose the CRPD in its efforts to break down this discrimination in the fields of work, housing, transport, etc. However, it does not follow from this aim that there is no place for treating unwell people without their consent in certain limited situations.

Professor Bartlett's main line of argument with regards to compulsory treatment appears to be that the Committee's interpretation is but one possible interpretation of the CRPD and that the Committee should be negotiating with the States on how to interpret the CRPD rather than imposing its will. There is no evidence for such an approach. Indeed, given that the Committee is charged by the Convention on interpreting the CRPD and producing reports on its implementation by each State, its power in interpreting the Convention is substantial.

Professor Bartlett makes the claim that no one would design such a system as the one we have if they were to start again, but I suspect that most of my colleagues would design a system in which compulsory admission and treatment had a role. This is a finding which is backed up by patients who have experienced such a system, with 64% of previously detained respondents agreeing that 'it is sometimes necessary to treat someone in hospital

against their wishes, even when they have the ability to make decisions for themselves and say they do not want to be treated in hospital'.²¹ A similar proportion agreed that 'restricting' human rights was sometimes necessary to protect a person's own safety.

The Committee's attempts to move the Overton window toward abolishing coercive care have been so extreme as to marginalise their views from mainstream mental health practice in the UK; the CRPD is irrelevant to the daily practice of UK psychiatrists. It is, however, highly relevant to a coterie of human rights lawyers with no or little clinical experience, and a minority of patients.

Unlike his previous position (see above), Professor Bartlett seems to leave open the possibility in this discussion of coercion based on tests of mental capacity, since he says that although the CRPD text is sacrosanct, the Committee's interpretation is not. It is the Committee that has rejected coercion on mental capacity, not the text itself. Given that the final review of the Mental Health Act also leaves open the possibility of a fusion law while noting CRPD objections to Northern Ireland's implementation of one, maybe this is finally some common ground. However, in practical terms the UK Government would still have to withdraw from the Convention and then re-sign it with reservations, noting its intention to retain substitute decision-making.

In passing, Professor Bartlett appears to endorse the view that there are only mental disabilities not mental illnesses, or at least that he is only interested in the rights of those with mental disabilities. In repeating this error from the Convention, he ignores the fluctuating nature of mental illness and associated impairments, which is the root of much of the Convention's problems; that is, attempting to apply a model of improving the rights of those with physical disability, in which disabilities are often static or slowly changing and do not usually affect a person's ability to make decisions, onto the concept of mental illness.

Finally, Professor Bartlett argues that it is not enough to criticise the Committee's interpretation without coming up with an alternative, but that this alternative must be based on the CRPD. Again, although I can agree with much of the CRPD, the insistence on banning compulsory treatment means that the whole Convention must be rejected. It is not sufficient to say that because most of the CRPD is reasonable then the unreasonable parts must be accepted as well.

I restate my case to withdraw from the CRPD, its absolutist stance is impeding progress in improving the lives of people with mental illness by forcing stakeholders into a binary position of accepting or rejecting the whole package. There does appear to be an emerging consensus around using decision-making capability to allow detention and compulsory treatment. It would be helpful if the Committee would listen and respond in a more constructive way to this proposed solution.

Paul Gosney

Against: rebuttal

I trust my initial argument addresses Dr Gosney's first objection to the CRPD: it is not 'incoherent'. It is a convention that endeavours to create a world of full and equal citizenship for people with disabilities (including mental or psychosocial disabilities). Much of that will be uncontroversial, and indeed welcomed, by readers of this Journal. What will be controversial is the CRPD Committee's challenge to compulsion. That seems to be Dr Gosney's position: the CRPD's efforts to combat discrimination outside psychiatry are to be lauded, but compulsion within psychiatry is a different matter. With respect, that is a little too convenient.

I do not claim that the CRPD Committee has the matter solved, or that development and implementation of new models will be

easy, but I do claim that fundamental re-thinking is required. Medical compulsion is inherently problematic: the lives and choices of people with mental disabilities are governed and controlled in a highly intrusive way. This extends not just to the immediacies of hospital admission and treatment, but to much of the individual's life. Unusual or 'inappropriate' behaviour is likely to trigger a call to the psychiatric system, so the medical control is likely to be experienced throughout the individual's life: Big Brother really does seem to be watching, however well-meaning and competent the professionals are. That is not the full citizenship enjoyed by the rest of us and envisaged by the CRPD, but a sort of 'citizenship up to a point'. In CRPD terms, that is a problem.

This intersects with the literature in psychiatric ethics. People who work at the interface of psychiatry and law have recognised for decades that there is something not quite right about psychiatric compulsion. Doctors do not like being agents of social control, and no one is particularly enthusiastic about the justifications for compulsion on offer: clinical benefit (too paternalistic and discriminatory), dangerousness (too imprecise and discriminatory) or capacity (too malleable and also, arguably, too paternalistic and discriminatory). The system continues not because anyone is enthusiastic about it, but in part because it is what we have always done (and are expected to do by the politicians and broader society) and in part, as Dr Gosney suggests, because at the point of presentation at an accident and emergency ward or psychiatric intensive care unit, there is perceived to be a real need: doing nothing seems callous and wrong.

Given the double imperative of the call for full citizenship of people with disabilities and the reality of people in crisis, how can things move forward? That is not a question that is going to be solved in the next few paragraphs, but the CRPD does offer some approaches that warrant consideration.

First is to actively engage with the process. The CRPD Committee has now issued seven General Comments interpreting the CRPD. Each was preceded by a consultation. Neither the Royal College, nor indeed any other major body of UK psychiatrists or mental health professionals, has responded to these consultations. UK psychiatrists do often have real understanding both of the problems of existing systems and the need to improve things for people with mental disabilities. Contributions that try to engage with the CRPD and the Committee really might be helpful.

Perhaps most important is the expectation is that people with disabilities will be involved in the development and implementation of any policies that affect them. The Wessely Committee offers some cause for gentle optimism here: people with experience of using the mental health system were included both on the Committee itself, and in its advisory groups. Although that is obviously encouraging, it is not something we should be complacent about. Ensuring that such involvement permeates the new system in its development and implementation is important.

The CRPD and its supporting literature speak forcefully about the need to provide support for decision-making, and for decisions to be made consistently with the will and preferences of the person with disability. When it really is not possible to determine the individual's own view, decisions are to be made best on our best estimation of the individual's will and preferences. What systems of support are appropriate, and how will and preferences are ascertained, are the subject of considerable debate. Does one, for example, look at the longstanding and consistent views of an individual in preference to the immediate choice of that individual, when that choice is inconsistent with the longstanding view? Is the answer different if their view may reasonably be expected to revert to their earlier view following intervention? Particularly when we are unsure of what the will and preferences are, and are making our best estimate of them, how do we stop this analysis of

will and preferences from becoming yet another iteration of ‘doctor knows best’? These are complicated questions and there is certainly much left here to work out, but the notion that we should start with the individual and what he or she wants (or would want) is an important reorientation of our mind-set.

Or is it? Good clinicians should already be taking these factors into consideration in determining the care and treatment plans for their patients. In that light, how different is the CRPD from good, existing clinical practice? Perhaps the CRPD is not something clinicians should be afraid of, but instead something clinicians should embrace. It might perhaps be a way not merely for people with disabilities to obtain the lives they want to live, but for clinicians to provide the services they want to deliver.

Peter Bartlett

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