

# The U.N. Convention on the Rights of Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with Developmental Disabilities

BRYAN Y. LEE\*

*When individuals with developmental disabilities are civilly committed into state institutions, they often lack the same procedural protections that are afforded to individuals with mental illnesses. Unable to retain partial decision-making autonomy, individuals with developmental disabilities cannot challenge their institutionalization or control other aspects of their lives. Rather, under the rules and regulations of many states, these individuals are often stripped entirely of their autonomy because of supposed incompetency. In contrast, the U.N. Convention on the Rights of Persons with Disabilities provides individuals with developmental disabilities, the partial decision-making autonomy that they currently lack in commitment hearings. This Note compares two states, New Jersey and Massachusetts, in their approaches to guardianship for individuals with developmental disabilities and argues that if the United States chooses to ratify the U.N. Convention on the Rights of Persons with Disabilities, states would need to make changes in existing statutes and regulations in order to comply with the U.N. Convention. These changes would create procedural protections for individuals with developmental disabilities that do not exist today.*

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\* Articles Editor, COLUM. J.L. & SOC. PROBS., 2010–2011. J.D. Candidate 2011, Columbia Law School. The author would like to thank Professor Kevin Cremin for his supervision; the *Journal* staff for their continual efforts in editing this Note; Disability Rights New Jersey for introducing him to this area of law; and, finally, his wife for her love and encouragement.

## I. INTRODUCTION

That individuals with developmental disabilities are held against their will in state institutions is a forgotten reality in the United States. Individuals in state institutions are usually thought of as “crazy” or “psychotic,” but another distinct, and quieter, group is also locked up. The latter group is composed of individuals with developmental disabilities and is often derogatively labeled as “retards” and “idiots.” Individuals with developmental disabilities suffer from life-long impairments such as cerebral palsy, autism, and Down syndrome. Frequently, these individuals live separate from society, conveniently tucked away in state institutions, regardless of their own wishes and desires.<sup>1</sup>

In the United States, individuals with developmental disabilities are an overlooked and under-protected minority. Perceived as a burden and threat to society for the past century, individuals with developmental disabilities have historically been segregated into institutional care.<sup>2</sup> Only recently has this population of individuals come to be viewed as a people with rights, including the right to be in the community.<sup>3</sup> Individuals with developmental disabilities have little say in how society treats them, not only because of commonly held doubt that individuals with developmental disabilities can voice their preferences, but also because of the legal presumption that these individuals are incapable of making decisions.<sup>4</sup>

Because individuals with developmental disabilities are usually considered as lacking the capacity to retain their decision-making autonomy, they often do not have the standing to challenge their institutionalization.<sup>5</sup> As deinstitutionalization and

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1. See generally H. RUTHERFORD TURNBULL, III, *The Effects of Law Reform on the Mental Health of Retarded Citizens and their Families*, in MENTAL HEALTH AND MENTAL RETARDATION: BRIDGING THE GAP 101, 103 (Frank J. Menolascino & Brian M. McCann eds., 1983).

2. ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* 331-85 (1937). Deustch sets out the difficulties faced by families who attempted to care for members with developmental disabilities. *Id.* All too frequently, these individuals were abandoned in the pauper system (and its successor, state institutions). *Id.*

3. See *Olmstead v. L.C.*, 527 U.S. 581 (1999).

4. See TURNBULL, *supra* note 1.

5. *Id.*; see generally WALTER E. BARTON, *THE HISTORY AND INFLUENCE OF THE AMERICAN PSYCHIATRIC ASSOCIATION* (1987); DEUTSCH, *supra* note 2, 331-85.

integration into the community become the increasing norm, the presumption that individuals with developmental disabilities lack capacity to manage any aspect of their lives becomes an outdated and harmful notion. Nevertheless, this presumption remains the status quo in many states.<sup>6</sup>

For individuals with developmental disabilities, the central issue of involuntary institutionalization is that the state empowers guardians to make all decisions for these individuals with limited decision-making capacity. Historically, the ability to make decisions and the status of guardianship have been conceived as binaries: either (i) an individual is fully capable of making decisions in his or her life and does not require a guardian; or (ii) the individual is not capable of making any decisions and therefore needs a legal guardian.<sup>7</sup> Recently, however, that legal concept of guardianship has evolved to include the idea of limited decision-making capacity — where an individual may be able to retain some decision-making autonomy despite having the need for a legal guardian.<sup>8</sup>

In the context of individuals with developmental disabilities, the issue of autonomy is a necessary discussion for the law. Whether individuals with developmental disabilities are capable of making decisions can clearly be discussed from medical, psychological, and social perspectives; but the legal perspective gives force to certain notions and actions when it holds these individuals against their will.<sup>9</sup> In responding to and reflecting many of

6. Interview with W. Emmett Dwyer, Dir. of Litig., Disability Rights N.J., in Trenton, N.J. (July 3, 2009).

7. See TURNBULL, *supra* note 1 (discussing the problems presented by guardianship over individuals with developmental disabilities).

8. DUANE F. STROMAN, *THE DISABILITY RIGHTS MOVEMENT: FROM DEINSTITUTIONALIZATION TO SELF-DETERMINATION* 207–42 (2003).

The Supreme Court *Olmstead v. L.C.* (1999) decision has been very instrumental in moving the federal government to begin programs to deinstitutionalize persons in long term care facilities. . . . President Bush announced a “New Freedom Initiative” by executive order on June 19, 2001, to implement the *Olmstead* decision. In 2001 the federal HHS announced a \$64 million grant to 37 states and one territory to develop programs for people with disabilities and long term illnesses that will provide support services in the least restrictive environments. By late 2001, 36 states had task forces or commissions to seek ways to integrate more persons with disabilities into their home communities by the means of individualized supports.

*Id.* at 233.

9. See, e.g., BARTON, *supra* note 5 (discussing the history of psychiatry in mostly medical contexts and only briefly in the legal context).

the social attitudes surrounding developmental disabilities, the law has defined autonomy in such a way as to justify and enable involuntary institutionalization.<sup>10</sup> However, over the last several decades, social attitudes have come to recognize individuals with developmental disabilities as being part of a larger, more general population of individuals with disabilities. Accordingly, individuals with developmental disabilities are now perceived as deserving of the same legal rights provided to anybody else. With the emergence of these new norms, the law must again respond to changing notions of autonomy and rights of individuals with developmental disabilities, particularly since the state is often the caretaker and guardian of these individuals. That is, if society is to recognize individuals with developmental disabilities as people entitled to the basic rights afforded to any other group of people, then current state statutes must be changed.

This Note explores how legal institutions might reconstitute guardianship in response to the changing social status of individuals with developmental disabilities. The antiquated dualistic conceptions of guardianship and autonomy are potentially challenged by the United States' status as a signatory nation to the U.N. Convention on the Rights of Persons with Disabilities.<sup>11</sup> If the U.N. Convention on the Rights of Persons with Disabilities is ratified by the United States, states will need to change their current approach of completely stripping individuals with developmental disabilities of their autonomy in order to comply with the standards of the U.N. Convention. Furthermore, while speculation on the possibility of U.S. ratification is outside the scope of this Note, it should be noted that even without ratification, the U.N. Convention signals a global shift in the way individuals with developmental disabilities are perceived and in what rights are afforded to them. These societal attitudes are likely to emerge within the United States, thereby precipitating legal changes similar to the ones proposed in this Note.

Although this Note focuses on possible legal changes for establishing guardianship of individuals with developmental disabili-

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10. See *infra* Part II.

11. *Status of the Convention on the Rights of Persons with Disabilities*, UNITED NATIONS TREATY COLLECTION (Feb. 27, 2011), [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en) (listing the countries that have signed and ratified the U.N. Convention).

ties, the history of institutionalization of individuals with developmental disabilities cannot be told without referring to the history of individuals with mental illnesses. Indeed, the very conception of what limited capacity for autonomy might look like for individuals with developmental disabilities stems from the legal protections currently afforded to individuals with mental illnesses.<sup>12</sup> Nevertheless, this Note strives to portray in their own light the unique challenges facing individuals with developmental disabilities, in particular because the law itself has distinguished between individuals with mental illnesses and individuals with developmental disabilities.<sup>13</sup> To the extent that legal protections for individuals with mental illnesses are explored, the intent is to show that the rationale for such legal protections also applies to individuals with developmental disabilities; put differently, the arguments wielded to advance legal protection for individuals with mental illnesses are just as robust when made for individuals with developmental disabilities, despite inherent differences between these two groups. Hence, the goal of this Note is twofold: First, to retell the legal history of individuals with developmental disabilities not simply as an afterthought, and, second, to explain and evaluate the U.N. Convention's standard for the involuntary commitment of individuals with developmental disabilities.

Part II of this Note provides a historical background of the treatment of individuals with developmental disabilities in the United States. Part III then briefly summarizes the legislative protections available and the history of litigation under such protections to challenge the involuntary civil commitment statutes for individuals with developmental disabilities. Part IV explains the standards for involuntary civil commitment procedures that could be required if the United States were to ratify the U.N. Convention. It also considers other bases for challenging the involuntary institutionalization of individuals with developmental disabilities under the U.N. Convention. In Part V, this Note compares the standards of New Jersey and Massachusetts to the U.N. Convention, particularly since these two standards reflect

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12. For example, Albert Deutsch relegates the history of treatment of individuals with developmental disabilities to a single chapter of his survey of the mentally ill in the United States. See DEUTSCH, *supra* note 2.

13. See *infra* Part III.B.1.

two very different approaches to institutionalization. It then considers how these standards would be impacted by U.S. ratification of the U.N. Convention. Lastly, Part VI offers some closing observations about the U.N. Convention and its possible ratification by the United States.

## II. HISTORICAL BACKGROUND

Before engaging in a broad overview of the legal history of the treatment of individuals with developmental disabilities, this Note explains why it is necessary to understand the historical background. First, a retelling of the history of individuals with developmental disabilities is important, because the story of individuals with developmental disabilities has been overshadowed and dominated by the narrative of individuals with mental illnesses. Although the legal treatment of individuals with mental illnesses must be examined because it has produced the vital concepts of limited decision-making capacity and limited guardianship, the institutionalization of individuals with developmental disabilities and the resulting legal discussion is a story unique to individuals with developmental disabilities. Secondly, complex legal issues surround the involuntary commitment of individuals with developmental disabilities, largely because these individuals' particular legal situation grows out of their treatment in society. Hence, the social and legal history must be taken together: the current legal treatment of individuals with developmental disabilities stems from the underlying social attitudes and views on such individuals.<sup>14</sup>

Prior to the rise of institutions in the United States, individuals with developmental disabilities were given little public attention. In the early 19th century, no distinction was made among dependent populations such as the sick and needy; as a result, individuals with developmental disabilities were cared for within the larger pauper system.<sup>15</sup> Having an established pauper system

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14. See TURNBULL, *supra* note 1 (briefly mentioning how social attitudes have, historically, shaped the legal treatment of individuals with developmental disabilities).

15. See DEUTSCH, *supra* note 2, at 116. The pauper system in which individuals with developmental disabilities were cared for included a large number of individuals with other disabilities, as well as indigents among the sick, the old, the young, the mentally ill, and the poor. *Id.* ("Sick poor, old poor, able-bodied poor, infant poor, insane and feeble-

in place, the state did not find it necessary to take special care of the disabled.<sup>16</sup> Even when the plight of individuals with developmental disabilities was brought to public attention, a Connecticut legislature responded that it had found “a settled conviction of the large majority of citizens of the commonwealth that idiots were a class so utterly hopeless that it was a waste of time even to collect any statistics concerning them.”<sup>17</sup> In fact, with the single exception of Kentucky’s “Pauper Idiot Acts,” no state made provisions to care for individuals with developmental disabilities until 1846, when New York and Massachusetts sought to provide public assistance to individuals with developmental disabilities.<sup>18</sup>

Beginning in the early 1840s, European intellectuals theorized that “idiocy” was a condition that came from the lack of proper education.<sup>19</sup> Americans who had traveled abroad in Europe and who had been exposed there to the training of individuals with mental disabilities returned to the United States with similar ideas for state-run “idiot schools.”<sup>20</sup> Individuals with developmen-

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mented—all were grouped together under the same stigmatizing label, ‘paupers.’”). Society cared for paupers in a variety of ways, the most common of which included (1) supplying provisions to the pauper in his or her own home; (2) auctioning off the pauper to the lowest bidder (i.e., at the lowest cost to the community); and (3) placing the pauper in a public almshouse. *Id.* at 117. Interestingly, individuals with developmental disabilities were often sought after in auctions because it was thought that “strong backs and weak minds” made good laborers. *Id.* at 118 (internal quotation marks omitted). Deutsch also notes that in some communities, support of all paupers was “contract[ed] . . . to a single individual at a fixed price,” *id.* at 117, but this form of support rarely affected individuals with developmental disabilities.

16. *Id.* at 115 (“Most of the states were still without special institutions for the mentally ill in the first quarter of the century.”).

17. NINA RIDENOUR, *MENTAL HEALTH IN THE UNITED STATES: A FIFTY-YEAR HISTORY* 46 (1961) (describing the early attitudes and early leadership of mental health within the United States prior to 1900).

18. DEUTSCH, *supra* note 2, at 339 (describing the historical background of “mental defectives,” including both broad European social intellectual movements as well as U.S. legislative actions).

19. *Id.* at 337–38 (describing the influence of Edward Seguin, a French physician who pioneered training individuals with developmental disabilities).

20. *Id.* at 340. Much of this movement was directed toward educating individuals with developmental disabilities. Dr. Wilbur, a superintendent of a training school opened in New York, wrote:

We do not propose to create or supply faculties absolutely wanting; nor to bring all grades of idiocy to the same standard of development or discipline; nor to make them all capable of sustaining, creditably, all the relations of a social and moral life; but rather to give to dormant faculties the greatest practicable development, and to apply those awakened faculties to a useful purpose under the control of an aroused and disciplined will. At the basis of all our efforts lies the

tal disabilities became a social cause.<sup>21</sup> By 1866, seven states had separate institutional provisions for individuals with developmental disabilities.<sup>22</sup>

Increasingly, the pressures to form new institutions grew from two divergent concerns. The first concern developed naturally out of the establishment of training schools. As the realization set in that some individuals would require lifelong care and supervision, the superintendents of these schools concluded that well-organized institutional care was better than home care.<sup>23</sup> Over time, optimism about educating individuals with developmental disabilities faded.<sup>24</sup> Unfortunately, in transitioning from educator to custodian, institutions made no provisions to obtain permanent custody over these individuals in institutions.<sup>25</sup> The

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principle that the human attributes of intelligence, sensibility and will are not absolutely wanting in an idiot, but dormant and undeveloped.

*Id.* at 343.

21. This sentiment was not unanimously held. A contemporaneous biography of Samuel G. Howe, an American physician who was instrumental in organizing the nation's first public institution for the feeble-minded, *id.* at 342, describes the satirical public reaction to that physician's earlier 1848 report recommending a special institution for individuals with developmental disabilities:

The Report created a profound sensation. There were people who laughed and said to one another: "What do you think Howe is going to do next? *He is going to teach idiots!*" They printed a caricature of him and Charles Sumner [the statesman and social reformer] as twin Don Quixotes tilting at windmills. A friend told my mother that "the Doctor's report was a report *for* idiots as well as concerning them."

*Id.* at 345 (modification in original).

22. *Id.* at 344; *see also* BARTON, *supra* note 5, at 71 (these institutions were in Massachusetts, New York, Pennsylvania, Ohio, Connecticut, Kentucky, and Illinois).

23. *See* BARTON, *supra* note 5, at 73 (describing the rise of institutions as training schools within the United States and their relative success).

24. *Id.* Barton notes that these early institutions' superintendents experienced declining optimism regarding the prospects of educating individuals with developmental disabilities; eventually, they formed the Association of Medical Officers of American Institutions for Idiots and Feeble-minded Persons in order to discuss and organize the long-term care of these individuals. *Id.* at 72-73; *see generally* RIDENOUR, *supra* note 17, at 45-50 (discussing the difficulties of institutionalizing individuals with developmental disabilities and noting that despite reformers' efforts to institutionalize a form of social welfare for those with developmental disabilities, reformers' paternalistic attitude, which viewed these individuals as in need of protection from abuse, survived); *see also* DEUTSCH, *supra* note 2, at 347 (portraying the breakdown of the educational ideal under the stress of numerous problems and making clear that, in part, paternalism was a reaction to the cruelty and abuse witnessed within the pauper system). Ironically, the persisting paternalistic spirit only reinforced the conception of individuals with developmental disabilities as second-class humans.

25. *See* DEUTSCH, *supra* note 2, at 347-48.



second concern arose out of the eugenics movement. A number of studies suggested that social ills were transmitted genetically and that one genetic marker was feeble-mindedness.<sup>26</sup> As a solution to these social ills and as a measure of protection from the menace of the feeble-minded, separate and permanent institutionalization was deemed necessary.<sup>27</sup> Historian Albert Deutsch, who created a detailed account of mental illness in America, succinctly captured the transformation: “The ‘school’ of an earlier generation was now the ‘institution’; the ‘pupil’ of yesterday was now the ‘inmate.’”<sup>28</sup>

As institutionalizing individuals with developmental disabilities became the norm, several problems arose. First was the problem of definition: who was developmentally disabled, and what did that term mean? The problem of formal categorization proved difficult as early studies attempting to standardize developmental disabilities showed that nearly half of the population was developmentally disabled or “mentally deficient.”<sup>29</sup> Second, even as methods of standardizing developmental disabilities improved, the population of developmentally disabled who were placed into institutions nearly trebled in the first two decades of the 20th century.<sup>30</sup> Attempting to house all individuals with de-

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But there were many more who could not be sent back [to friends and families] at all. Included among these were the low-grade defectives, some utterly hopeless and helpless, requiring lifelong care and supervision. Others, who under favorable circumstances might have enjoyed a contented, harmless existence among relatives or friends, had to be institutionalized for life because the impoverished condition of their families was too acute to stand the added burden of their support. Then there were high-grade defectives—“moral imbeciles” as they came to be called—who could be trained to economic efficiency, but who were tainted with hyper-sexual or delinquent tendencies which made it socially unsafe and undesirable to release them into the stream of normal life.

*Id.*

26. *Id.* at 349–51 (describing how the theories of Darwin and Dugdale led many to see individuals with developmental disabilities as a social ill).

27. *Id.* at 367. (“For nearly two decades all our knowledge of the feeble-minded indicated that the obvious and logical remedy was life-long segregation, and this became the policy in nearly every state.” (internal quotation marks omitted)).

28. *Id.*

29. *Id.* at 355–56 (“When the statistical results of these [mental tests of men drafted during World War I] were compiled, it was shown that fully 47.3 per cent of the white drafted men had mental ages of twelve years and less. . . . Taking the results of the Army examinations as a basis, it was calculated that some 50,000,000 Americans—nearly half the total population—came under the category of mentally defective.” *Id.* at 356.).

30. *Id.* at 368. Deutsch describes the difficulties presented by the increasing number of individuals with developmental disorders who were being civilly committed into state

velopmental disabilities proved to be economically and administratively impossible.<sup>31</sup> As World War II ended and the horrors of Nazi Germany's own eugenics programs came to light, the enthusiasm for eugenics came to an end, and the rationale for institutionalizing individuals with developmental disabilities rested solely upon the paternalistic belief that such individuals needed to be cared for.<sup>32</sup>

The historical shifts in social attitude towards disabilities can be largely understood in two heuristic models: the medical model and the social model. The history of attempting to house and cure developmental disabilities falls within the medical model, which understands disability as an intrinsic aspect of the individual.<sup>33</sup> The following discussion of the legal history of disability largely tracks the emergence of a social model that understands disability as a conflict between a society that imposes arbitrary barriers and the purportedly disabled individual, who is denied accommodations that take into account his or her unique limitations.<sup>34</sup> Lastly, although much of this Note focuses upon the social model, the intent is not to advocate one model over the other. Rather, the intent is to track the shifting social attitudes and the corresponding legal changes.

### III. LEGAL HISTORY OF CHALLENGING INVOLUNTARY CIVIL COMMITMENT

#### A. LEGISLATION PROTECTING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Although the rise of institutions for individuals with developmental disabilities stemmed from state responses to public perception, a number of factors emerged in the 1960s that resulted in a movement for deinstitutionalization. Part of the shift was a change in how disabilities were viewed: disabilities came to be

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institutions. *Id.* Exactly why this population trebled is unclear; one explanation might be that, as the United States industrialized, more families needed or sought outside care for relatives with developmental disorders.

31. *Id.*

32. *Id.* at 375.

33. See Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 649–59 (1999).

34. *Id.* at 18–21.

seen less as a medical impairment in need of cure or aid and more as the result of *social* impairments imposed upon individuals with disabilities.<sup>35</sup> In addition to this shift towards a social model of disability, people began to understand disability rights as a civil rights movement, and more awareness was brought to the problems of institutions, especially with the rise of mass media.<sup>36</sup>

Key legislation passed by Congress reflected and framed much of the discussion of what it meant to be disabled. The Rehabilitation Act of 1973<sup>37</sup> and the Americans with Disabilities Act<sup>38</sup> (“ADA”) encouraged a dual medical and social understanding of disability by acknowledging, via funding to states, medical needs and also forbidding discrimination against individuals with disabilities.<sup>39</sup> Congressional records at the time of the ADA’s passage show that Congress was concerned with the institutional conditions faced by individuals with developmental disabilities.<sup>40</sup>

More specifically, the Rehabilitation Act of 1973 largely echoed the growing sentiment of disability rights as a civil rights movement.<sup>41</sup> As a result, it reads as an enactment protecting civil liberties, so much so that “[a]ll [its] prohibitions sound as if they could have been lifted directly from regulations setting forth the prohibitions of the Civil Rights Act of 1964 or the Education Amendments of 1972, with regard to race, religion, national origin, or sex.”<sup>42</sup> While this observation rings true for the bulk of the Rehabilitation Act, there were new concepts that emerged, such as “reasonable accommodation” and “undue hardship.”<sup>43</sup> Litiga-

35. *Id.*

36. *Id.* at 160–64 (describing the struggles and victories of the developmental disabilities rights movement within the paradigm of litigation-focused, civil rights advocacy).

37. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355 (1973) (codified as amended in scattered sections of 29 U.S.C.).

38. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended in scattered sections of 42 U.S.C.).

39. See generally JACQUELINE VAUGHN SWITZER, *DISABLED RIGHTS: AMERICAN DISABILITY POLICY AND THE FIGHT FOR EQUALITY* (2003) (describing how the federal government became more involved with disability rights, beginning with the passage of the 1963 Mental Retardation Facilities and Community Health Centers Act, and, in turn, began to shape what it meant to be disabled).

40. See Brief for United States as Intervenor at 24–30, *N.J. Prot. & Advocacy, Inc. v. Velez*, No. 08-1858 (D.N.J. June 29, 2009) (detailing the Congressional record at the time the ADA was passed).

41. See TURNBULL, *supra* note 1 (explaining the legal history of litigation).

42. Chai R. Feldblum, *The (R)evolution of Physical Disability Antidiscrimination Law: 1976–1996*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 613, 614 (1996).

43. *Id.*

tion following the Rehabilitation Act firmly established that institutionalized individuals with developmental disabilities are covered by the Act.<sup>44</sup>

The passage of the ADA further expanded the groundwork laid out by the Rehabilitation Act of 1973.<sup>45</sup> While the Rehabilitation Act was limited to programs receiving federal financial assistance, the ADA sought to cover private actors as well.<sup>46</sup> In the case of individuals with developmental disabilities, the Rehabilitation Act covered institutional care because states often funded these institutions with federal tax dollars.<sup>47</sup> Where the state did not fund these institutions with federal financial assistance, Title II of the ADA did apply, as that title covers the programs of public entities.<sup>48</sup> Much like the Rehabilitation Act, litigation under the ADA has settled that individuals with developmental disabilities in institutional care are covered by the ADA.<sup>49</sup>

#### B. LITIGATION CHALLENGING INVOLUNTARY CIVIL COMMITMENT OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

In addition to fomenting legislative action, the 1960s laid the foundations in the coming decades for challenging institutionalization through the judicial system. Many cases were brought to challenge the status of institutionalized individuals with the purpose of pushing forward de-institutionalization. A series of cases brought in the 1970s established that individuals in institutions have the right not only to custodial care but also to habilitation in the least restrictive environment.<sup>50</sup> Much litigation since has been focused on enforcing legal precedent and slowly moving

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44. See, e.g., *Martin v. Voinovich*, 840 F. Supp. 1175 (S.D. Ohio 1993).

45. DEBORAH LEUCHOVIVUS, ACTION INFORMATION SHEETS: ADA Q&A ... THE REHABILITATION ACT AND THE ADA CONNECTION 1 (2003), available at <http://www.pacer.org/parent/php/PHP-c51f.pdf>.

46. Department of Justice, *A Guide to Disability Rights*, ADA.GOV (Sept. 5, 2005), <http://www.ada.gov/cguide.htm#anchor62335> (describing the rights that individuals with disabilities have under federal laws such as the ADA and the Rehabilitation Act).

47. Interview with W. Emmett Dwyer, *supra* note 6.

48. *Id.*

49. See, e.g., *Martin*, 840 F. Supp. 1175.

50. *Pennsylvania Ass'n for Retarded Children v. Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971).

states towards compliance.<sup>51</sup> Finally, the hallmark achievement came in 1999 when the Supreme Court decided *Olmstead v. L.C.*, holding that isolated institutionalization is a form of discrimination under Title II of the ADA; accordingly, states are required to develop plans to end unnecessary institutionalization and to provide individuals with developmental disabilities the most integrative setting in the community, unless such changes would be a “fundamental alteration” of the state’s services.<sup>52</sup>

The establishment of children’s right to privacy proved critical in establishing due process protections for individuals with developmental disabilities; the legal groundwork for challenging involuntary civil commitment came about in a series of constitutional law cases that established a “zone of privacy” into which the state could not intrude.<sup>53</sup> In the context of abortion rights that have tested the limits of the “zone of privacy,” the Supreme Court held in *Planned Parenthood of Central Missouri v. Danforth* that minors could have abortions without the prior permission of their parents.<sup>54</sup> In *Danforth*, the Supreme Court reviewed the constitutionality of a Missouri statute that required parental consent for minors to obtain abortions.<sup>55</sup> The court reasoned that a minor has a constitutional right to privacy, separate from her parent’s right to decide what is best for his or her child.<sup>56</sup> *Danforth* and a number of later abortion cases attempted to balance the interests of the parent and the interests of the child while recognizing the minor’s independent constitutional right to privacy.<sup>57</sup>

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51. See *Heller v. Doe*, 509 U.S. 312 (1993); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Thomas S. v. Flaherty*, 902 F.2d 250 (4th Cir. 1990); *Doe v. Austin*, 848 F.2d 1386 (6th Cir. 1988); *Messier v. Southbury Training Schl.*, 562 F. Supp. 2d 294 (D. Conn. 2008); *Heichelbech v. Evans*, 798 F. Supp. 708 (M.D. Ga. 1992).

52. STROMAN, *supra* note 8, at 233 (describing the success of *Olmstead* in deinstitutionalizing persons in long-term care facilities).

53. TURNBULL, *supra* note 1, at 103. The zone of privacy is established by two cases, *Roe v. Wade* and *Doe v. Bolton*, where the Supreme Court found that an adult woman has the right to an abortion and that the state may not intrude into this decision, which is protected by a constitutionally created “zon[e] of privacy.” See *Roe*, 410 U.S. 113, 152–56 (1973); see also *Bolton*, 410 U.S. 179 (1973).

54. 428 U.S. 52 (1976).

55. *Id.* at 57–59.

56. *Id.* at 73–75.

57. *Id.*; see *Bellotti v. Baird*, 428 U.S. 132 (1976) (upholding the constitutionality of a Massachusetts statute placing restrictions on teen abortions); *but see Bellotti v. Baird*, 443 U.S. 622 (1979) (plurality opinion) (explaining that the previous *Bellotti v. Baird* decision did not allow states to prohibit teenagers from getting abortions without parental consent).

This constitutional right to privacy created the legal foothold for challenging involuntary civil commitment of individuals with developmental disabilities.<sup>58</sup> In *Parham v. J.R.*, parents of a minor with developmental disabilities placed their child into a state institution over his objections.<sup>59</sup> He raised the challenge of whether he was entitled to judicial review of his parents' decisions.<sup>60</sup> Engaging in the same analysis as *Danforth*, the Supreme Court decided that the child had a recognizable independent right to not be wrongfully institutionalized and to be free from the stigma of being labeled as developmentally disabled.<sup>61</sup> Although not extending the full protections of due process, the Court concluded that when constitutional rights could be infringed, the Constitution required a bare minimum of due process.<sup>62</sup> Hence, a neutral review of the parents' decision to institutionalize their child was required.<sup>63</sup>

Since the establishment of the right to privacy for children with developmental disabilities, challenges to involuntary civil commitment of adults have relied on the courts' analyses in *Danforth* and *Parham*.<sup>64</sup> That is, plaintiffs argue that since the right of privacy has been extended to children with developmental disabilities, all individuals with developmental disabilities require the bare minimum of due process in their commitment hearings.<sup>65</sup> While this argument has been fairly successful in challenging involuntary commitment, reliance on *Danforth* and *Parham* rais-

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58. See 442 U.S. 584 (1979).

59. *Id.* at 589-96.

60. *Id.* at 601-02 ("We next deal with the interests of the parents who have decided, on the basis of their observations and independent professional recommendations, that their child needs institutional care. Appellees argue that the constitutional rights of the child are of such magnitude and the likelihood of parental abuse is so great that the parents' traditional interests in and responsibility for the upbringing of their child must be subordinated at least to the extent of providing a formal adversary hearing prior to a voluntary commitment.").

61. *Id.* at 599-617.

62. *Id.* at 604.

63. *Id.* at 606.

64. TURNBULL, *supra* note 1, at 104 (describing the risks of analogizing a minor's right to abortion, as in *Danforth*, to the right to be free from erroneous institutionalization, treated in *Parham*); Interview with W. Emmett Dwyer, *supra* note 6.

65. TURNBULL, *supra* note 1, at 104.

es serious concerns over analogizing children's intellectual abilities and those of individuals with developmental disabilities.<sup>66</sup>

### 1. *Equal Protection Challenges*

As courts recognized that individuals with developmental disabilities are individuals entitled to rights, plaintiffs often argued that the differences between the legal status of individuals with developmental disabilities and individuals with mental illnesses constituted a violation of the Equal Protection Clause.<sup>67</sup> Because there is such rich case law on and abundant protections afforded to individuals with mental illnesses, a successful Equal Protection challenge would extend such protections to individuals with developmental disabilities. Moreover, given that individuals with mental illnesses and individuals with developmental disabilities are placed into very similar institutions, successful challenges of discrimination seemed imminent.<sup>68</sup> As a result, numerous plaintiffs challenged these differences in institutionalization as discrimination both under the ADA<sup>69</sup> and the Equal Protection Clause of the Constitution.

Many of these Equal Protection challenges have been unsuccessful. The majority of appellate courts have concluded that the differences between individuals with developmental disabilities and those with mental illnesses are distinct enough to warrant separate procedural processes and institutions.<sup>70</sup> However, in

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66. It should also be noted that even the basic outlines of due process now afforded come from *Vitek v. Jones*, 445 U.S. 480 (1980), where a prisoner with a mental illness was being transferred to a mental institution without due process. There are substantial concerns about how drawing upon children's cases, prisoners' cases, and mental illness cases will influence societal impressions and conceptions about what it means to be developmentally disabled. Implications that individuals with developmental disabilities are like children run contrary to our society's developing notions of self-determination; further, comparisons to individuals with mental illnesses or prisoners are not particularly illuminating.

67. Although tracking the legal differences between individuals with mental illnesses and individuals with developmental disabilities is beyond the scope of this Note, it suffices to say that individuals with mental illnesses have consistently challenged their legal status and have been afforded substantial due process protections as a result.

68. Interview with W. Emmett Dwyer, *supra* note 6.

69. See *infra* Part III.B.2.

70. As noted earlier, the intention in providing this history is to show why individuals with developmental disabilities are in a unique legal situation unlike that of individuals with mental illnesses, not to suggest that individuals with developmental disabilities are somehow similar to individuals with mental illnesses.

some circuits, courts have interpreted the Equal Protection Clause more broadly and have afforded more protections to individuals with developmental disabilities.

For example, in *Doe v. Austin*, the court held that the different procedural protections provided against commitment into state institutions to individuals with developmental disabilities and to those with mental illnesses violated the Equal Protection Clause.<sup>71</sup> The court stated that “[i]f a state enacts legislation which treats different classes of people differently, the classification drawn by the statute must be rationally related to a legitimate state purpose.”<sup>72</sup> It then concluded that there was no rational basis for distinguishing between the mentally ill and the mentally retarded in the judicial determination of their eligibility for civil commitment.<sup>73</sup>

This mixed reception of Equal Protection challenges by appellate courts came to a halt when the Supreme Court held in *Heller v. Doe* that there were differences between individuals with developmental disabilities and individuals with mental illnesses, justifying their different treatments.<sup>74</sup> The challenged Kentucky statute allowed for a lower standard of proof and for family members and guardians to be parties in the commitment hearings for individuals with developmental disabilities.<sup>75</sup> In contrast, Kentucky’s statute for individuals with mental illnesses afforded more protection, including a higher standard of proof and excluding family members and guardians from being parties in the commitment hearing.<sup>76</sup> These differences were challenged as violations of the Equal Protection Clause of the Fourteenth Amendment.<sup>77</sup>

The Supreme Court in *Heller* was unsympathetic to the challenge. Stressing that “rational basis review in equal protection

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71. 848 F.2d 1386 (6th Cir. 1988).

72. *Id.* at 1394 (citing *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985)).

73. *Id.* (“However, the mere identification of differences is not enough; equal protection “require[s] that a distinction made have some relevance to the purpose for which the classification is made.” (citing *Baxstrom v. Herold*, 383 U.S. 107, 111 (1966) (modification in original)).

74. 509 U.S. 312 (1993).

75. *Id.* at 315–18.

76. *Id.*

77. *Id.* at 314.



analysis ‘is not a license for courts to judge the wisdom, fairness, or logic of legislative choices,’”<sup>78</sup> the Supreme Court stated that Kentucky was justified in using a lower standard to assay the need for commitment by the “differences in the ease of diagnosis and the accuracy of the prediction of future dangerousness and by the nature of treatment received after commitment.”<sup>79</sup> Furthermore, the Court postulated that “Kentucky may have concluded that close relatives and guardians, both of whom likely have intimate knowledge of mentally retarded persons’ abilities and experiences, have valuable insights that should be considered during the involuntary commitment process.”<sup>80</sup>

Following the Supreme Court’s decision in *Heller*, challenges under the Equal Protection Clause have proved unfruitful,<sup>81</sup> and one avenue by which to provide more robust protections to individuals with developmental disabilities was closed off.<sup>82</sup>

## 2. Challenges Under the Rehabilitation Act of 1973 and the Americans with Disabilities Act

Challenges to involuntary civil commitment have been more successful as discrimination claims under the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Indeed, complainants are often careful to make distinctions between Equal Protection challenges and those under the Rehabilitation Act or the ADA, lest the court import Equal Protection analysis into the discrimination claims.<sup>83</sup> In responding to these challenges, the

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78. *Id.* at 319 (quoting *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313 (1993)).

79. *Id.* at 328.

80. *Id.* at 329.

81. See *Bartlett v. N.Y. State Bd. of Law Exam’rs*, 970 F. Supp. 1094 (S.D.N.Y. 1997) (in the context of learning disabilities), *aff’d in part and vacated in part*, 156 F.3d 321 (2d Cir. 1998), *cert. granted and vacated*, 527 U.S. 1031 (1999); *Hightower v. Olmstead*, 959 F. Supp. 1549 (N.D. Ga. 1996), *aff’d*, 166 F.3d 351 (11th Cir. 1998); *but see Martin v. Voinovich*, 840 F. Supp. 1175 (S.D. Ohio 1993); Interview with W. Emmett Dwyer, *supra* note 6 (explains that such Equal Protection challenges were less frequently argued given the cost of litigation).

82. TURNBULL, *supra* note 1, at 104 (explaining how challenges to involuntary civil commitment must now stem from other grounds); Interview with W. Emmett Dwyer, *supra* note 6.

83. Interview with W. Emmett Dwyer, *supra* note 6 (stressing that the difference in analysis between a statutory challenge to discrimination under the ADA and a constitutional challenge under the Equal Protection Clause will decide whether the claim will be successful).

Supreme Court has made statements hinting at review similar to Equal Protection analysis. In *Traynor v. Turnage*,<sup>84</sup> the Supreme Court stated that “[t]here is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons.”<sup>85</sup>

Despite such language, some lower courts have held that under the Rehabilitation Act and the ADA, differing involuntary commitment procedures for individuals with developmental disabilities and for those with mental illnesses are discriminatory. In *Martin v. Voinovich*,<sup>86</sup> individuals with developmental disabilities challenged the treatment and institutionalization procedures in developmental centers in Ohio. The U.S. District Court rejected the state’s reliance upon *Traynor v. Turnage* to justify such disparate treatment:

[A]s a matter of statutory construction, nothing in the language of § 504 [of the Rehabilitation Act] suggests that it can never apply between persons with different handicaps. Rather the language of § 504 evinces an intent to eliminate handicap-based discrimination and segregation. A strict rule that § 504 can never apply between persons with different disabilities would thwart that goal. Such a rule would, in effect, allow discrimination on the basis of disability. The relevant inquiry is whether the application [of] § 504 between persons with different or varying degrees of disability

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84. 485 U.S. 535 (1988). In *Traynor v. Turnage*, veterans who, because of alleged disabilities, had not completely used certain education benefits within ten years as prescribed by statute challenged the denial of extension on the basis that such denial was discrimination under the Rehabilitation Act. *Id.* at 538–39. The Court dismissed this argument:

[T]he regulations promulgated by the Department of Health, Education, and Welfare in 1977 with regard to the application of § 504 to federally funded programs provide that “exclusion of a specific class of handicapped persons from a program limited by Federal statute or executive order to a different class of handicapped persons” is not prohibited. It is therefore not inconsistent with the Rehabilitation Act for only those veterans whose disabilities are not attributable to their own “willful misconduct” to be granted extensions of the 10-year delimiting period applicable to all other veterans.

*Id.* at 549 (citation omitted) (quoting 45 C.F.R. § 84.4(c) (1986)).

85. *Id.* at 549.

86. 840 F. Supp 1175 (S.D. Ohio 1993).

further the goal of eliminating disability-based discrimination.<sup>87</sup>

As *Martin v. Voinovich* suggests, some courts have been far more receptive to challenges under the Rehabilitation Act or the ADA.<sup>88</sup>

More importantly, while the Supreme Court has recognized that there have been divergent applications of the Rehabilitation Act to the civil commitment statutes for individuals with developmental disabilities,<sup>89</sup> the Court has recognized the prevailing lower courts' expansive reading of the ADA.<sup>90</sup> In *Olmstead v. L.C.*, plaintiffs with mental illnesses and developmental disabilities challenged their repeated institutionalizations and denials of their preference for community care due to lack of funding.<sup>91</sup> Holding that institutionalization is a form of discrimination and that developmental disabilities fall within the protection of the ADA, the Supreme Court affirmed that the ADA covers institutionalization of individuals with developmental disabilities.<sup>92</sup>

Of further note, the Supreme Court in *Olmstead* made clear that such institutionalizations challenged under the ADA were discriminatory, even without a comparison class.<sup>93</sup> Rejecting the State's argument that there was no discrimination because discrimination "necessarily requires uneven treatment of similarly situated individuals, and [the plaintiffs] had identified no comparison class, i.e., no similarly situated individuals given preferential treatment," Justice Ginsburg succinctly stated that "Congress had a more comprehensive view of the concept of discrimination advanced in the ADA."<sup>94</sup> Hence, unlike the Equal Protec-

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87. *Id.* at 1192. As the relevant provision of the ADA is virtually identical to the at-issue Rehabilitation Act provision, the court also finds a claim under the ADA. *Id.*

88. See also *L.C. v. Olmstead*, 138 F.3d 893 (11th Cir.), *cert. granted*, 525 U.S. 1054 (1998), *cert. amended by* 525 U.S. 1062 (1998), *aff'd in part and vacated in part*, 527 U.S. 581 (1999); *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995).

89. *Olmstead v. L.C.*, 527 U.S. 581, 600 n.11 (1999) (noting that some lower courts have read the Rehabilitation Act as not encompassing institutionalization as a form of discrimination).

90. *Id.* at 597–603.

91. *Id.* at 593–96.

92. *Id.* at 597.

93. SUSAN STEFAN, UNEQUAL RIGHTS: DISCRIMINATION AGAINST PEOPLE WITH MENTAL DISABILITIES AND THE AMERICANS WITH DISABILITIES ACT 114 (2001).

94. *Olmstead*, 527 U.S. at 598 (internal quotation marks omitted). Interestingly, in footnote ten, the *Olmstead* majority addresses the issue that discrimination could happen within a class:

tion challenges, which sought to compare individuals with developmental disabilities to individuals with mental illnesses, the ADA recognizes the institutionalization of individuals with developmental disabilities as being discriminatory without making such class comparisons.<sup>95</sup>

In conclusion, the ADA challenges have proven to be more successful than challenges under the Equal Protection Clause in arguing that differing approaches to individuals with mental illness and to individuals with developmental disabilities constitute discrimination. Nevertheless, it is unclear exactly how rigorous a search for discrimination must be under Title II of the ADA, and consequently, states vary widely in this aspect.<sup>96</sup> Given that no comparison class is needed to bring an ADA claim, plaintiffs undoubtedly find it easier to make challenges of discrimination; conversely, courts may not award the same protections to other classes of individuals with disabilities and instead choose to limit the scope of their review to the plaintiffs and to extend protections only to that class.

Because challenges for more robust protections are limited to discrimination claims under the ADA and not to Equal Protection claims, state statutes prescribe fewer procedural protections for individuals with developmental disabilities in involuntary commitment hearings. As will be explored in Part V, these procedures provide practically non-existent reviews of decisions to institutionalize individuals with developmental disabilities. While costly litigation has slowly moved state statutes into compliance with the bare minimums of due process, the U.N. Convention of the Rights of Persons with Disabilities offers a fresh opportunity to re-examine the procedural protections of involuntary commit-

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The dissent is driven by the notion that “this Court has never endorsed an interpretation of the term ‘discrimination’ that encompassed disparate treatment among members of the *same* protected class,” *post*, at 2194 (opinion of Thomas, J.), that “[o]ur decisions construing various statutory prohibitions against ‘discrimination’ have not wavered from this path,” *post*, at 2194, and that “a plaintiff cannot prove ‘discrimination’ by demonstrating that one member of a particular protected group has been favored over another member of that same group,” *post*, at 2195. The dissent is incorrect as a matter of precedent and logic.

*Id.* at 598 n.10 (modification in original).

95. *Id.*

96. Interview with W. Emmett Dwyer, *supra* note 6.

ment hearings and to redraft such protections to comport with the constitutional requirements of due process.

#### IV. THE U.N. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

As indicated in the discussion of the history and legal background of involuntary institutionalization, societal attitudes concerning individuals with developmental disabilities — and indeed, disabilities in general — have followed two models: the medical model, under which disabilities are viewed as an intrinsic aspect of the individual and thereby diminish the individual's quality of life; and the social model, under which systemic societal barriers that fail to take into account the varying limitations of individuals are the cause of diminished quality of life.<sup>97</sup> Keeping in mind that societal attitudes towards disability vary to an incredible extent, these two models are useful heuristics in tracking the academic and legal debate surrounding disability law and its impact upon general societal attitudes in the United States over the past century.<sup>98</sup> These differences in understanding disability are further magnified in the international context where cross-cultural understandings lead to a breakdown in such uniform theoretical categorizations. It is important to consider within this context what impact the U.N. Convention on the Rights of People with Disabilities will have. Accordingly, this Part will first analyze the U.N. Convention; it will then explore the approaches of two particular states, New Jersey and Massachusetts, as well as prospective changes in state law.<sup>99</sup>

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97. See Crossley, *supra* note 33, at 649–59; see also, STROMAN, *supra* note 8, at 21–23 (discussing the strengths of the medical model and the social model). Although the two models of approaching disabilities within this country have already been introduced, it should be noted that how people understand, perceive, and approach disabilities varies not only from individual to individual but also cross-culturally and in scope.

98. In the United States, each individual state's approach to the issue of guardianship varies widely. See *infra* Part V.

99. Given the international stage of the U.N. Convention on the Rights of Persons with Disabilities, it is particularly important to acknowledge and contextualize the background of creating a global understanding and regulation of disability rights. Within the United States, New Jersey and Massachusetts are particularly notable. New Jersey has struggled with institutionalization and only very recently has begun to place individuals with developmental disabilities into the community. Interview with W. Emmett Dwyer, *supra* note 6. On the other hand, Massachusetts has often been regarded as being very progressive, having theoretically eliminated involuntary civil commitment in the 1970s

A. THE SCOPE OF THE CONVENTION ON THE RIGHTS OF  
PERSONS WITH DISABILITIES

Within the evolving disability rights movement in the United States, the U.N. Convention may redefine what it means to be disabled and what rights are associated with being disabled.<sup>100</sup> Even without ratification, the U.N. Convention marks global changes in societal attitudes towards individuals with disabilities;<sup>101</sup> these shifting attitudes have the potential to dramatically influence U.S. jurisprudence regarding disability rights. Increasingly, international instruments have recognized the rights of persons with disabilities over the past three decades, starting in 1981 with the World Programme of Action Concerning Disabled Persons.<sup>102</sup> As the international culmination of disability rights advocacy, the U.N. Convention on the Rights of Persons with Disabilities (“CRPD” or “U.N. Convention”) seeks to re-affirm rights previously established within the context of human rights conventions, extend further protections and rights to people with disabilities, supersede past criticized standards — like the Prin-

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(although in practice, individuals with developmental disabilities are still committed). Telephone Interview with Robert Fleischner, Dir., Ctr. for the Pub. Representation’s Mental Health Prot. and Advocacy Project (February 3, 2010).

100. A brief note should be made about the impact of U.S. ratification of the U.N. Convention. In the United States, ratification of a multi-lateral treaty like the U.N. Convention is accomplished by a two-thirds vote of the United States Senate. U.S. CONST. art. III, § 2, cl. 2. Once ratified, compliance with the treaty is mandated, and the U.N. Convention has domestic force. U.S. CONST. art. VI, cl. 2. Therefore, in an area of law such as involuntary civil commitment where states have much legal flexibility, and given that Article 33 of the U.N. Convention requires states to establish a legal or administrative framework to implement the Convention, *see* CRPD, *infra* note 105, art. 33, states are bound to pass statutes that would comply with the standards set out by the U.N. Convention on the Rights of People with Disabilities. *Cf.* Carlos Manuel Vázquez, *Treaties as Law of the Land: The Supremacy Clause and the Judicial Enforcement of Treaties*, 122 HARV. L. REV. 599, 603 (2008) (advocating that treaties, self-executing or otherwise, must be given full domestic force under the Constitution).

101. *Frequently Asked Questions: Why Is It Necessary to Have a Convention on the Rights of Persons with Disabilities?*, U.N. ENABLE, (“The Convention is necessary in order to have a clear reaffirmation that the rights of persons with disabilities are human rights and to strengthen respect for these rights. Although existing human rights conventions offer considerable potential to promote and protect the rights of persons with disabilities, it became clear that this potential was not being tapped.”), <http://www.un.org/disabilities/default.asp?navid=23&pid=151> (last visited Feb. 27, 2011).

102. *Frequently Asked Questions: What Other International Instruments Recognize the Rights of Persons with Disabilities?*, U.N. ENABLE, <http://www.un.org/disabilities/default.asp?navid=23&pid=151> (last visited Feb. 27, 2011).

principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care — and place obligations on States which have signed the Convention to protect these rights.<sup>103</sup>

### B. “DISABILITY” DEFINED UNDER THE CRPD

Although it may seem strange to examine the definition of “disability” when analyzing the CRPD’s impact on involuntary civil commitment, exploring its approach to defining disability reveals the “social model” lens through which to interpret the rest of its provisions.<sup>104</sup> Interestingly, Article 2, the definitional article of the CRPD, lacks a formal definition of “disability.”<sup>105</sup> Nevertheless, the definition of disability and, more importantly, its reason for not being defined are provided within the preamble and Article 1. Article 1 establishes an operating definition of persons with disability: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments.”<sup>106</sup> Several important observations should be made about this definition. First, the CRPD makes clear that it had the rights of individuals with developmental disabilities in mind by including intellectual impairments.<sup>107</sup> Second, by using the word “include” within the Article 1 definition, the CRPD suggested that this definition does not seek to limit the coverage and application of the CRPD but, rather, to expand it.<sup>108</sup>

Furthermore, the preamble supplies a partial explanation for why a more concrete definition is missing: “[D]isability is an evolving concept[;] disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in socie-

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103. See generally *Frequently Asked Questions*, U.N. ENABLE, <http://www.un.org/disabilities/default.asp?navid=23&pid=151> (last visited Feb. 27, 2011).

104. The social model presumption will be revisited when analyzing Article 12, whose heated drafting history suggests a compromise between the medical model and the social model. See *infra* Part IV.C.2. With the exception of Article 12, however, it seems that the drafters of the CRPD meant to embrace the social model. See *Frequently Asked Questions*, *supra* note 103.

105. Convention on the Rights of Persons with Disabilities art. 2, *opened for signature* Mar. 30, 2007, 46 I.L.M. 443 [hereinafter CRPD].

106. *Id.* art. 1, para. 2.

107. *Id.*

108. *Id.*

ty on an equal basis with others.”<sup>109</sup> In describing disability as an evolving concept, the U.N. Convention recognizes that disability is not inherent in the individual but stems from society’s inability to accommodate adequately individuals with varying degrees of abilities.<sup>110</sup> This stance explicitly rejects the medical model: the U.N. Convention clarifies that “[d]isability is not something that resides in the individual as the result of some impairment.”<sup>111</sup>

The General Principles of the Convention, contained in Article 3, clearly endorse the social model of disability.<sup>112</sup> They emphasize that the rights and opportunities afforded to individuals with disabilities should be equal to what is offered to individuals who may not be disabled.<sup>113</sup> As such, the General Principles include individual autonomy, non-discrimination, full participation in society, equality of opportunity, and a “[r]espect for difference and acceptance of persons with disabilities as part of human diversity and humanity.”<sup>114</sup> Overwhelmingly, the interpretation of the CRPD espouses a social model of disability, locating the disability within the obstacles and barriers that individuals face.<sup>115</sup> However, several commentators have noted that the definition of a per-

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109. *Id.* pmb., para. e.

110. *Frequently Asked Questions (FAQs)*, U.N. ENABLE [hereinafter *FAQs*], <http://www.un.org/esa/socdev/enable/faqs.htm> (last visited Feb. 27, 2011). Examples of disabilities under the U.N. Convention include a person in a wheelchair who might have difficulties being gainfully employed not because of her condition but because there are environmental barriers such as staircases in the workplace which obstruct her access and a child with an intellectual disability who might have difficulties going to school due to the attitudes of teachers, school boards, and, possibly, parents who are unable to adapt to students with different learning capacities. *Id.* A person with extreme myopia (nearsightedness) would not be considered disabled in a society where corrective lenses are available; however, someone with the same condition in a society where corrective lenses were not available would be considered to have a disability, especially if his level of vision prevented him from performing expected tasks, such as shepherding, sewing, or farming. *Id.*

111. *Id.*

112. *See* CRPD, *supra* note 105, art. 3.

113. *Id.*

114. *Id.* paras. a–e.

115. *See* *Frequently Asked Questions*, *supra* note 103 (“[D]isability is not considered as a medical condition, but rather as a result of the interaction between negative attitudes or an unwelcoming environment with the condition of particular persons. By dismantling attitudinal and environmental barriers — as opposed to treating persons with disabilities as problems to be fixed — those persons can participate as active members of society and enjoy the full range of their rights.”); *see also* Council of Canadians with Disabilities, *CRPD: A Launch Pad for Action*, ABILITIES.CA (“Through the CRPD, the global community recognized the equality of people with disabilities and rejected the medical model approach to disability.”), <http://www.abilities.ca/organizations/2010/03/12/crpd/> (last visited Feb. 27, 2011).



son with disabilities opens the door to a medical model interpretation, as the CRPD defines a person with a disability as an individual with an impairment.<sup>116</sup> Moreover, it should be noted that the provisions, when taken alone and out of the overarching context of the CRPD, are more ambiguous and can be interpreted in differing ways. This is particularly true of Article 12,<sup>117</sup> where the lengthy debate during drafting sessions depicts a compromise between the two models.<sup>118</sup>

### C. LEGAL CAPACITY AND THE RIGHT TO CONSENT

The CRPD's approach to involuntary civil commitment is best addressed in two parts: (i) there must be the requirement of free and informed consent to medical treatment; and (ii) the individual with disability must have the capacity to give that consent.<sup>119</sup>

#### 1. *The Requirement for Free and Informed Consent*

The CRPD addresses the requirement of free and informed consent in Article 25(d) by stating that health care must be provided on the basis of free and informed consent.<sup>120</sup> The legal ques-

116. Professor Gregor Wolbring points to this deficiency:

In short, the Convention can be described as adhering to a social construction of disability but a medical — a deficiency — construction of the perception of a person with a disability.

Preamble (c)bis [sic] of the Convention (August 27, 2006 version) sees disability as a consequence of the barriers faced by a person with an impairment, not as barriers faced by a person with a variation in functioning.

Since impairment is not defined in the Convention, the World Health Organization International Classification of Functioning (ICF) definition will likely be used to interpret the term impairment in the Convention. Many countries already use the ICF. It defines impairment as “problems in body function or structure such as a significant deviation or loss.”

Gregor Wolbring, *NBCIS and the UN Convention on the Rights of Persons with Disabilities*, INNOVATION WATCH (Sept. 15, 2006), <http://innovationwatch-archive.com/choiceisyours/choiceisyours.2006.09.15.htm>.

117. See CRPD, *supra* note 105, art. 12 (dealing with the legal capacity to make decisions).

118. See *infra* Part IV.C.2.b.

119. See generally Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions*, 34 SYRACUSE J. INT'L L. & COM. 405 (2007).

120. See CRPD, *supra* note 105, art. 25, para. d (“[State Parties shall] [r]equire health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the

tion is whether individuals with developmental disabilities facing involuntary civil commitment into state institutions are covered by Article 25's requirement.<sup>121</sup> Article 25 begins by stating that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability."<sup>122</sup> It then lists with particularity Article 25(d), which requires free and informed consent. Article 25(d) specifies that such consent is necessary in "public . . . health care," a category which would include state institutions for individuals with developmental disabilities.<sup>123</sup> A state party to the Convention that took the position that individuals with developmental disabilities do not need to give free and informed consent would be in violation of Article 25 as such a position would constitute discrimination on the basis of disability.<sup>124</sup> It follows then that the protections extended to individuals without disabilities must be extended to those with disabilities — including people with developmental disabilities — and that under Article 25(d), individuals with developmental disabilities are entitled to civil commitment to state institutions only by free and informed consent.<sup>125</sup>

## 2. *Legal Capacity*

The second consideration of involuntary civil commitment is whether an individual with developmental disabilities has the legal capacity to provide consent. Article 12 of the CRPD deals

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human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care . . .").

121. See Minkowitz, *supra* note 119, at 406–08 (making clear that the CRPD applies to individuals in developmental centers and distinguishing the CRPD from previous treaties); *cf.* United Nations, Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, paras. 14, 28, 34, E/C. 12/2000/4 (Aug. 11, 2000).

122. CRPD, *supra* note 105, art. 25.

123. *Id.* art. 25, para. d; *see also* Minkowitz, *supra* note 119, at 406 ("States Parties are under an affirmative duty to ensure that health care providers (whether private or *public*) respect the free and informed consent of persons with disabilities, to the same extent as guaranteed to others under domestic and international law." (emphasis added)).

124. Minkowitz, *supra* note 119, at 408.

125. See *id.* Minkowitz was a member of the U.N. Working Group that produced the first draft text of the CRPD. *Id.* at 405 n.\*. She also led the International Disability Caucus's work on certain articles of the Convention, *id.*, and maintains that Article 25 actually places an affirmative duty upon states to make sure that health care providers respect the free and informed consent of persons with disabilities, *see generally id.*

specifically with the issue of legal capacity.<sup>126</sup> In examining the construction and the drafting history of Article 12, two possible interpretations arise: a limited substituted decision-making standard and a supported decision-making standard.

*a. Limited Substituted Decision-Making Standard*

When Article 12 is read in the broader context of its surrounding provisions and the general principles outlined in Article 3, the Convention does not conceive of capacity as binary, where one either has or does not have capacity. Rather, in order to maximize individual autonomy in a way that truly respects the freedom to make one's own choices as expressed in Article 3,<sup>127</sup> Article 12 must be conceived as granting capacity in all circumstances except when support is needed and then only to the extent that it is needed.<sup>128</sup>

One might argue that substituted decision-making under Article 12(2) is an acceptable standard. Indeed, when read alone, Article 12(2) simply states that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and the standard of substituted decision-making can be applied equally to individuals with and without disabilities.<sup>129</sup> Thus the question can be asked of all individuals whether they have the capacity to make decisions.

However, when Article 12(2) is read in the broader context of other Articles, the CRPD clearly demonstrates that an interpretation of Article 12 supporting substituted decision-making would be incorrect. For example, substituted decision-making would conflict with the general principles set out in Article 3.<sup>130</sup> Reading

126. CRPD, *supra* note 105, art. 12.

127. *Id.* art. 3.

128. *Id.* art. 12; *see* Minkowitz, *supra* note 119, at 408 ("The Convention replaces the dualistic model of capacity versus incapacity with an equality-based model that complements full legal rights to individual autonomy and self-determination with entitlement to support when needed.").

129. CRPD, *supra* note 105, art. 12, para. 2.

130. *Id.* art. 3.

The principles of the present Convention shall be:

- (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;

Article 12 in this manner would confound Article 3's principles like non-discrimination, full and effective participation and inclusion in society, equality of opportunity, and respect for difference and acceptance of persons with disabilities as part of human diversity.<sup>131</sup> Further, allowing for substituted decision-making would undermine Articles 23, 25, and 29, which, respectively, afford to individuals with disabilities equal rights to start and manage families,<sup>132</sup> to receive health services,<sup>133</sup> and to participate in political and public life.<sup>134</sup> Substituted decision-making challenges the capacity to develop one's potential and personality, which are protected in Article 24;<sup>135</sup> to choose one's work environment, safeguarded by Article 27;<sup>136</sup> and to take part on an equal basis with others in cultural life, shielded by Article 30.<sup>137</sup> In essence, the issue of legal capacity underlies nearly every aspect of the lives of individuals with developmental disabilities. Interpreting Article 12 as allowing for substituted decision-

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- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
  - (e) Equality of opportunity;
  - (f) Accessibility;
  - (g) Equality between men and women;
  - (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

*Id.*

131. Minkowitz, *supra* note 119, at 408–09.

132. CRPD, *supra* note 105, art. 23, para. 1. (“States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others . . . .”)

133. *Id.* art. 25. (“States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability . . . .”)

134. *Id.* art. 29. (“States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others . . . .”)

135. *Id.* art. 24, para. 1.

States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning directed to:

- (a) The full development of human potential and sense of dignity . . . ;
- (b) The development by persons with disabilities of their personality, talents and creativity . . . .

*Id.*

136. *Id.* art. 27, para. 1. (“States Parties recognize the right of persons with disabilities to work, on an equal basis with others . . . .”)

137. *Id.* art. 30, para. 1. (“States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life . . . .”)

making undermines the very purpose and spirit of the U.N. Convention.

Moreover, interpreting Article 12(2) as supporting substituted decision-making would be inconsistent within Article 12 itself. Article 12(4) states that “measures relating to the exercise of legal capacity . . . are proportional and tailored to the person’s circumstances . . . .”<sup>138</sup> Article 12(4), then, clearly defines limitations to substituted decision-making, thereby conceiving the capacity of decision-making to be a scale of ability, dependent upon the facts and circumstances of each individual. Taken as a whole, Article 12 constructs a standard that recognizes that individuals with developmental disabilities can have the capacity to make some decisions even if they are not able to make all decisions. The general principles of the CRPD suggest that even when individuals with developmental disabilities are unable to make decisions, their wishes should be taken into account by the decision-maker.<sup>139</sup> Therefore, one interpretation of Article 12 is a limited substituted decision-making standard.

A court might apply a limited substituted decision-making standard by placing a burden on those wishing to make decisions for an individual with disability, to show the necessity of removing decision-making autonomy from such individual in a specific context. If this burden is met, then the individual with disability would be stripped of his or her decision-making autonomy only in the context of the decisions that he or she has been shown to be incapable of making. However, even when that decision-making autonomy is taken away and placed in the hands of a guardian, the guardian should take into account the perspective of the individual with the disability. Thus, in one possible interpretation of Article 12, to the extent that guardianship is recognized, the standard is a limited form of guardianship that recognizes and respects the autonomy of the individual with the disability, substituting decision-making only to the extent of the individual’s disability.

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138. *Id.* art. 12, para. 4.

139. *See id.* art. 3(a) (the general principles include “respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons.”)

*b. Supported Decision-Making Standard*

A drafting controversy supplies another interpretation of Article 12, one that creates a supported decision-making standard. This standard does not allow for guardians to substitute their decisions for individuals with developmental disabilities unless they have met their burden of showing why the decisions of individuals with developmental disabilities should not be respected.<sup>140</sup> The supported decision-making standard focuses on respecting the desires of the individual with developmental disability; the guardian's more limited role is to help the individual make an informed decision. This section will first examine the lengthy discussions on what "legal capacity" means within Article 12 and then the procedural protections contemplated by the U.N. Convention while drafting Article 12.

The debate centers around Article 12, paragraph 2, which states that "State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."<sup>141</sup> Tina Minkowitz, a member of the U.N. Working Group that produced the first draft of the CRPD, argues that this statement alone should require a change in law to recognize that individuals with mental illnesses have sufficient legal capacity to prevent their institutionalization:

This guarantee is the heart of the Convention for people with psychosocial disabilities. All laws directed at restricting our freedom and self-determination are premised on an equation of psychosocial disability with legal incapacity, and legal incapacitation is the primary way that the law deals with persons with psychosocial disabilities. A guarantee of legal capacity on an equal basis with others in all aspects of life should result in the elimination of all such legal regimes.<sup>142</sup>

Although Minkowitz speaks specifically to individuals with mental illnesses, the same argument can be mustered in support of individuals with developmental disabilities. Like involuntary

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140. See *infra* Part VI.

141. CRPD, *supra* note 105, art. 12, para. 2.

142. Minkowitz, *supra* note 119, at 408.

institutionalization for individuals with mental illnesses, involuntary institutionalization for individuals with developmental disabilities is premised on the notion that their disabilities prevent them from having the capacity to determine whether they need institutional care.<sup>143</sup>

Before examining the more relevant discussion on the procedural protections for legal capacity, it is important to understand what the U.N. Convention means by “legal capacity.” The precise meaning of “legal capacity” under Article 12 sparked much debate.<sup>144</sup> When the Working Group text was introduced to the U.N. Convention, some countries made a distinction between the legal capacity for rights and the legal capacity to act.<sup>145</sup> The distinction between the two was that the capacity to act “implies personal authority to exercise rights and responsibilities.”<sup>146</sup> When an individual does not have the capacity to act, he or she formally has rights as an individual, but the authority to make decisions is placed in another person.<sup>147</sup> The Working Group text recognized that the capacity for rights was universally recognized, but that the capacity to act was not.<sup>148</sup> Initially, the Ad Hoc Committee reviewing the Working Group text inserted a footnote recognizing that the meaning of legal capacity was “capacity for rights” in Russian, Arabic, and Chinese.<sup>149</sup> Given that U.N. Conventions are widely considered universal and non-derogable, countries

143. See TURNBULL, *supra* note 1.

144. See Minkowitz, *supra* note 119, at 411.

145. *Id.* at 410–11 (describing the controversy over the definition of legal capacity).

146. *Id.* at 410; see Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34 SYRACUSE J. INT’L L. & COM. 429 (2007) (explaining what the stakes of the controversy over legal capacity was and the controversy itself).

147. Minkowitz, *supra* note 119, at 410. Defining legal capacity as the capacity for rights implies that individuals with developmental disabilities would have all constitutional rights, including due process, but still not be able to make their own decisions. Given the international outrage at attempting to define legal capacity as the capacity for rights, it is unlikely to be defined as such by the United States. Nevertheless, it remains a possibility as Egypt has declared legal capacity as the capacity for rights. See *infra* note 152.

148. Dhanda, *supra* note 146, at 438–40.

149. *Id.* at 453. The footnote in Article 12 of the draft CRPD stated, “In Arabic, Chinese, and Russian, the term ‘legal capacity’ refers to ‘legal capacity for rights’, rather than ‘legal capacity to act[.]’” U.N. Gen. Assembly, Ad Hoc Comm. on a Comprehensive and Integral Int’l Convention on the Prot. and Promotion of the Rights and Dignity of Pers. with Disabilities on its 8th Sess., Aug. 14–25, 2006, art. 12 n.a, U.N. Doc. A/AC.265/2006/4 (Sept. 1, 2006).

worried that the footnote was altering substantive commitments made only by certain nations.<sup>150</sup> The ensuing uproar caused the deletion of the footnote, and numerous countries made official statements interpreting legal capacity as either the capacity to act or the capacity for rights<sup>151</sup> — a great majority defining it as the capacity to act.<sup>152</sup> As such, CRPD itself leaves the definition ambiguous.

These interpretive limitations on “legal capacity” place into context the more relevant discussion of crafting procedural safeguards to protect legal capacity. Article 12, paragraph 4 addresses the issue of procedural protections for legal capacity:<sup>153</sup>

[S]afeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.<sup>154</sup>

Before Article 12 took on this final form, discussions surrounded the question of whether decision-making authority could be given to a guardian — particularly since one of the General Principles of the CRPD in Article 3 was recognizing individual autonomy.<sup>155</sup> The International Disability Caucus argued that substituted decision-making authority by a guardian should not be recognized and that a supported decision-making framework provided protection for the human rights of individuals with dis-

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150. Dhanda, *supra* note 146, at 452–54.

151. *Id.* at 454–56.

152. See, e.g., *Statements Made on Adoption of the Convention on the Rights of Persons with Disabilities*, U.N. ENABLE, <http://www.un.org/esa/socdev/enable/convstatementgov.htm> (last visited Mar. 2, 2011). Of the nations to ratify the U.N. Convention, only Egypt has explicitly declared that Article 12 would be interpreted as a right and not as a capacity to act. See *Declarations and Reservations*, U.N. ENABLE, <http://www.un.org/disabilities/default.asp?id=475> (last visited Mar. 22, 2011).

153. Dhanda, *supra* note 146, at 450 (discussing the discussion leading to procedural safeguards found in Article 12, paragraph 4).

154. CRPD, *supra* note 105, art. 12, para. 4.

155. Dhanda, *supra* note 146, at 442–54.



abilities.<sup>156</sup> What took shape was a modified version of Article 12 in which safeguards for guardianship considered both a standard of supported decision-making and limited substituted decision-making.<sup>157</sup>

Despite open interpretation of Article 12 as a standard of supported decision-making or one of limited substituted decision-making, there seems to be greater evidence that Article 12 creates a supported decision-making standard; particularly since the U.N. Convention specifically considered using a “best interest” standard for capacity, but rejected this standard as it denotes an understanding of the relationship between the guardian and the individual with the disability that resembles substituted decision-making.<sup>158</sup> In other words, “the standard of ‘best interest’ was insufficient since it allows the substituted decision-maker to act according to what he or she thinks is in the best interest of the person with disability, whether or not the person with disability thinks likewise.”<sup>159</sup>

Therefore, although the resulting Article 12 has two possible interpretations — a limited substituted decision making standard or a supported decision-making standard — the lengthy and

156. Int’l Disability Caucus, *Comments, Proposals, and Amendments Submitted Electronically*, U.N. ENABLE, <http://www.un.org/esa/socdev/enable/rights/ahcstata12fiscoment.htm> (last visited Mar. 2, 2011). The IDC hoped to create a provision more oriented toward supported decision-making, one in which the wishes of an individual with developmental disabilities who had been helped to understand the consequences of his or her actions would be followed. *Id.* This provision did not gain sufficient support. Dhanda, *supra* note 146, at 450–51. Their proposed changes appear below:

States Parties shall ensure that all legislative or other measures that relate to (ADD: support in) the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse (DELETE: in accordance with international human rights law). Such safeguards shall ensure that measures relating to (ADD: support in) the exercise of legal capacity respects the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances (DELETE: apply for the shortest time possible) and are subject to periodic impartial and independent judicial review. (DELETE: The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.)

*Id.* at 450 n.99 (quoting Int’l Disability Caucus, Correction to Compilation Article 12).

157. *Comments, Proposals and Amendments Submitted Electronically*, U.N. ENABLE, <http://www.un.org/esa/socdev/enable/rights/ahcstata12sevscoment.htm> (last visited Mar. 22, 2011) (showing various comments and interpretations of Article 12 from countries participating in the drafting of Article 12, in particular the Report on National Consultations, as either supported decision-making or limited substituted decision-making).

158. Dhanda, *supra* note 146, at 441.

159. *Id.*

heated drafting debate suggests that the final intent of Article 12 is to encourage a supported decision-making standard, while acknowledging the possibility of limited substituted decision-making.<sup>160</sup> Both the inclusion of Article 12, paragraph 4, and the specific rejection of the “best interest” standard show that the substituted decision-making process, even when limited, is an inadequate standard.

In conclusion, two interpretations of Article 12 are possible, but the intent of Article 12 was to promote the adoption of the supported decision-making standard. Insofar as Article 12 contemplates the substituted decision-making standard, it is allowed so long as there is no conflict of interest, no undue interest, and it is proportional and tailored to the circumstances, applies for the shortest time possible, and is subject to regular judicial review.<sup>161</sup> The supported decision-making standard encouraged by Article 12 stresses the importance of the individual’s decision, even where the individual might lack capacity; the result is that if the individual’s wishes are not respected, the court must review the guardian’s decision and justification for not respecting the individual’s decision.<sup>162</sup> The implication of either standard is that a case-by-case analysis must be done to see whether guardianship should be allowed and, if so, whether and how that guardianship will be limited. Given that commitment hearings in the United States already require case-by-case reviews of guardian decisions to protect due process,<sup>163</sup> Article 12 does not place an undue burden on the state.

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160. See *Comments, Proposals, and Amendments Submitted Electronically*, *supra* note 156; but see *Comments, Proposals, and Amendments Submitted Electronically*, *supra* note 157.

161. CRPD, *supra* note 105, art. 12, para. 4; see also Dhanda, *supra* note 146 at 460.

162. *Comments, Proposals, and Amendments Submitted Electronically*, *supra* note 157 (showing that various comments, in particular the Report on National Consultations, support the notion that in instances where individuals may require assistance in making a decision, such assistance should support individuals in making informed choices); see *infra* Part VI.

163. See *supra* Part III.

### 3. *Other Bases to Challenge Involuntary Commitment in the U.N. Convention*

As the discussion above on Article 12 and 25 shows, the U.N. Convention would extend the protections granted to people without disabilities to people with disabilities — and consequently, to individuals with developmental disabilities.

Articles 5 and 15 reaffirm this conclusion, albeit through an instrument other than the CRPD. Article 5 establishes that persons with disabilities cannot be discriminated against on the basis of their disability and guarantees equal and effective legal protection against discrimination on all grounds.<sup>164</sup> It provides a basis for challenging the notion that persons with developmental disabilities are not entitled to free and informed consent.<sup>165</sup> Much in the same vein, Article 15 states that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”<sup>166</sup> From a human rights perspective, the definition of torture can also include involuntary drug treatments, which individuals with developmental disabilities often face.<sup>167</sup> Both Article 5 and Article 15 are examined more closely below.

#### *a. Challenging the Difference in Treatment Between Individuals with Mental Illness and Individuals with Developmental Disabilities*

Traditionally, Article 5 has been read in a literal fashion, prohibiting discrimination between individuals without disabilities and individuals with disabilities. Article 5 states that “all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.”<sup>168</sup> It goes on to add that “States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against

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164. CRPD, *supra* note 105, art. 5, para. 1.

165. *See infra* Part IV.C.3.a. This basis stems from the discriminatory protections afforded to individuals with mental illnesses but not to individuals with developmental disabilities. *Id.*

166. CRPD, *supra* note 105, art. 15, para. 1.

167. Minkowitz, *supra* note 119, at 414.

168. CRPD, *supra* 105, art. 5, para. 1.

discrimination on all grounds.”<sup>169</sup> However, it is possible to read Article 5 in another fashion, which is to prevent discrimination among individuals with disabilities.

Given that individuals with mental illnesses are afforded more due process protections under the Equal Protection Clause than individuals with developmental disabilities,<sup>170</sup> it is interesting to consider whether Article 5 prohibits differing treatment between these two groups. Although it is true that the ADA would generally cover such differing treatment as discrimination, numerous courts have ruled otherwise; these differing interpretations of the Rehabilitation Act and the ADA have led to different state outcomes where individuals with mental illnesses can be afforded more legal protections than individuals with developmental disabilities.<sup>171</sup>

While it is possible that Article 5 litigation could also lead to differing state outcomes, the expansive notions of disability rights within the U.N. Convention undoubtedly provide a stronger basis for arguing that Article 5, at a minimum, prohibits discriminatory treatment among individuals with disabilities on the basis of their disabilities. Article 5 provides more robust protection because there are two possible interpretations of Article 5 — and in both interpretations, Article 5 would prohibit discrimination among individuals with disabilities. If Article 5 is interpreted as prohibiting discrimination between individuals with disabilities and individuals without disabilities, then it would prohibit discrimination within the class of individuals with disabilities as well. Within this interpretation, Article 5 would be more expansive than the Equal Protection Clause as well as some interpretations of the ADA.<sup>172</sup> Courts could import the Supreme Court’s *Olmstead* analysis that allows for claims of discrimination even without a comparison class.<sup>173</sup> This would allow complainants to argue an Article 5 violation without reference to another class of individuals who are not discriminated against.

In the alternative interpretation of Article 5, if courts do not engage in an *Olmstead*-like analysis, then it would mean discrim-

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169. *Id.* art. 5, para. 2.

170. *See supra* Part III.

171. *See supra* Part III.

172. *See supra* Part III.

173. *See supra* Part III.B.2.

ination among classes of individuals with disabilities is prohibited. That is, should U.S. courts upon ratification of the U.N. Convention decline to interpret Article 5 as prohibiting discrimination *between* individuals with disabilities and individuals without disabilities, then Article 5 must mean, at a minimum, that discrimination *among* individuals with developmental disabilities is prohibited. Interpreting Article 5 as neither prohibiting discrimination between individuals with disabilities and individuals without disabilities nor prohibiting discrimination among individuals with disabilities would render Article 5 devoid of any substantive meaning. This reading provides another basis for challenging the differing approach between individuals with mental illnesses and individuals with developmental disabilities. As such, there are three possible outcomes of Article 5 interpretation: (1) prohibiting discrimination between individuals with disabilities and those without; (2) prohibiting discrimination without a comparison class; or (3) prohibiting discrimination within classes of individuals with disabilities. Regardless of which interpretation is taken, litigation on Article 5 should have, at the very least, the same amount of success as Title II of the ADA has had, if not more.

Lastly, in much of the same Article 5 analysis as above, Article 17 also provides a basis for challenging involuntary institutionalization. Article 17 provides that “[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.”<sup>174</sup> Like Article 5, if Article 17 is to have any substantive meaning, then it must mean, at a minimum, that individuals with developmental disabilities have a right to respect for mental integrity on an equal basis with individuals with disabilities. The reason for this is that ‘others’ must either reference individuals without disabilities, in which case individuals with developmental disabilities would be afforded the same right as any other individual, or reference individuals with disabilities. Therefore, regardless of the population that the term ‘others’ references, individuals with developmental disabilities would be afforded a right that they currently do not have. Any procedure allowing for involuntary institutionalization for individuals with developmental disabilities would be in violation of

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174. CRPD, *supra* note 105, art. 17.

Article 17, as such procedure fails to place the mental integrity of individuals with developmental disabilities on an equal basis as those without developmental disabilities.<sup>175</sup> Hence, similar to Article 5, Article 17 prohibits discrimination on the basis of disability.

*b. Human Rights Violations as a Basis for Challenging Involuntary Commitment*

Interestingly, an alternative basis for challenging involuntary civil commitment is found not by demanding higher standards as in Article 12 and Article 25, but rather by alleging that the psychiatric treatment that accompanies involuntary civil commitment is a form of torture. Article 15 states that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.”<sup>176</sup> It has been suggested in the past several decades that nonconsensual psychiatric care is a form of torture or cruel, inhuman, or degrading treatment or punishment, and this specific issue has been brought, unsuccessfully, to the Human Rights Committee under a number of other U.N. Conventions.<sup>177</sup>

To make clear the connection: while these challenges have been in the context of nonconsensual administration of psychiatric drugs to individuals with mental illnesses, many of the very same psychiatric drugs have been administered to individuals with developmental disabilities within state institutions.<sup>178</sup> As

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175. *Id.*

176. CRPD, *supra* note 105, art. 15, para. 1.

177. Minkowitz, *supra* note 119, at 414–15; see, e.g., T.P. v. Hungary, Decision of the Human Rights Committee Under the Optional Protocol to the International Covenant on Civil and Political Rights Concerning Communication No. 496/1992, U.N. Doc. CCPR/C/47/D/496/1992 (Apr. 1, 1993), available at <http://www1.umn.edu/humanrts/undocs/html/496-1992.html>; K.L.B.-W. v. Australia, Decision of the Human Rights Committee Under the Optional Protocol to the International Covenant on Civil and Political Rights Concerning Communication No. 499/1992, U.N. Doc. CCPR/C/47/D/499/1992/Rev.1 (June 7, 1993), available at <http://www1.umn.edu/humanrts/undocs/html/499-1992.html>. For dismissal for lack of sufficient argument, see also *Bozena Fijalkowska v. Poland*, Views of the Human Rights Committee Under the Optional Protocol to the International Covenant on Civil and Political Rights Concerning Communication No. 1061/2002, U.N. Doc. CCPR/C/84/D/1061/2002 (July 11–29, 2005), available at <http://www1.umn.edu/humanrts/undocs/1061-2002.html>.

178. Interview with W. Emmett Dwyer, *supra* note 6.

such, the same challenges concerning involuntary administration of psychiatric drugs in state institutions could likely be raised for individuals with developmental disabilities.

Minkowitz argues that where past challenges have proved unsuccessful, the CRPD may be a more successful legal basis upon which to make a challenge.<sup>179</sup> One of the rationales for rejecting nonconsensual psychiatric drug administrations as a human rights violation is that there is “a standard of therapeutic necessity that permits force to be used ‘to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom [the medical authorities] are therefore responsible.’”<sup>180</sup> If Article 12 is interpreted as not allowing substituted decision-making, this rationale would no longer be valid within the CRPD; therefore, under Article 15, such force would be deemed a human rights violation.

Along with the possible change in standard for capacity under the CRPD, Minkowitz further argues that notions of torture have slowly been evolving and expanding to the point where proposed amendments to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has contemplated including the use of psychiatry as a form of torture.<sup>181</sup> Minkowitz points out that U.N. Special Rapporteurs have concluded that the force-feeding and drugging of detainees in Guantanamo Bay is a form of torture since consent was not given and therefore, the right to refuse treatment was denied.<sup>182</sup> She argues that torture now includes forced drugging.

Despite the different context of the U.N. Special Rapporteurs report, this last development has interesting implications for individuals with developmental disabilities; such treatment has been viewed as torture, due to its use for purposes other than healing. While the argument for treating nonconsensual psychiatric drug administrations to individuals with mental illness may be defended as helping to heal their illness, such arguments cannot be made for individuals with developmental disabilities, be-

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179. Minkowitz, *supra* note 119, at 413–26.

180. *Id.* at 415 (quoting *Herczegfalvy v. Austria*, App. No. 10533/83, 15 Eur. H.R. Rep. 437, 484 (1992) (modification in original)).

181. *Id.*

182. *Id.* at 416–17 (citing Comm’n on Human Rights, *Situation of Detainees at Guantanamo Bay*, ¶ 82, U.N. Doc. E/CN.4/2006/120 (Feb. 27, 2006)).

cause individuals with developmental disabilities have, by definition, a life-long impairment that cannot be healed through drug treatment.<sup>183</sup> Possibly then, individuals with developmental disabilities may have a colorable argument that such psychiatric treatments, common within institutionalization, are a violation of their human rights.

Whether petitioners are arguing that differences in treatment are violations of the CRPD or arguing that such treatment is a human rights violation, the CRPD offers unique alternative challenges to involuntary civil commitment of individuals with developmental disabilities. However, as novel legal challenges, it may be difficult to make these arguments successfully in court. For individuals with developmental disabilities, the previous discussion of legal capacity in Article 12 and 25 provides a stronger basis for challenging involuntary civil commitment. These provisions necessitate a direct and immediate response should the United States ratify the U.N. Convention — state law would need to be changed in order to comply with the standards of Article 12 and 25.

## V. STATE LAW COMPARISONS

Having examined what legal capacity means in the context of the U.N. Convention, this Note will now explore the existing standards for legal capacity in two states, New Jersey and Massachusetts. These two states are of particular interest because (i) New Jersey has struggled with institutionalization and currently cares for one of the largest populations of persons with developmental disabilities within its state institutions,<sup>184</sup> and because (ii)

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183. See Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, § 102(8), 114 Stat. 1677, 1683–84, available at <http://www.acf.hhs.gov/programs/add/ddact/DDACT2.html> (defining developmental disability as a mental or physical impairment likely to continue indefinitely); see also *Developmental Disabilities*, THE EUNICE KENNEDY SHRIVER NAT'L INST. OF CHILD HEALTH & HUM. DEV., [http://www.nichd.nih.gov/health/topics/developmental\\_disabilities.cfm](http://www.nichd.nih.gov/health/topics/developmental_disabilities.cfm) (last visited Apr 17, 2011) (stating that many developmental disabilities have no cure).

184. NJ Council on Developmental Disabilities Public Policy Committee, *Statistical Snapshot of Institutional Populations in the States June 2009*, <http://www.njcd.org/ResourcesforPolicyMakers/copy/STATIS~1.DOC> (providing statistics showing New Jersey as having one of the largest populations of individuals with developmental disabilities in state-care institutions in the country).



Massachusetts is widely considered a model of de-institutionalization, having in the past theoretically done away with involuntary civil commitment for individuals with developmental disabilities.<sup>185</sup> Moreover, Massachusetts has recently adopted the Uniform Probate Code, which is applied in eighteen other states.<sup>186</sup> Hence, analysis of the U.N. Convention's effect upon the New Jersey standard will demonstrate the radical transformation in law that would be necessary to conform with the U.N. Convention's standard, while the analysis of the U.N. Convention's effect upon the Massachusetts standard would likely apply to other states that have adopted the Uniform Probate Code.

#### A. NEW JERSEY AND THE U.N. CONVENTION

##### 1. *The New Jersey Standard*

New Jersey's approach to guardianship provides for both general guardianship and limited guardianship over an incapacitated individual.<sup>187</sup> An "incapacitated individual" is defined as an "individual who is impaired by reason of mental illness or mental

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185. According to Dybwad and Herr, "In 1971, Massachusetts abolished civil commitments on the basis of mental retardation. Under Massachusetts law, a retarded person can only be committed if he or she is also mentally ill, or is a criminal defendant found incompetent to stand trial or not guilty by reason of mental defect." Gunnar Dybwad & Stanley S. Herr, *Unnecessary Coercion: An End to Involuntary Civil Commitment of Retarded Persons*, 31 STAN. L. REV. 753, 760 (1979). However, some practitioners do not agree with this assessment, claiming that civil commitment continues regardless of the formal law. Telephone Interview with Matthew Engel, Senior Attorney, Disability Law Center (February 3, 2010). A more accurate statement of previous Massachusetts law is that the probate code simply did not address civil commitment of individuals with developmental disabilities. *Id.* Fleischner notes that courts would likely substitute "mental illness" for "mental retardation" or apply a best interest standard. Interview with Robert Fleischner, *supra* note 99; see also JOHN H. CROSS, ET AL., *GUARDIANSHIP AND CONSERVATORSHIP IN MASSACHUSETTS* 227–28 (2d ed. 2000). Therefore, Massachusetts has only "theoretically" done away with involuntary civil commitment; in practice, involuntary civil commitment remains a reality.

186. The Uniform Probate Code is a statutory model written by the National Conference of Commissioners on Uniform State Laws for unifying and modernizing probate laws. UNIF. PROBATE CODE (amended 2006), available at <http://www.law.upenn.edu/bll/archives/ulc/upc/final2005.htm> (last visited Apr. 17, 2011). States that have adopted the Uniform Probate Code include Alaska, Arizona, Colorado, Florida, Hawaii, Idaho, Maine, Michigan, Minnesota, Montana, Nebraska, New Mexico, North Dakota, South Carolina, South Dakota, and Utah. See *Uniform Probate Code Locator*, LEGAL INFORMATION INSTITUTE, <http://www.law.cornell.edu/uniform/probate.html> (last visited Feb. 28, 2011).

187. N.J. STAT. ANN. § 3B:12-24.1 (West 2010).

deficiency to the extent that he lacks sufficient capacity to govern himself and manage his affairs.”<sup>188</sup> In contrast to the CRPD’s definition, the New Jersey definition clearly subscribes to the medical model of disability. Moreover, the issue of limited guardianship is not further explored in the New Jersey Statutes with regard to commitment into state developmental centers.

To the extent that consent is necessary within a commitment proceeding, the New Jersey Administrative Code, set by the Department of Human Services, prescribes that a guardian can give consent.<sup>189</sup> The relevant provision in the New Jersey Administrative Code, section 10:46B-4.1(g) states, “When the Division agrees that the individual is in need of guardianship services and a family member or Bureau of Guardianship Services is pursuing guardianship, the Division shall recognize the proposed guardian as the decision-maker.”<sup>190</sup> Working in tandem with this provision is New Jersey Administrative Code section 10:48, which determines the appeal procedure.<sup>191</sup> Under section 10:48, a person authorized to make an appeal does not include incapacitated persons but only their appointed guardians.<sup>192</sup> Thus, New Jersey allows guardians to give consent during a commitment proceeding for an individual with a developmental disability. Moreover, New Jersey allows only the guardian to make an appeal, not the individual with a developmental disability. Therefore, New Jersey follows a capacity model in which there is substituted decision-making; completely depriving individuals with developmental disabilities of their decision-making autonomy.

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188. *Id.* § 3B:1-2 (West 2010).

189. *See* N.J. ADMIN. CODE § 10:46B (2010). New Jersey’s approach to consent to state institutionalization is dictated by § 10:46B, as established by the New Jersey Department of Human Services. *See* N.J. STAT. ANN. § 30:4-25.6 (West 2009) (amended 2010) (“The commissioner shall, upon proper application for admission, forthwith admit the eligible mentally retarded person, and provide him with appropriate functional service to the extent available. In the event that the functional service which has been specified as most appropriate from time to time is not immediately available, the commissioner shall provide alternate service and, at the request of the applicant, shall also place the eligible mentally retarded person on a waiting list for the preferred service pending its availability.”).

190. N.J. ADMIN. CODE § 10:46B-4.1(g).

191. *See id.* § 10:48.

192. *Id.* § 10:48-1.5.

## 2. *The U.N. Convention on the New Jersey Standard*

While New Jersey's general approach to guardianship is likely to satisfy the capacity protections required by Article 12 of the CRPD, the proceedings as structured by the Department of Human Services are not likely to satisfy the requirements set out by Article 12. As discussed above, two New Jersey regulations, New Jersey Administrative Code sections 10:48 and 10:46B-4.1(g), work in tandem to devalue the individual's autonomy, especially in the important context of medical consent.<sup>193</sup> Analyzing the New Jersey standard in light of the U.N. Convention requires recognizing that, as noted earlier, the standard set out by Article 12 is subject to debate.<sup>194</sup> One interpretation of Article 12 would allow for no substituted decision-making,<sup>195</sup> a prohibition that would require a revision of the two New Jersey regulations that only allow for substituted decision-making.<sup>196</sup> The alternative reading of Article 12 would allow for substituted decision-making but only to the necessary extent.<sup>197</sup> While not requiring a complete revision of the two New Jersey regulations, both interpretations of Article 12 would require limited guardianship in the application of sections 10:46B-4.1(g) and 10:48. This requirement of limited guardianship would also require a revision of New Jersey's guardianship statute, as it currently allows for both general and limited guardianship.<sup>198</sup> Therefore, New Jersey's guardian-

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193. See *supra* Part V.A.1.

194. See *supra* Part IV.C.2.

195. See *supra* Part IV.C.2.b.

196. N.J. ADMIN. CODE §§ 10:46B-4.1(g), :48 (2010).

197. See *supra* Part IV.C.2.a.

198. N.J. STAT. ANN. § 3B:12-24.1 (West 2010). In relevant part, the statute states:

*General Guardian.* If the court finds that an individual is incapacitated as defined in N.J.S.3B:1-2 and is without capacity to govern himself or manage his affairs, the court may appoint a general guardian who shall exercise all rights and powers of the incapacitated person. The general guardian of the estate shall furnish a bond conditioned as required by the provisions of N.J.S.3B:15-1 et seq., unless the guardian is relieved from doing so by the court.

*Limited Guardian.* If the court finds that an individual is incapacitated and lacks the capacity to do some, but not all, of the tasks necessary to care for himself, the court may appoint a limited guardian of the person, limited guardian of the estate, or limited guardian of both the person and estate. A court, when establishing a limited guardianship shall make specific findings regarding the individual's capacity, including, but not limited to which areas, such as residential, educational, medical, legal, vocational and financial decision making, the incapacitated person retains sufficient capacity to manage. A judgment of limited

ship statute would need to be revised to mandate a preference for limited guardianship.

Additionally, New Jersey's statute does not satisfy Article 12's requirement of being "subject to regular review by a competent, independent and impartial authority or judicial body."<sup>199</sup> The two New Jersey regulations, sections 10:46B and 10:48, allow for the outcome of the hearing to be internally reviewed only by the Department of Human Services in New Jersey.<sup>200</sup> Such an agency would likely not be considered an independent authority. Furthermore, regular review is not mandated within the New Jersey provisions.<sup>201</sup> Therefore, a revision would also need to address these two concerns about the appeals process for individuals with developmental disabilities in New Jersey, most likely through regularly scheduled administrative hearings.

## B. MASSACHUSETTS AND THE U.N. CONVENTION

### 1. *The Massachusetts Standard*

Massachusetts approaches the issue of guardianship differently than New Jersey does. As noted earlier, its approach is of particular interest, as it adopted the guardianship provisions of the Uniform Probate Code on July 1, 2009.<sup>202</sup> Because eighteen other states have adopted the Uniform Probate Code, the CRPD's impact is likely to be similar in these states. The relevant provision for the procedure of establishing guardianship over an incapac-

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guardianship may specify the limitations upon the authority of the guardian or alternatively the areas of decision making retained by the person. The limited guardian of the estate shall furnish a bond in accordance with the provisions of N.J.S.3B:15-1 et seq., unless the guardian is relieved from doing so by the court.

N.J. STAT. ANN. § 3B:12-24.1(a)–(b).

199. CRPD, *supra* note 105, art. 12, para. 4.

200. See N.J. ADMIN. CODE § 10:46B-5.1(a) (2010) (providing that appellate procedure is established in N.J. Admin. Code § 10:48). Section 10:48 sets forth the structure of an appeal: non-settled, contested appeals are presented to the Office of Administrative Law, N.J. ADMIN. CODE § 10:48-1.3, -7.1(a)–(b) (2010); complainants may further appeal to the Director of the N.J. Division of Medical Assistance and Health Services, who renders final judgment, N.J. ADMIN. CODE. § 10:48-7.1(d).

201. Section 10:46B of the New Jersey Administrative Code does not allow for regular review. § 10:46B.

202. *Massachusetts Law About Guardianship and Conservatorship*, MASS. TRIAL COURT LAW LIBRARIES, <http://www.lawlib.state.ma.us/subject/about/guardian.html> (last visited Mar. 2, 2011).

tated individual can be found in Massachusetts General Laws (“Mass. Gen. Laws”) chapter 190B, section 5-303. Formal definition of an incapacitated person is given within Mass. Gen. Laws chapter 190B, section 5-101, and describes the disability as a “clinically diagnosed condition,” thereby prescribing to the medical model of disability.<sup>203</sup> Individuals with developmental disabilities fall within the category set out in Mass. Gen. Laws chapter 190B, section 5-303, as intellectual disabilities are specifically referenced within the procedures for appointing a guardian of an incapacitated person.<sup>204</sup>

Section 5-303 is more nuanced than the New Jersey provisions because it creates a presumption for establishing limited guardianship rather than the dualistic notion of total capacity or no capacity at all. Section 5-303(10) asks that the petition includes “the reason why a guardianship is necessary, the type of guardianship requested, and if a general guardianship, the reason why limited guardianship is inappropriate, and if a limited guardianship, the powers to be granted to the limited guardian.”<sup>205</sup> Hence, even though the Uniform Probate Code establishes a substitute decision-making paradigm, it does so only to the extent necessary.

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203. MASS. GEN. LAWS ch. 190B, § 5-101(9) (2010). Under the definition of an incapacitated person, individuals with developmental disabilities are included as having an “inability to receive and evaluate information or make or communicate decisions . . .” *Id.* It is also worth noting that individuals with developmental disabilities fall within the category of being a “mentally retarded person” under the statute. The statute describes a “mentally retarded person” as

an individual who has a substantial limitation in present functioning beginning before age 18, manifested by significantly subaverage intellectual functioning existing concurrently with related limitations in 2 or more of the following applicable adaptive skills areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functioning academics, leisure, and work.

*Id.* ch. 190B, § 5-101(12). For the purposes of this Note, it suffices to note that individuals with developmental disabilities are functionally covered by the definition of an incapacitated person.

204. MASS. GEN. LAWS ch. 190B, § 5-303(a)–(b) (2010) (amended 2010) (“An incapacitated person [or a person with an intellectual disability] or any person interested in the welfare of the person alleged to be incapacitated may petition for a determination of incapacity, in whole or in part, and the appointment of a guardian, limited or general.”).

205. *Id.* ch. 190B, § 5-303(b)(10).

## 2. *The U.N. Convention on the Massachusetts Standard*

As mentioned earlier, the U.N. Convention does not clearly establish a standard in Article 12. Should Article 12 be interpreted as creating a supportive decision-making paradigm and prohibiting the guardian from committing an individual with developmental disability over his or her objection, then Massachusetts's adoption of the Uniform Probate Code falls short of the standard created by the U.N. Convention.<sup>206</sup> Although Massachusetts only incorporates substituted decision-making paradigm to the extent necessary, the U.N. Convention would not allow substituted decision-making at all. If the U.N. Convention were so interpreted, Massachusetts would need to revise its Uniform Probate Code to require supportive decision-making.

If Article 12 were interpreted as creating a substitute decision-making paradigm, it would seem that the Uniform Probate Code would comport with the U.N. Convention's standards for legal capacity. The Uniform Probate Code creates a presumption for the most limited guardianship possible,<sup>207</sup> as does Article 12 of the U.N. Convention.<sup>208</sup> However, even under an interpretation of Article 12 that allows for substitute decision-making, a searching review of Article 12's history suggests that the Uniform Probate Code is not protective enough of the rights of individuals with developmental disabilities.

When Article 12 was written, a debate arose about whether the "best interest" standard should be used to determine whether guardianship should be established.<sup>209</sup> This standard was specifically rejected because the "best interest" standard allowed the guardian to act in what she believed to be the best interest of the individual with disabilities, even over his objection.<sup>210</sup> That the "best interest" standard was considered and rejected suggests that some weight should be given to the objection of the individu-

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206. *See supra* Part IV.

207. MASS. GEN. LAWS ch. 190B, § 5-303(b)(10).

208. *See supra* Part IV.C.

209. *See supra* Part IV.C.2.b; *see also* Dhanda, *supra* note 146, at 441 ("[F]or these members of the working group, the standard of 'best interest' was insufficient since it allows the substituted decision-maker to act according to what he or she thinks is in the best interest of the person with disability, whether or not the person with disability thinks likewise.").

210. *See supra* Part IV.C.2.b.

al with disability.<sup>211</sup> Therefore, if Article 12 is interpreted in a nuanced fashion as allowing for substitute decision-making only to the extent necessary and as giving some weight to the objections of the individual with developmental disabilities, then it would follow that § 5-303, would need an added provision to give some weight in the hearing to the individual with developmental disabilities' own decision.

## VI. THE IMPACT OF U.S. RATIFICATION OF THE CRPD

### A. WHY THE SUPPORTED DECISION-MAKING STANDARD OFFERS MORE PROTECTION

Both interpretations of the CRPD — the limited substituted decision-making standard and the supported decision-making standard — create more robust and practical protection for individuals with developmental disabilities. As explored in Part V, even the progressive standard of Massachusetts does not provide individuals with developmental disabilities a voice in the decisions that guardians make on their behalf. One might ask, however, how much of a difference exists between (i) the CRPD's supported decision-making standard or the CRPD's limited substituted decision-making standard and (ii) the substituted decision-making standard of progressive states such as Massachusetts.

Arguably, the two standards are quite similar. Both standards incorporate limited decision-making capacity and, therefore, both appoint guardians to make decisions only where it has been shown that individuals with developmental disabilities are unable to do so. Furthermore, both standards require independent reviews of such decisions to protect the rights of individuals with developmental disabilities.<sup>212</sup> Even interpreting Article 12 as a limited substituted decision-making standard forces courts to review the decision to ensure that individuals with developmental disabilities truly lacked capacity to make the decision themselves.

Nevertheless, the CRPD's supported decision-making standard creates an additional procedural safeguard that the substi-

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211. See *supra* Part IV.C.2.b.

212. See *supra* Part IV.C.2.b; see also CRPD, *supra* note 105, art. 12, para. 4.

tuted decision-making standard lacks. When a guardian makes a decision for an individual with development disabilities, the burden lies upon the guardian to show that the desires of an individual with developmental disabilities should not be respected.<sup>213</sup> This requires the court to look to the circumstances of the situation and evaluate whether they warrant enforcing the guardian's decision. Hence, rather than simply enforcing the decision of the guardian as in substituted decision-making, the court itself must review this decision.

Finally, this extra procedural protection is not costly or impractical. Given that states must already undertake administrative hearings, the supported decision-making standard merely adds one last step in the legal analysis that the court must take. Thus, the court must determine (i) whether the decision at issue is one for which the individual should retain decision-making autonomy and (ii) whether the circumstances warrant enforcing the decision of the guardian over the wishes of the individual with developmental disability. Although very similar in appearance to limited decision-making, this additional procedural protection forces guardians to justify their decision, thereby ensuring that the wishes of individuals with developmental disabilities will have been considered.

#### B. POSSIBLE ADVERSE INTERPRETATIONS OF THE CRPD

Before concluding, there are several potential adverse interpretations of the CRPD that are worth highlighting, especially those that detail what burden the state must bear to satisfy the provisions of the CRPD. The burden on the state will first be examined in the context of Article 19 and the *Olmstead* decision. Then more broadly, this Note will examine the burden on the state for complying with all the provisions of the CRPD.

Notably, a corollary to *Olmstead's* integration mandate exists in Article 19, which states that individuals with disabilities have a right to live in the community.<sup>214</sup> Such similar language suggests that the general principles of the U.N. Convention and the overall perspective on disability found in the CRPD are in keep-

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213. See *supra* Part IV.

214. CRPD, *supra* note 105, art. 19.



ing with the recent trend of deinstitutionalization and granting more rights to individuals with disabilities.

Article 19 lacks the “fundamental alteration” defense, which allows the state to mount an affirmative defense if it chooses not to comply with the integration mandate of *Olmstead*.<sup>215</sup> Although it might seem that Article 19 is a very strong version of the *Olmstead* integration mandate, it should be noted that the general obligations of states outlined in Article 4 creates only a duty of adopting *appropriate* measures.<sup>216</sup> However, it is not clear what “appropriate measures” means. If “appropriate measures” means merely a good faith effort to comply, then it would seem to be weaker than the *Olmstead* burden of showing a fundamental alteration of state services. Exactly what would satisfy this burden of good faith is unknown and near-impossible to predict. Nevertheless, even if it is interpreted as weaker than the fundamental alteration defense, the state must still show fundamental alteration of state services in order to satisfy the integration mandate of *Olmstead*. As a result, in the context of the integration mandate, plaintiffs would likely need to mix and match their claims, appealing first to the more robust Article 12 right to live in the community. Should the state demonstrate good faith effort, plaintiffs can then rely upon the integration mandate found in *Olmstead*, where the state must mount the difficult “fundamental alteration” defense.

However, given that the heavy burden of fundamental alteration covers only the context of integration, this concern about what *appropriate* measures are carries beyond Article 19 and into every article of the CRPD. Exactly what standard “appropriate measures” represents will likely determine the success of the CRPD (should the United States ratify it). Moreover, Article 4, paragraph 2, states that every “State Party undertakes to take measures to the maximum of its available resources.”<sup>217</sup> Once again, how exactly this qualification upon the state’s obligations to comply with the CRPD will affect the implementation of the

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215. *Olmstead v. L.C.*, 527 U.S. 581, 595 (1999). If the state can show that complying with the integration mandate of *Olmstead* would require a “fundamental alteration” of state services, then the state has met its burden to not comply with *Olmstead*. See, e.g., *id.* at 607–08 (Stevens, J., concurring).

216. CRPD, *supra* note 105, art. 4, para. 1, §§ a, b, e.

217. CRPD, *supra* note 105, art. 4, para. 2.

CRPD remains questionable. Even though deinstitutionalization began in the 1960s, many states continue to institutionalize as a method of caring for individuals with developmental disabilities today. A relaxed reading of appropriate measures and available resources would likely result in a slow and difficult reform in how states care for individuals with developmental disabilities.

Finally, the last hurdle within the CRPD is the definition of “reasonable accommodation.” Article 2 defines “reasonable accommodation” as a “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden.”<sup>218</sup> This raises the problem of how burdensome an accommodation must be in order to be a disproportionate or undue burden. Moreover, the definition of reasonable accommodation uses the words “modification” and “adjustment,” thereby suggesting that such changes do not have to fundamentally alter the state’s services.<sup>219</sup> Hence, Article 2 suggests that states would only need to take reasonable steps to reform state services and comply with the CRPD. The CRPD, then, does not signal rapid change for individuals with developmental disabilities; instead, it signals a long and arduous journey of reform.

### C. RATIFICATION AND ENFORCEMENT

The extent of the CRPD’s impact on U.S. law may be affected by any declarations at time of ratification. As numerous other countries have done, including El Salvador, Egypt, and the Netherlands, the United States is able to limit or expressly interpret a provision in a certain way.<sup>220</sup> For example, El Salvador has declared that the U.N. Convention applies “to the extent that its provisions do not prejudice or violate the provisions of any of the precepts, principles and norms enshrined in the Constitution of the Republic of El Salvador, particularly in its enumeration of principles.”<sup>221</sup> A large number of countries have protested this limitation as being too ambiguous a derogation from the U.N.

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218. *Id.* art. 2.

219. *Id.*

220. *Declarations and Reservations*, U.N. ENABLE, <http://www.un.org/disabilities/default.asp?id=475> (last visited Mar. 2, 2011).

221. *Id.*

Convention.<sup>222</sup> The manner in which the U.N. Convention could be limited is exemplified by Egypt's declaration, where Egypt expressly stated that Article 12 allowed individuals to have "the capacity to acquire rights and assume legal responsibility ('ahliyyat al-wujub) but not the capacity to perform ('ahliyyat al-'ada'), under Egyptian law."<sup>223</sup>

Despite ambiguities in the U.N. Convention, the enforcement provisions of the U.N. Convention will encourage interpretations that offer more decision-making to individuals with developmental disabilities. Because the U.N. Convention creates a committee that will receive reports from each state party about its compliance to the U.N. Convention, the U.N. Convention pushes for a worldwide standard.<sup>224</sup> This would prevent more lenient interpretations of Article 12 and would likely create the supported decision-making standard as the norm for compliance.

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222. See, e.g., *id.* Austria, for example, declared:

The Government of Austria has examined the reservation to the Convention on the Rights of Persons with Disabilities and Optional Protocol thereto made by the Government of El Salvador.

According to its reservation, El Salvador envisages becoming Party to the Convention only to the extent that its provisions do not prejudice or violate the provisions of any of the precepts, principles and norms enshrined in the Constitution of the Republic of El Salvador, particularly in its enumeration of principles. In the absence of further clarification, this reservation does not clearly specify the extent of El Salvador's derogation from the provisions of the Convention. This general and vague wording of the reservation raises doubts as to the degree of commitment assumed by El Salvador in becoming a party to the Convention and is therefore incompatible with international law.

The Government of Austria objects to the reservation made by the Government of the Republic of El Salvador to the Convention on the Rights of Persons with Disabilities and Optional Protocol thereto.

This objection, however, does not preclude the entry into force, in its entirety, of the Convention between Austria and El Salvador.

*Id.*

223. *Id.* It should be noted that if the United States were to limit the definition of capacity to the capacity to have rights, one could argue that substituted decision-making would be allowed, as Article 12 could be interpreted as allowing individuals with developmental disabilities to have rights but allowing others to make decisions about how to exercise those rights. However, if capacity were defined in this way, it should be noted that Article 12 protects individuals with disabilities by mandating that states provide support, CRPD, *supra* note 105, art. 12, para. 3, and protects individuals by requiring a guardian who is "free of conflict of interest and undue influence," *id.* art. 12, para. 4. Lastly, Article 12 requires that the "rights, will and preferences" of the individual with disabilities are respected, which would cut against the notion of allowing substituted decision-making. *Id.* art. 12, para. 4. Respecting the preference of an individual necessitates supported decision-making. See *supra* Part IV.C.2.

224. CRPD, *supra* note 105, arts. 33–37.

## VII. CONCLUSION

The U.N. Convention incorporates a progressive understanding of disabilities and provides broad rights for individuals with disabilities. For an overlooked and underrepresented population, the CRPD offers robust protections to individuals with developmental disabilities, particularly in the context of involuntary civil commitment. More specifically, the right to free and informed consent in Article 12 establishes that in commitment hearings where there is limited guardianship, guardians cannot simply substitute their decision to provide consent but instead must facilitate either a supported decision-making process or a limited substituted decision-making process.<sup>225</sup> This would provide an additional procedural protection by courts in their review of the guardians' decisions. Furthermore, the U.N. Convention offers other grounds rooted in human rights violations for challenging involuntary commitment into state institutions.<sup>226</sup>

Although varying interpretations on Article 12 are possible, both New Jersey and Massachusetts statutes would require revision to conform with the standards of the U.N. Convention, should it be ratified. New Jersey would need to incorporate a preference for limited guardianship as well as establish regular review procedures by an independent authority. Massachusetts would need to change from allowing substituted decision-making to requiring supported decision-making for commitment hearings of individuals with developmental disabilities.

Certainly, should the United States choose to ratify the U.N. Convention, individuals with developmental disabilities would be afforded more rights and protections than ever before. Even without ratification, however, the U.N. Convention establishes the international standard for disability rights, such that its changes to notions of disability are likely to be reflected in evolving U.S. case law. Although enforcement of the CRPD and sweeping reform will be a slow and difficult process, for individuals with developmental disabilities who have faced life-long segregation and discrimination, ratification of the U.N. Convention

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225. *See supra* Part IV.C.2.

226. *See supra* Part IV.C.3.

would be an enormous success in giving these individuals control and autonomy over their own lives.