IMPLEMENTING A PARADIGM SHIFT: IMPLEMENTING THE CRPD IN THE CONTEXT OF MENTAL DISABILITY LAW

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Abstract: The passage of the CRPD in 2006 promises a paradigm shift in the rights of people with disabilities. Implementing this paradigm shift is a major undertaking requiring the involvement of a wide range of stakeholders. The required reforms extend across the legal landscape, and attainment of any consensus on many reforms may take many years in some areas. In the interim, people with disabilities remain subject to situations that are indefensible in human rights terms, whether that is understood in the pre- or post-CRPD paradigm. This creates a set of dilemmas: how do human rights advocates argue for the amelioration of manifest abuses in the short to mid-term without undermining the underlying transformative promise of the CRPD’s new paradigm; and how is the pressure on states parties to be maintained in the long process of finding ways fully to implement the CRPD? These difficulties are discussed in the context of laws relating to mental disability, both in general and with particular reference to the revisions to the Standard Minimum Rules for the Treatment of Prisoners (SMR) now under consideration.

Introduction

[For 650 million persons around the world living with disabilities, today promises to be the dawn of a new era -- an era in which disabled people will no longer have to endure the discriminatory practices and attitudes that have been permitted to prevail for all too long.]

We all rejoiced when the CRPD was passed in 2006, with its promise of a paradigm shift in the human rights of people with disability. People with disabilities are to be full and participating members of society, able to make their own choices and live their own lives – heady promises indeed. Non-discrimination, the order of the day, is buttressed with expectations of meaningful reasonable accommodation to allow the aspirations of people with disabilities to be made real in all aspects of life. The problems related to disability were articulated as flowing from social responses, not as intrinsic to the people with disabilities themselves.

After the party, we now face the morning after – the bleary hangover of implementation, a process that will take many years. This is, of course, a problem with any new treaty, but the CRPD is meant to be not merely a new treaty but a new paradigm. Where

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the traditional view of treaties is that they consolidate previous developments in international law, a considerable aspect of the CRPD’s importance is its break with previous international law. For example, far from being a guide to the interpretation of the CRPD, the UN High Commissioner for Human Rights and the UN Special Rapporteur on Torture expressly identified the UN Mental Illness Principles as no longer reliable statements of international law because of their inconsistencies with the CRPD. The impetus for the CRPD was not that the existing law required consolidation; it was that existing law was not working for people with disabilities, and that something new was required.

The CRPD thus opens up a new range of possibilities, but at the same time, this creates particular difficulties for implementation. Consistent with its role as a convention, the CRPD provides the human rights standards and values of this brave new world into which we are venturing; but also quite properly for a convention, it does not generally provide specific requirements as to how those values are to be implemented. Individual States Parties must determine this consistently with their own legal and political cultures. This paper will argue below that conceptualisation of specific forms of legal regulation to implement the values in the CRPD are in their infancy. New forms of law require development and testing in the contexts in which they will be implemented. All that takes time.

Further, while the community of people with disabilities may have taken up the new paradigms contained in the CRPD, many people in the remainder of the population have not. Meaningful change on the ground cannot be introduced by administrative fiat: the new approaches must be ‘owned’ by the people who administer them on the ground if they are to be successful. For matters such as reasonable accommodation in housing, employment, and social inclusion, that means ownership by the bulk of the population. That is primarily a political process rather than a legal one, and that, too, will take time.

In this period of transition, what should our advocacy look like? We cannot simply say that we will force the new ideas onto domestic governments and the body politic of the States Parties. First, we do not always yet know what specific laws we would demand, and second, without the support of the governed, laws cannot succeed. It is equally unacceptable however to say that we will leave things as they are until the relevant legal interpretations are agreed upon. People with disabilities have been told for decades that they are next year’s priority. Under any standards, people with disabilities face unacceptable human rights violations in many countries of the world. Allowing the CRPD to become an excuse to delay improvements while we wait for the perfect, near-perfect, or consensus legal models of implementation to arise would be reprehensible.

The result leaves us in a practical dilemma. Following the old paradigms of human rights law to improve the human rights of people with disabilities may be more attainable in the short to mid-term because those paradigms enjoy greater acceptance among a wider range

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of stakeholders in many countries. This may make real improvements in the lives of people with disabilities in those countries. Reliance on these old paradigms however provides them with a credibility and status that may undercut the ongoing political efforts to implement the new paradigm. At the same time, waiting for a consensus on how to proceed under the new CRPD paradigms is reached may take years if not decades, leaving people with disabilities in indefensible conditions in the interim.

There are multiple questions that result from this situation:

- How do we keep the heat on governments and other actors to ensure that the developmental work occurs and that the paradigm shift promised by the CRPD does actually occur? The CRPD is likely to be a once-in-a-lifetime opportunity to make significant changes in the way people with disabilities are dealt with in law and policy and in the community; it is too important to let slip.
- How do we work to prepare the political ground so that the legislative developments to implement the CRPD are ‘owned’ not only by the communities of people with disabilities but also by lawmakers, the people who will be administering the new law, and the public at large?
- Pending those changes, how do we work to improve the lives of people with disabilities without undercutting the larger project of social and legal change called for by the CRPD?
- A volume of papers compiled by the United Nations Special Rapporteur on Torture establishes that it is appropriate to ask what sorts of steps that office and other international bodies like it ought to be taking to further the above points.

This paper examines these tensions in the context of mental disability law. It does not purport to provide definitive answers or a doctrinaire way forward. It is intended instead to open discussion on the subject.

**Mental Disability Law as a Case Study**

Mental disability law provides a particularly good case study on this problem. There can be little doubt that implementation of the CRPD requires fundamental changes to most states’ mental disability law.

First, the CRPD requires social integration of people with disabilities through, for example, the provision of community living (Art 19), education (Art 24), and employment opportunities (Art 27). Express rights are provided to social and political integration (Arts 29, 30). While their inclusion in a formal convention relating to disability is, of course, significant, these Articles can be seen as a development of previous international instruments and good practice and should not, therefore, be controversial. They do not, however, reflect the current reality in which people with mental disabilities (be they developmental or psychosocial disabilities) live; in much of the world, large closed institutions remain the main mode of care. Often, those institutions often lack adequate conditions regarding, for example, the physical state of the institutions; healthcare provision; the availability of adequate food, clothing, and warmth; social contacts with the outside world; educational and other rehabilitation facilities and programmes; and assuring the safety of inhabitants.4

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4 Regarding the conditions in such institutions, see, for example, the reports of the U.N. Subcomm. for the Prevention of Torture, available at [http://www2.ohchr.org/english/bodies/cat/opcat/spt_visits.htm](http://www2.ohchr.org/english/bodies/cat/opcat/spt_visits.htm), and, for
The implementation of these ‘uncontroversial’ aspects of the CRPD will, therefore, be a significant change in the way mental disability is considered in many countries. The experience of countries with systems of community living is, however, that such systems take time to develop. This includes both obtaining the physical community housing for previously institutionalised people to move into and also developing the social services structures to provide the systems of support that will make such moves practical. Even if the political will exists to implement community living, and often it does not, there will be a significant period of transition in which many people will be living in the institutions.

On the above issues, the CRPD is relatively clear in its terms and requirements (although even regarding deinstitutionalisation, the nature of the social services that are required for the people now living in the community is not entirely clear). On other key issues relevant to mental disability law, however, the CRPD is ambiguous. Based on the drafting history, Article 17’s right to integrity appears to be intended at least in part to address the use of medication under compulsion. The actual wording of Article 17 can be viewed as the result of failed negotiations; the drafting committee debated detailed wordings but did not agree upon any of them.\(^5\) The wording in the Convention therefore merely provides a right to ‘integrity’. This right does not exist per se in other international law, so there is no established canon of interpretation. The result is unsatisfactory. Freedom from enforced medication is a vital human rights issue for people with mental disabilities (particularly, but not exclusively, psychosocial disabilities), but it may well be many years before a settled view as to what this article means is reached. Further, the degree to which the article extends into matters beyond medication remains entirely unclear.

While this is a particularly clear example of interpretive ambiguity, it is by no means the only one. The right to equality before the law (Art 12) addresses issues of incapacity – issues that are of tremendous importance to people with mental disabilities – but it is not entirely clear what it requires. At times, it seems to preclude any form of decision-making on behalf of others (Art 12(2)), but at other points, it is more ambiguous (Art 12(4)). Additionally, there is the broad interpretive question of the extent to which the CRPD provides new rights (clearly sometimes yes – eg., Art 17), and how far it instead is intended to ensure the equal application of existing rights to people with disabilities (and what, precisely, that means).

The early interpretations of the CRPD establish that it has a considerable impact on the traditional centre of mental health law. The UN High Commissioner for Human Rights has stated that CRPD compliance requires the demise of compulsory detention on the basis of mental disability: mental health acts as we know them have to go.\(^6\) Similarly, criminal defences based on mental disorders – long a staple of criminal law – are viewed as inconsistent with the CRPD.\(^7\) Legal regimes that base findings of incapacity on mental


\(^7\) UNHRC Study on Enhancing Awareness of CRPD, *supra* note 3, ¶ 47.
disability must change their laws,\(^8\) if indeed capacity can be used as a legal concept at all. The Special Rapporteur on Torture has called into question the use of psychiatric medication without the consent of the patient.\(^9\) All of these would require fundamental changes in the legal provisions of virtually every country, and there is no suggestion that politicians, political and professional stakeholders, or the public are ready to countenance these changes.\(^10\)

Notwithstanding the merits of such interpretations, sufficiently developed concepts and legislative models are not in place for legal reform to reflect the new paradigm. Which legal powers should be entirely abolished and which maintained in a fashion that makes them applicable to the population as a whole rather than just to people with mental disabilities? It does seem that current laws that allow intervention to stop people with mental disabilities from injuring themselves but do not permit such intervention for people without disabilities are discriminatory; but it may be the case that we would wish to amend the law not to abolish the power but, in some circumstances, to extend it to the population as a whole. No thought has been given to what those circumstances might be, how to define them, or indeed if such a way forward is desirable at all. Similarly, while it seems obvious that many laws relating to mental capacity must change radically, there is no consensus as to what a new law would look like. Certainly, any express reference to mental disability as a prerequisite to a finding of incapacity seems in violation of the CRPD, but can a capacity-based system of law that is disability-neutral on its face be developed in such a way as not to affect people with mental disabilities disproportionately, and therefore avoid indirect discrimination? Thinking in such areas is in its infancy, and even the systems that have been developed, such as that by Bach and Kerzner,\(^11\) have not been subjected to field trials; we do not know what will happen if we implement them.

Indeed, the reports noted above contain their own difficulties in this regard. The UN High Commissioner makes a point of noting that the abolition of conventional mental health law should not be taken to preclude the possibility that people would be preventively detained; merely that it should not be done on the basis of disability. This is a surprising comment. Can it really be the High Commissioner’s view that a statute allowing detention of people based on, for example, perceived dangerousness would be consistent with human rights? The difficulty of prediction in this area makes this a startling view; indeed, it is these difficulties of prediction that have made dangerousness a controversial detention criterion in mental health law for many years. For such a system to be credible for the general population, it would at the very least require immense forensic research and public debate.

This serves as a reminder that disability law does not exist in its own bubble. Changes to disability law raise issues in other legal contexts, including other human rights contexts. It is all very well to say that the insanity defence is discriminatory, for example, but criminal conviction of people who lack ‘responsibility’ is not merely a question of disability law but also of criminal theory more generally. Certainly, domestic law must comply with the CRPD,

\(^8\) Id. ¶ 45; Special Rapporteur on Torture, Report on Feb. 1, 2013, supra note 3, ¶¶ 65-66.

\(^9\) Special Rapporteur on Torture, Report on Feb. 1, 2013, supra note 3, ¶ 64.


but the result must also make sense in the context of the theory of criminal law. If it is expected that the new structures will not merely be neutral on their face but also will lack a discriminatory effect based on disability, that is likely to be a fiercely complex undertaking.

At the same time, the human rights violations to which people with mental disabilities are subject are legion: enforced treatment with powerful drugs, detention based on prospective dangerousness to self or others or ‘in their own interests’, and removal of decision-making authority through the use of guardianship legislation are three of the most obvious examples. Even with reference to the pre-CRPD paradigms, these often occur with inadequate legal oversight to ensure compliance with existing domestic law, which is itself often inadequate. These examples are before one even begins to consider social and economic rights such as rights to adequate healthcare, to employment, to social inclusion, and to proper community housing. All these issues are pressing and must be addressed as a matter of urgency. They cannot wait while the larger legal debates occur as to how to re-structure society in a non-discriminatory way despite how important those debates may be.

Implementation Possibilities

1. Preparing the Ground for Reform

The disability communities and others in the human rights community were first to interpret the CRPD, and a variety of strong interpretations have, therefore, entered the mainstream legal discourse. The reports of the UN High Commissioner for Human Rights and the Special Rapporteur on Torture noted above are particularly clear examples of these and have been particularly helpful in establishing an agenda for change.

Divergent interpretations, however, are now beginning to appear. Some place the CRPD in the context of the international law that came before, and are thus more conservative in their approach. Others are based on restrictive readings of the wording of the Convention itself. Some medical professionals, for example, view psychosocial disabilities as ‘illnesses’ rather than disabilities, and their viewpoints are, therefore, outside the scope of the Convention. This reading effectively slips through the back door the medical model of disability back into the discourse. Others take the view that the definition of disability in the CRPD is triggered only when social responses to impairments result in adverse impacts and, therefore, that the CRPD does not apply to the impairment absent the social element. If given credence, this too would significantly restrict the effect of the Convention.

Divergent interpretations were bound to arise, and we must engage with them. Sometimes, this will be by way of direct challenge to an interpretation that is not consistent with the text or is not supported by the standard canons of legal interpretation, and this is one place where official international officials and organisations, including but not limited to the Special Rapporteur on Torture, should use their influence to ensure that interpretations are supported by the Convention itself. It must however be acknowledged that the early articulations do not have a monopoly on the interpretation of the Convention: we are at a stage where we must accept the wording of the CRPD as it is and not as we wish it had been. Similarly, no individual or organisation has a monopoly on interpretation of the Convention apart from the CRPD Committee. New interpretations open up new meanings. Some of those will be viewed by human rights and disability activists as helpful and some not, but that is the nature of international human rights law.
Engagement with key stakeholders will be essential in any event. For the CRPD to have effect, the body politic as a whole, including all stakeholder groups, need to own it. Insofar as it is possible, there needs to be one integrated conversation regarding CRPD implementation, not a multitude of discussions in isolation from each other. Just talking to our friends is not sufficient. Certainly, service users and service user organisations must be central throughout the conversation, both because that is right and because it is required by the CRPD itself; but if change is going to be effective, it is necessary to both talk and listen to the diversity of stakeholders and the broader body politic.

2. Developing Reform Possibilities

As noted, the process of reforming domestic law has barely begun. Some work has been done on possible developments relating to legal capacity and Article 12, but it is still at a relatively early stage. Little if any work appears to have been done on other key issues relating to mental disability law, such as reform of criminal law and of mental health law. These involve major re-organisations of existing legal structures, and appropriate reforms will arise only after considerable effort. It is appropriate that the CRPD Committee recognise this. While it is realistic to expect that implementation of this sort of major reform may take considerable time, it is reasonable for the Committee to insist on evidence that the process is taking place. Absent such a process, reform never occurs.

While this is the case for legal reform, it is also the case for new policy. As noted above, countries that have moved to systems of care in the community have experienced that it takes time to get programmes right. While it is reasonable to expect some time to be taken, it is equally reasonable to insist that concrete steps be evidenced promptly and throughout the reform process that appropriate reforms are actually occurring.

Once again, this will involve discussions with stakeholders across a wide range of legal and policy fields. At the moment, it is questionable whether this is occurring. For example, for implementation of the right to community living, housing lawyers and academics must start to see the CRPD as integral to their work, and the developments in criminal law will require a similar commitment from criminal law practitioners and academics. It is not obvious that this cross-fertilisation is occurring to any significant degree, and that is a significant problem if the CRPD is to have actual effect. It would be appropriate for the CRPD Committee to require information on what national programmes are in place to drive these changes forward.

3. Developing Measures toward Full Implementation

Some elements of the CRPD will take time to implement. The rights to community living, to education, to adequate standards of living, and to social integration, for example, will take time to reach full realisation. Too often, however, ‘progressive realisation’ becomes a justification for states to do nothing. In principle, developing measures to monitor the implementation of these rights is not difficult: how many people with disabilities are in community living (and how many in institutional environments); how many in what sort of education; how many in employment; what standard of living is provided for those without employment; how many are participating in broader society more generally?

Consistent with Article 31 of the CRPD, the CRPD Committee should insist on the collection of this information. It is not their sole responsibility, however. The issues in
question overlap with the mandates of other international bodies. Those bodies should be expected to be active in pressing for implementation of the CRPD as relevant to their mandates.

This may, sometimes, involve a re-assessment of the mandates of these organisations. The United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (“SPT”), for example, has tended to view its mandate on inspections as focused on the conditions of detention. These are of tremendous importance for people with mental disabilities, as for anyone else. The provision of appropriate programmes for people with mental disabilities in prisons; the availability of appropriate physical health care for people with mental disabilities; the provision of appropriate standards of food, heat, and other necessaries; and the provision of reasonable accommodation within the meaning of Article 5 of the CRPD to people with mental (and other) disabilities really do matter. They are not, however, the only issues in these facilities. Too frequently, the life of a person with mental disabilities starts with early institutionalisation where inadequate education, care, and social integration are provided. Upon attaining adulthood, the individual is unable to be integrated into the community and is therefore moved to an institution for adults where they may remain for the rest of their life (or may, upon reaching old age, be again moved to yet another institution, this time for old people). This pattern of institutionalization is itself an example of inhuman or degrading treatment, and that violation is not dependent on the quality of the food or the other matters currently viewed as central to the mandate of the SPT and similar bodies. Bodies of this type need to understand their mandates as extending to the inappropriate institutionalisation of people with disabilities. They need to be asking questions about the provision of community alternatives to institutional care. The damaging effects of inadequate care, particularly for children, are well-known; this is not a case where there is much by way of dispute. Certainly, the development of alternative models of care takes time, but the failure of international bodies to probe into the development of those alternatives amounts to collusion in the human rights violation itself.

4. The Contextual Complexity of Reform in the Here and Now

As noted, there are situations where reform cannot wait for the grand projects envisaged by the CRPD. Sometimes this occurs in particularly serious cases involving people with disabilities – the provision of particularly intrusive forms of medical treatment without consent, for example - and sometimes it involves broader human rights reforms where the rights of persons with disabilities are significant but not the only relevant issue.

Further, reform does not occur in the abstract, but on the ground, in the context of existing environments and institutions. As with the issues of legal reform noted above, the issues that arise are not merely geographically and socially specific, but they may also raise issues in fields beyond disability. Like the legal issues discussed above, they may involve human rights situations that are pressing and immediate, where precise requirements of the CRPD may yet be unclear, and where those charged with reform may have little experience in international law of disability, and may not intuitively support its objectives. The precise direction of reform in such situations may be unclear, and even if clear, may not be politically achievable. Even if politically achievable, such reforms may not be implemented on the ground, through intransigence or hostile incomprehension of people in the system. Approach to reform in these situations is, therefore, complex. How does one provide reforms that
address the immediate needs of people with disabilities without undermining the greater reforming vision of the CRPD?

A concrete example of the difficulties can be seen in the current reform processes relating to the United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR). The SMR are a core text relating to standards of detention for individuals and are routinely referred to in much of the world. They are a floor for human rights, designed to provide basic standards of protection both in the developed world and in countries that have minimal traditions of such safeguards and minimal resources available for compliance. Conditions of detention in prisons and similar criminal facilities are of considerable importance to people with disabilities in general and to people with mental disabilities in particular: people with developmental and psychosocial disabilities are encountered frequently in prisons and similar criminal justice institutions, and may be particularly singled out for bullying or violence in those environments. Too frequently, little if any regard is paid to the needs that flow from their disabilities.

The purpose of the current discussion is not to argue for what changes are or are not appropriate to the SMR as they relate to people with disabilities; others are engaged in that exercise. Instead, the object is to articulate the sorts of tensions that arise when choosing advocacy positions in the context of an important issue that includes but also extends beyond people with disabilities.

The SMR are an instructive example for current purposes. They are an example where serious human rights violations relating to persons with mental disabilities are occurring, whether one articulates those according to pre- or post-CRPD paradigms. At the same time, the rules involve not just prisoners with disabilities but also prisoners as a whole, and the disability-related issues are, therefore, not free-standing; they must sit within the overall rules relating to prison governance.

Certainly, some changes can and should be introduced into the SMR that are entirely consistent with the CRPD. Non-discrimination, including the requirement of the provision of reasonable accommodation, consistent with Article 5 of the CRPD should be included. Those requirements of reasonable accommodation should be clearly articulated to establish that all persons with disabilities should have access to the reformatory programmes of the prison. Other amendments are consistent both with the CRPD and other pre-existing international law and practice. Thus protections regarding consent to health interventions are certainly required by Art 25 of the CRPD, but also by other international law. Given the interpretation provided by the Special Rapporteur on Torture it is at least arguable that restrictions on the use of solitary confinement and restraints (including chemical restraints)

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are now required, although other international protocols (eg., the Istanbul Protocol on the use and effects of solitary confinement) are actually clearer on the point.

Other points are more problematic. Ideally, and consistent with the CRPD’s requirements of non-discrimination and reasonable accommodation, people with mental disabilities in these environments should have specific programmes and support provided to ensure that they can benefit from the rehabilitative programmes of the prison. They would be housed in the general population where they would be accepted as part of the prison community and where appropriate supports would be in place to meet their needs and ensure their freedom from exploitation, violence, and abuse. Medical care would be available to them, based on free and informed consent, fully to meet their needs and on a basis equivalent to that available to the general public. Tailored educational programmes would be made available for them to develop fully in preparation for taking their place without discrimination in the community once their debt to society is paid.

In wealthy countries with a history of advocacy relating to mental disability, this vision has much to recommend it. These countries should be pushed hard to bring about these conditions. The reality is, however, that this grand vision is unrealistic for the vast bulk of the world. This is partly for financial reasons: the vision noted above is not inexpensive to introduce, and many countries in the world cannot afford it. It also implies a mentality about prisons that is not necessarily shared internationally. While a philosophy of rehabilitation may enjoy broad support among human rights theorists, it is less obvious that it is always supported by the public, prison administrations and staff, and politicians. These actors are more likely to view prisons as places where prisoners are subject to hierarchical controls and where their rights are removed. This ethos is difficult to integrate with the empowerment philosophy of the CRPD. It is further not obvious that all prisoners will be accepting of people with mental disabilities in their communities. If people with such disabilities are to be safe, levels of surveillance may be required which are both impractical and raise human rights concerns regarding privacy. The overall conditions that exist in many prison environments in the world are unlikely to be conducive to the health and well-being of people with mental disabilities. This is unsurprising. The attitude in many parts of the world is that prisons are meant to be punitive and, therefore almost by definition may be environments that are inappropriate for people with mental disabilities. For these and other reasons, simply imposing the CRPD vision onto the SMR without taking into account the local conditions is unlikely to have much impact on the ground. It may perhaps still be worth doing- the SMR have a symbolic value as statements of good practice, and symbols do matter- but that increased level of abstraction will affect the way the SMR are perceived by prison administrators. If they become statements of ideals perceived as unattainable and therefore ‘pie in the sky’ by local administrators, their use will be correspondingly limited in making improvements in the short term.

If advocacy for the CRPD ideal is unattainable and potentially counterproductive, what other options are available? Consistent with much international law prior to the CRPD, the SMRs as they stand tend to favour the removal of people with mental disabilities from prisons into psychiatric hospitals and similar environments. This is also problematic. Often, if the country is one where prison conditions are lacking, the conditions in psychiatric facilities may not be much good either. Further, the move to a psychiatric environment is likely to involve the removal of key legal rights. People in psychiatric facilities often lose the right to consent to all or some medical treatment, particularly when the treatment relates to their mental disorder. That is a significant loss (although it is fair to wonder whether such rights
are always respected in prison environments either). Admission to a psychiatric facility may result in stigmatisation, although once again, it is fair to wonder whether this is more or less significant that the stigmatisation that flows from imprisonment. While some programmes in the psychiatric environment may well be more suitable for people with mental disabilities, it would be wrong to assume that these are either of universally high standards internationally or indeed that they are tailored to the needs of the individual. Sometimes they will be, sometimes not.

Whether the approach is one of removal of the individual to a psychiatric environment or the provision of reasonable accommodation within the standard prison system, individualised assessment of the prisoners will be required. Who is to do this? The answer has traditionally been that prison medical officers should do this, ideally with administrative systems providing those officers with some degree of independence from prison authorities. Such officers, the theory has traditionally said, are best placed to determine the needs of individuals with mental disabilities. An idealised CRPD approach would question this. The Convention rejects the medical model of disability, and it is difficult to see how the use of prison medical officers to determine appropriate programmes for people with such disabilities will not reintroduce the medical model squarely into the prison environment. While this is certainly arguable, it does not address the question of who is meant to do the assessments to determine what reasonable accommodations are appropriate. In wealthy countries, a range of possible answers may be available, but the SMR are meant to apply to poor as well as to wealthy countries. In poor countries, options are likely to be much more limited. In such countries, prison staff such as guards are unlikely to have the requisite training and will also potentially be involved in conflicts of interest (running a ‘peaceful ward’ rather than the needs of the individual prisoner). Prison medical staff may well be the only other practical option. At least in theory, they have some independence from the governance of the prison. How real that independence is may well be a fair question, but given the choices available, it may be the best option for prisoners with disabilities in the short to mid-term. Again, the question arises whether the short-term results warrant a departure from the overarching CRPD principle.

The object here is not to advocate for one choice over another in these matters. It is rather to note that the choices taken will have advantages and disadvantages in the short and long term.

Conclusion

In a sense, the problems identified above are those faced by advocates on a daily basis: the tension between short-term and long-term goals; the difficulties in international advocacy in taking into account vastly different geographical, cultural, economic and legal contexts; and trade-offs between the ideal and the attainable in negotiations. The CRPD does introduce a different dynamic, however, because it is meant to constitute a break from previous international law at least as much as a continuation. The efficacy of the CRPD will therefore depend on its new values and norms – its new paradigm – being accepted into the daily life not only of people with disabilities but also of politicians, administrators and other stakeholders. A number of its key articles also require the development of new legal forms within a wide array of laws to bring about disability-neutral policy. All of this will take time. Notwithstanding the triumphalist language of Kofi Annan with which this article began, we are at the beginning of the journey, not the end, and the journey will not be short.
The pressure for reform will therefore need to continue for many years. This is not something we can take for granted. The CRPD is a new Convention, and as a result has been ‘flavour of the month’ since its introduction. That will not continue. New human rights issues will arise, and UN agencies and similar bodies will respond to them as they have to the CRPD. If disability rights are to continue to develop, therefore, disability advocates must be ready to fight our corner to ensure that the fundamental and ongoing developments to disability policy do not slip off international and domestic agendas.

In the course of those fundamental and often long-term reforms, we cannot lose track of the immediate needs and human rights violations that affect people with disabilities on a daily basis. Addressing those needs in the specific geographic, cultural, and legal contexts in which they arise may create tensions with some of the directions of the long-term policy reform. Strategies must be developed in individual instances to address those tensions, but ignoring immediate needs cannot be viewed as consistent with human rights advocacy.