Thy Will Be Done: Addressing the Insufficiency of the Mental Health Act in Relation to the Principle of Universal Legal Capacity Under Article 12 of the United Nations Convention on the Rights of Persons with Disabilities, to Ensure and Protect the Legal Capacity of Persons with Disabilities, in All Stages of Life

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I. INTRODUCTION

A. Background of the Study

Mental health includes every human being's emotional, psychological, and social well-being and directly affects how one thinks and acts.[1] It is pivotal in every stage of life as it helps determine how humans handle stress, relate to others, and make healthy choices.[2]

In 2020, the World Health Organization (WHO) officially assessed and declared the novel Coronavirus (COVID-19) as a pandemic.[3] The pandemic caused an alarming increase in the demand for mental health services which exacerbated the mental health conditions of people due to bereavement of the

1. Center for Disease and Control Prevention, About Mental Health, *available at* https://www.cdc.gov/mentalhealth/learn/index.htm (last accessed Apr. 30, 2023).

2. *Id.*

3. World Health Organization, WHO Director General's Opening Remarks at the Media Briefing on COVID 19, *available at* https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 (last accessed Apr. 30, 2023) [https://perma.cc/AP9U-CAZP].

loss of loved ones, forced confinement, fear, and loss of income, among others.[4] In the Philippines, mental health conditions or illnesses have been identified as the third most common form of morbidity.[5] During the pandemic alone, 3.6 million Filipinos were found to have been suffering from at least one type of mental health condition.[6] It cannot be further emphasized that mental health should be at the forefront priority during the pandemic and even the slightest neglect in this area can cause tremendous harm.

Every year, more than $12 billion per working day are lost due to mental illness globally.[7] Around $16 trillion is lost due to the detrimental effects of mental health conditions.[8] In the Philippines, mental health conditions cost the economy ₱68.9 billion ($1.37 billion) each year, equivalent to 0.4% of the Gross Domestic Product (GDP).[9] Ninety-six percent of such cost is due to loss of productivity brought about by mental health conditions.[10]

4. World Health Organization, COVID 19 Disrupting Mental Health Services in Most Countries, *available at* https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey (last accessed Apr. 30, 2023) [https://perma.cc/99HJ-6BB7].

5. John Lally, Rene M. Samaniego, & John Tully, *Mental Health Legislation in the Philippines*: *Philippine Mental Health Act*, 16 CAMB. U. PRESS 65, 65 (2019).

6. Department of Health, DOH Calls for Unified Response to Mental Health, *available at* https://doh.gov.ph/press-release/Your-Mind-Matters-DOH-Calls-for-Unified-Response-to-Mental-Health (last accessed Apr. 30, 2023).

7. Grace Ryan, et al., *Mental Health for Global Prosperity*: *We Afford to Ignore the Impact of Mental Health on the Global Economy*, *in* MENTAL HEALTH INNOVATION NETWORK, at 2 (2019).

8. *Id.*

9. World Health Organization, Investing in Mental Health Benefits People and The Economy, *available at* https://www.who.int/philippines/news/detail/22-11-2021-investing-in-mental-health-benefits-people-and-the-economy (last accessed Apr. 30, 2023) [https://perma.cc/W5LX-44GS].

10. *Id.*

Unfortunately, only 2.65% of the health budget is allotted to mental health.[11] The total number of human resources working in government mental health facilities, or those who undertake private practice per 100,000 general population, is just 3.43% of the base.[12] Further, only 0.42% are psychiatrists, 0.14 % psychologists, and 1.62% are non-medical professions who are mental health workers.[13] In effect, the ratio of a competent medical professional to handle mental health conditions is less than 1% every 100,000 people.[14] There are only 46 facilities catering to mental health conditions, and such facilities can only treat 123.3 users per 100,000 Filipinos.[15] The rate of users per 100,000 general population per facility for day treatment facilities and community based psychiatric inpatient units are 4.42 and 9.98, respectively.[16] Around 48% of all admissions to community-based inpatient psychiatric units are involuntary.[17] Based on the data alone, the resources allotted to mental health is not commensurate with the necessity and urgency it entails.

In the Philippines, persons who suffer from mental illness may be considered as Persons with Disabilities (PWD), subject to the qualifications and standards set by the law. Section 4 of Republic Act No. 7277, otherwise known as the Magna Carta For Disabled Persons, provides that "[d]isabled persons are those suffering from restriction or different abilities, as a result of a *mental*, physical[,] or sensory impairment, to perform an activity in the manner or within the range considered normal for a human being."[18]

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11. World Health Organization, Philippines: Special Initiative for Mental Health Situational Assessment, *available at* https://www.who.int/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---philippines---2020.pdf?sfvrsn=4b4ec2ee_8 (last accessed Apr. 30, 2023).

12. WORLD HEALTH ORGANIZATION IN PARTNERSHIP WITH DEPARTMENT OF HEALTH, WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN THE PHILIPPINES 17 (2007).

13. *Id.* at 18.

14. *Id.* at 16.

15. *Id.*

16. *Id.* at 5.

17. *Id.* at 10.

18. An Act Providing for the Rehabilitation, Self-Development and Self-Reliance of Disabled Persons and Their Integration into the Mainstream of Society and for

To safeguard the rights of PWDs, the Philippines ratified, on 15 April 2008, the United Nations (UN) Convention on the Rights of Persons with Disabilities (UNCRPD), which entered into force on 3 May 2008.[19] This is in pursuit of the State's legal obligation to uphold and protect health, which necessarily includes mental health, in relation to the rights of persons with disabilities.[20] The purpose of the UNCRPD is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[21] The UNCRPD acknowledges persons experiencing mental illness as PWDs. The Philippines ratified the UNCRPD so it has become legally binding upon the State,[22] having the force and effect of a domestic law.[23]

Article 12 of the UNCRPD provides that PWDs are entitled to "*equal recognition before the law*."[24] Equal recognition before the law is vital to human rights[25] because "it articulates the right of every person to be a holder of rights and obligations under the law, which is a necessary precondition for the exercise of all other human rights and fundamental freedoms."[26]

Other Purposes [Magna Carta for Disabled Persons], Republic Act No. 7277, § 4 (1992) (emphasis supplied).

19. Convention on the Rights of Persons with Disabilities, *available at* https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-Disabilities.html (last accessed Apr. 30, 2023).

20. PHIL. CONST. art. XIII, §§ 11-13.

21. Convention on the Rights of Persons with Disabilities art. 1, *opened for signature* Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter UNCRPD].

22. *See generally* Land Bank of the Phils. v. Atlanta Industries, Inc., G.R. No. 193796, 729 SCRA 12 (2014).

23. Republic v. Sandiganbayan, G.R. No. 104768, 407 SCRA 10, 137 (2003).

24. UNCRPD, *supra* note 21, art. 12 (emphasis supplied).

25. Report of the Special Rapporteur on the Rights of Persons with Disabilities, Human Rights Council, ¶ 13, U.N. Doc. A/HRC/37/56 (Dec. 12, 2017) (by Catalina Devandas Aguilar) [hereinafter Report on PWD Rights].

26. *Id.*

Fundamentally, equal recognition before the laws is intertwined with legal capacity.[27]

Equal recognition entails that a human being must be recognized in the legal order as someone who possesses legal personality and protected by the law.[28] Legal capacity guarantees that such person is a holder of rights and duties (legal standing) and has the power to exercise such rights and duties (legal agency).[29] The right to equal recognition under the laws shows that there is a human being, who is considered a person under the law, entitled to legal capacity on equal basis with everyone else regardless of any disability.[30] If legal capacity is denied, the person's status under the law is likewise denied.[31]

Unfortunately, a person's legal capacity is restricted mainly due to having mental health conditions, because such person's decisions are usually perceived as poor, unsound, or unwise.[32] The result of this mental capacity assessment becomes one of the most common grounds for the restriction of legal capacity.[33] Thus, General Comment No. 1 explains that the assessment of mental capacity should *not* be conflated with universal legal capacity.[34] By practice, the effect of this conflation would be to place such person experiencing mental illness under a *substitute decision-making regime* such as guardianship or conservatorship.[35]

Under these circumstances, persons who suffer from mental illnesses under a substitute decision-making regime would "lose their capacity to exercise all or almost all of their rights and have no control over decisions related to their lives, from entering into contracts to choosing where and with

27. Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014)*, ¶ 11, U.N. Doc. CRPD/C/GC/1 (May 19, 2014) [hereinafter *General Comment No. 1*]

28. *Id.*

29. *Id.* ¶ 13.

30. *Id.*

31. *Id.* ¶ 15.

32. *Id.*

33. Report on PWD Rights, *supra* note 25, ¶ 15.

34. *General Comment No.* 1, *supra* note 27, ¶ 13.

35. Report on PWD Rights, *supra* note 25, ¶ 15 (emphasis supplied).

whom to live."[36] Generally, a substitute decision-maker is a person who makes medical treatment decisions, among other forms of decisions, for a person who has lost his or her decision-making capacity even against such person's wills and preferences.[37] The substitute decision-maker decides on behalf of the person experiencing mental illness. *The UNCRPD denounces and seeks to avoid this regime, even if it has been practiced for a long time.* Thus, General Comment No. 1 provides that a person's disability, even during periods of impairment, must never be a ground for denying legal capacity or any of the rights provided under Article 12.[38] All forms of practices which would violate any of the provisions under Article 12 must be abolished to ensure full legal capacity to persons with disabilities on equal basis with others.[39]

On 21 June 2018, President Rodrigo Duterte signed the landmark legislation, Republic Act No. 11036, otherwise known as the Mental Health Act (MHA).[40] While the MHA is praiseworthy, as it adopts the supported decision-making regime as mandated by the UNCRPD,[41] Section 10[42] and Section 13[43] of the law provide for the application of substitute decision-making and measures akin to involuntary treatment of service users on the basis of a representative's decision during certain instances. This is a restriction

36. *Id.* ¶ 16.

37. End of Life Directions for Aged Care, Factsheet: Substitute Decision-Making, *available at* https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet (last accessed Apr. 30, 2023) [https://perma.cc/2AQK-6ZHZ].

38. *General Comment No. 1*, *supra* note 27, ¶ 42.

39. *Id.* ¶ 42.

40. An Act Establishing a National Mental Health Policy for the Purpose of Enhancing the Delivery of Integrated Mental Health Services, Promoting and Protecting the Rights of Persons Utilizing Psychosocial Health Services, Appropriating Funds Therefor and Other Purposes, [The Mental Health Act], Republic Act No. 11036 (2018).

41. The Mental Health Act, § 11.

42. *Id.* § 10.

43. *Id.* § 13.

to a person's legal capacity which circumvents the mandate of the UNCRPD to uphold universal legal capacity in all stages of life.

To reiterate, the UNCRPD denounces restriction on the universal legal capacity of a person. While the MHA acknowledges this mandate, it still provides for exceptions that might render the purpose of the UNCRPD and the MHA, itself, futile. In effect, this would place the rights of 3.6 million Filipinos, who suffer from mental health conditions, at risk of being violated and abused. Violation of the universal legal capacity is not the only issue as they would also be subject to haphazard health care met with severe lack of support and resources that is vulnerable to neglect. This also constitutes another violation of the right to the highest attainable standard of health. Thus, this Note examines the adequacy of the protection afforded by the MHA in relation to its duty to uphold the universal legal capacity of persons with disabilities under the UNCRPD.

B. Significance and Objective of the Study

While the innovations of the MHA contribute to the protection of mental health, certain provisions of the law are in the danger of restricting the universal legal capacity of persons with disabilities, which is violative of the UNCRPD provision on the equal recognition before the law.

By thoroughly evaluating different resources and materials and comparatively analyze the treaties vis-à-vis the domestic laws, this Note aims to address the gaps or conflicts in the MHA. *As mental health is an important aspect of one's personhood, Filipinos, who experience mental health disorders, should always be afforded the best possible aid in order for them to fully exercise their universal legal capacity, regardless of any impairment. This is a fundamental human right that transcends even the boundaries of law and is indispensable for a truly free, progressive, and prosperous society.*

II. MENTAL HEALTH RIGHTS UNDER THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

A. Mental Health in Relation to Persons with Disabilities

Mental illnesses are defined as "health conditions involving changes in emotion, thinking, or behavior (or a combination of these)"[44] which are associated with "distress and/or problems functioning in social, work[,] or family activities."[45] Mental illnesses may result in mental disability which is defined by the Implementing Rules and Regulations (IRR) of the Magna Carta for Disabled Persons as a "disability resulting from organic brain syndromes (example: mental retardation, acquired lesions of the central nervous system, dementia) and mental illnesses (psychotic and non-psychotic disorders)."[46] Disability means "(1) a physical or mental impairment that substantially limits one or more psychological, physiological[,] or anatomical function of an individual or activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment."[47]

People with mental illnesses may suffer from mental disability and such person may be considered as PWDs. PWDs are defined as those "suffering from restriction or different abilities, as a result of a mental, physical or sensory impairment, to perform an activity in the manner or within the range considered normal for a human being."[48] Mental health is inevitably linked to mental disability and when a person suffers from mental disability, he or she may be considered a person with disability.

B. The United Nations Convention on the Rights of Persons with Disabilities

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44. American Psychiatric Association, What is Mental Illness?, *available at* https://www.psychiatry.org/patients-families/what-is-mental-illness (last accessed Apr. 30, 2023) [https://perma.cc/797L-Z67S].

45. *Id.*

46. Department of Health, Rules and Regulations Implementing the Magna Carta for Disabled Persons, Republic Act No. 7277, rule I (1992).

47. *Id.*

48. Magna Carta For Disabled Persons, § 4 (a).

The Philippines is a State Party to the UNCRPD.[49] The UNCRPD "adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms."[50] The importance of this treaty in relation to the rights of PWDs is that the UNCRPD "clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced."[51] As the Philippines is a State Party to the UNCRPD, the Philippines is legally bound to follow the provisions of the treaty.[52]

1. Article 12 and Equal Recognition Before the Law

Equality before the law, regardless of any disability, is important to the exercise of human rights.[53] Accordingly, Article 12 of the UNCRPD provides:

> Equal recognition before the law
>
> (1) State[] Parties reaffirm that persons with disabilities have the *right to recognition everywhere* as persons before the law.
>
> (2) State[] Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others *in all aspects of life*.
>
> (3) State[] Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
>
> (4) State[] Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, *will and preferences of the person*, *are free of conflict of interest and undue influence*, *are proportional and tailored to the person's circumstances*, *apply for the shortest time possible*[,] *and are subject to regular review* by a competent, independent[,] and impartial authority or judicial body. The safeguards shall be

49. Mental Health Act, § 2, para. 3.

50. *Id.*

51. *Id.*

52. Bayan Muna v. Romulo, 656 Phil. 246, 270 (2011).

53. UNCRPD, *supra* note 21, art. 12.

> proportional to the degree to which such measures affect the person's rights and interests.
>
> (5) Subject to the provisions of this article, State[] Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.[54]

Traditionally, PWDs have been denied rights which Article 12 seeks to address by identifying the elements that State Parties must follow to ensure that PWDs are treated equally under the law. *PWDs have been denied equal recognition before the law because of the restriction of their legal capacity, manifested through the implementation of substitute decision-making regimes.*[55] Substitute decision-making regimes are systematized in many forms such as guardianship, conservatorship, and mental health laws that allow forced and non-consensual treatment, etc.[56]

The core of Article 12 and equal recognition before the law lies in the understanding that "legal capacity is a universal attribute inherent in all persons by virtue of their humanity and must be upheld for persons with disabilities on an equal basis with others."[57] The denial of legal capacity to PWDs effectively violates equal recognition before the law.[58]

2. Universal Legal Capacity

i. Interpreting the Provisions of Article 12.

General Comment No. 1, by the Committee on the Rights of Persons with Disabilities (Committee), explains the significance of each provision of Article 12. General comments seek to "interpret and clarify substantive provisions, not only with regard to the reporting duties of State Parties[,] but also when it

54. *Id.* (emphases supplied).

55. *See General Comment No. 1*, *supra* note 27, ¶ 14.

56. *See generally id.*

57. *Id.* ¶ 8.

58. *Id.* ¶ 15.

comes to providing guidance and suggesting approaches to the implementation of the treaty provisions or thematic issues in question."[59]

Paragraph 1 emphasizes that PWDs should be recognized before the law as they possess legal personality which is a prerequisite to the recognition of a person's legal capacity.[60] Paragraph 2 states that PWDs enjoy legal capacity on equal basis in life as the person is both a holder of rights and an actor under the law.[61] Being a holder of rights "entitles a person to full protection of his or her rights by the legal system,"[62] while being an actor under the law, "recognizes that person as an agent with the power to engage in transactions and create, modify[,] or end legal relationships."[63] Having both of these elements combined gives a person the power to transact and create or terminate legal relationships.[64]

Neither intellectual nor mental impairment should affect the legal capacity of a PWD.[65] There should be no restriction nor deprivation of legal capacity based on any impairment. Not even partial restriction or exception is allowed because Article 12.2 is explicit in stating that legal capacity must be recognized "in all aspects of life."[66] Any legal provision which derogates from such absolute rule vis-à-vis the legal capacity of a PWD is considered a violation.[67] Further, legal capacity necessarily includes legal agency which mainly involves the right to decide for oneself.[68] No reason can impair or deny a PWD the right to decide for oneself.[69] *Accordingly, a substitute decision-making regime denies a person's right to make decisions for oneself because of the fact that decision-making powers are*

59. *Id.*

60. *Id.* ¶ 11.

61. *General Comment No. 1*, *supra* note 27, ¶ 11.

62. *Id.* ¶ 13.

63. *Id.*

64. *Id.*

65. Antonio Martinez-Pujalte, *Legal Capacity and Supported Decision-Making: Lessons from Some Recent Legal Reforms*, 8 LAWS 1, 3 (2019).

66. UNCRPD, *supra* note 21, art. 12.2.

67. Special Rapporteur, *supra* note 25, ¶ 51.

68. *General Comment No. 1*, *supra* note 27, ¶ 13.

69. *Id.*

transferred to another, however appointed.[70] The logic rests on the idea that PWDs enjoy equal recognition under the law which also means that they have equal legal capacity as that of persons without disabilities.[71]

Paragraph 3 highlights the obligations of each State to ensure that the PWDs are given access to support.[72] State Parties must be able to provide PWDs with the necessary support in order to make their decisions have legal effect.[73] Under international law, legal capacity is a civil right which must be immediately effected.[74] *The type of support envisioned under paragraph 3 is to promote and uphold, and not to replace the wills and preferences of PWDs*.[75] The UNCRPD seeks to promote the shift from the best interest model, a system of treatment determined by the patient's clinical needs,[76] to the wills and preferences model, which respects the rights of the PWD and uphold his/her autonomy.[77] The wills and preferences model is best represented by the supported decision-making system and the range of support can vary from universal designs to non-conventional methods.[78]

Paragraph 4 provides for the safeguards in the supported decision-making regime found under Paragraph 3 in order to ensure equal legal capacity.[79] It seeks to set aside "aspects of the safeguards provision that do not fit well with an inclusive system of legal capacity that replaces all forms of substitute decision-making with support that respects individual autonomy."[80] The safeguards are an element of support without which results to a violation of

70. Special Rapporteur, *supra* note 25, ¶ 15 (emphasis supplied).

71. *Id*.

72. *General Comment No. 1*, *supra* note 27, ¶ 16.

73. *Id*.

74. *Id*. ¶ 30.

75. *See id*. ¶ 17.

76. Helen J. Taylor, *What Are 'Best Interests?' A Critical Evaluation of 'Best Interests' Decision-Making in Clinical Practice*, 24 MED. L. REV. 176, 179 (2016).

77. *General Comment No. 1*, *supra* note 27, ¶ 17.

78. *Id*.

79. *Id*. ¶ 20.

80. Martinez-Pujalte, *supra* note 65, at 4 (2019).

Article 12.[81] Hence, every support measure or system must include safeguards.[82]

Lastly, Paragraph 5 provides that State Parties are to take legislative, judicial, administrative, and other practical measures in order to ensure the rights of PWDs in terms of financial and economic affairs.[83] Traditionally, PWDs have been treated less favorably by the laws in this area hence the protection by the provision.[84]

State Parties are tasked to legislate or amend their domestic laws in consonance with the directives found under Article 12. Conformably, State Parties must recognize the "the full capacity of people with disabilities to exercise their rights (legal agency) [and] no restriction of legal capacity for any reason linked to disability is allowed by Article 12."[85] *Second, the domestic laws of the State Parties must be amended in order to "replace substitute decision-making systems by support mechanisms which help persons with disabilities who need it to exercise their legal capacity, always based on respect for their will and preferences and aimed at facilitating the process of taking and expressing their decisions*."[86] These support systems must be broad and flexible enough to accommodate the needs of the PWDs on a case to case basis.[87] *Lastly, domestic laws must be able to "provide for appropriate safeguards to ensure that support mechanisms effectively respect the rights, will*[,] *and preferences of the person supported and to prevent any abuse; one of these safeguards being its regular review by a competent judicial body*."[88]

81. *General Comment No. 1*, *supra* note 27, ¶ 20.

82. *Id.*

83 *Id.*

84. Clíona de Bhailís & Eilionóir Flynn, *Recognising Legal Capacity: Commentary and Analysis of Article 12 CRPD*, 13 INT'L. J. L. CONTEXT 6, 16 (2017).

85. Martinez-Pujalte, *supra* note 65, at 6.

86. *Id.* (emphasis supplied).

87. *General Comment No. 1*, *supra* note 27, ¶ 50.

88. Martinez-Pujalte, *supra* note 65, at 6 (emphasis supplied).

ii. The Difference Between Legal Capacity and Mental Capacity

The legal capacity of a person is frequently restricted because it is commonly misunderstood that legal capacity and mental capacity are the same.[89] As established, the universal legal capacity of a person must always be upheld.

Legal capacity is inherent in the principle of equal recognition before the laws, which makes it inherent in all people.[90] It is defined as the "right to be recognized as a person before the law and therefore to have one's decisions legally recognized."[91] Legal capacity encompasses both legal standing and legal agency. Legal standing is where a person is a holder of rights and recognizes as a person before the law.[92] Meanwhile, legal agency is where a person is an actor in law.[93] Some examples of legal standing include being able to have a birth certificate, passport, registering to be a voter, etc.[94] On the other hand, legal agency is the aspect of legal capacity that is frequently denied or violated in relation to PWDs.[95] For example, a PWD may have legal standing as they are allowed by law to own property.[96] Their legal agency, however, may be diminished as their decision to buy or sell or perform acts of ownership on a particular property may be restricted on the basis of their disability.[97] *Under Article 12, legal capacity is inherent in all people without any qualification by virtue of*

89. *General Comment No. 1*, *supra* note 27, ¶ 14.

90. Martinez-Pujalte, *supra* note 65, at 6.

91. Eilionóir Flynn & Anna Arstein-Kerslake, *The Support Model of Capacity: Fact, Fiction or Fantasy?*, 32 BERKELEY J. INT'L. L. 124, 129 (2014).

92. *General Comment No. 1*, *supra* note 27, ¶ 14.

93. Bernadette Mcsherry, *Legal Capacity Under the Convention on the Rights of Persons with Disabilities*, 20 J. L. MED. 22, 25 (2012).

94. *General Comment No. 1*, *supra* note 27, ¶ 14.

95. *Id.* ¶ 7.

96. *Id.* ¶ 14.

97. *Id.*

being human.[98] These two aspects cannot be separated without violating the essence of legal capacity.[99]

Mental capacity, meanwhile, refers to "a combination of cognitive ability, impairment[,] and a person's extent of understanding of the consequences of their actions."[100] Frequently, mental capacity is used by many states to assess and deny legal capacity.[101] Mental capacity tests are often implemented in order to determine whether a person's decision is legally binding.[102] Some examples of actions, based on mental capacity, include medical treatment, acts of ownership over assets, and decisions about where and with whom to live.[103]

Although every individual has varying decision-making ability because of disabilities, this should not bear any impact to an individual's right to legal capacity.[104] Rightfully, this is what equal recognition before the law and universal legal capacity signify. The UNCRPD expressly states that discriminatory tactics or any form of diminishment of mental capacity is not a valid reason to deny a person of his or her legal capacity.[105] Regardless of decision-making ability or disability, every person has an inherent right to universal legal capacity and equal recognition before the law.[106]

Substitute decision-making regimes mainly rely on assessments based on the mental capacity of a person.[107] A person who may be suffering from a disability is compelled to undergo a test that would determine his or her mental capacity. If the mental capacity is found to be diminished, then his or her legal capacity may be restricted and a third-party may be appointed on

98. *See id*. ¶ 8.

99. *Id*.

100. Bhailís & Flynn, *supra* note 84, at 10.

101. *Id*.

102. *Id*.

103. Mental Capacity Act 2005, c.3, § 3 (U.K.).

104. *General Comment No. 1*, *supra* note 27, ¶ 29.

105. UNCRPD, *supra* note 21, art. 12.

106. *General Comment No. 1*, *supra* note 27, ¶ 14.

107. Eilionóir Flynn & Anna Arstein-Kerslake, *Legislating Personhood: Realising the Right to Support in Exercising Legal*, 10 INT'L. J. L. CONTEXT 81, 84 (2014).

behalf of such person who will then make legal decisions as if it were the person with the mental illness deciding.[108] The legal right to make a decision from an individual is removed and is vested in a third party who usually decides based on the "best interests" of the person.[109]

Article 12 of the UNCRPD, therefore, seeks to change this practice.[110] *The different forms of decision, ways of making decisions, and the different levels of cognitive ability should not be used in order to assess and subsequently restrict a person's legal capacity.*[111]

iii. The Best Interest Paradigm vs the Wills and Preferences Paradigm

Central to protecting the universal legal capacity is upholding one's individual autonomy and freedom to make choices, and have such choices be legally respected.[112] This is inherent in the person's right to the highest attainable standard of health.[113] Right to freedom and entitlements are generally accepted principles in healthcare which upholds the principle of autonomy[114]

108. *Id.* at 86.

109. Agnieszka Jaworska, Advance Directives and Substitute Decision-Making, *available at* https://plato.stanford.edu/entries/advance-directives (last accessed Apr. 30, 2023) [https://perma.cc/LE5M-Y2NV].

110. *See* Eilionóir Flynn & Anna Arstein-Kerslake, *The General Comment in Article 12 of the Rights of Persons with Disabilities: A Roadmap for Equality Before the Law*, 20 INT'L. J. HUM. RTS. 471, 480 (2016).

111. *See* Tina Minkowitz, Norms and Implementation of Article 12 CRPD, *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2037452 (last accessed Apr. 30, 2023) [https://perma.cc/S36G-FJMY].

112. *Id.* ¶ 33.

113. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, ¶ 21, 64th Session of the General Assembly, U.N. Doc. A/64/272 (Aug. 10, 2009) (by Anand Grover).

114. Taylor, *supra* note 76, at 176 (citing Richard Huxtable, *Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law*, 22 MED. L. REV. 459 (2014)).

and the right of the patient to self-determination or choice.[115] Non-consensual medical treatment is unlawful[116] no matter how unwise or unsound the patient's decision may appear.[117] Accordingly, the UNCRPD expressly states that the determination of the "wills and preferences" of an individual is pivotal and must replace the "best interest" paradigm.[118]

General Comment No. 1 mentioned the term *best interests* as that which refers to the "objective" best interests of a person. Under the United Kingdom's Mental Capacity Act of 2005, which is frequently cited by legal journalists, the term "best interests" can be defined as the patient's clinical needs,[119] or it can take into account the "subjective evaluation of the patient's wider social and welfare preferences, separately and subsequent to the doctor's determination of clinical interests."[120] *The best interest paradigm is best associated with the substitute decision-making regime.* Though having a substitute decision-maker does not necessarily result to such person deciding on the patient's best interest, it nevertheless gives rights to the decision maker to be able to decide based on the person's "objective" best interest contrary to the person's wills and preferences. Further, doctors are likely to continue making decisions "based on an evaluation of best clinical interests in the absence of more definitive and accessible guidance in applying the best interests standard"[121] when implementing this type of regime.[122] Some examples of decisions by substitute decision makers, on the basis of the objective best interest of the patient, include "force feeding to sustain the life of a patient with anorexia"[123]

115. Taylor, *supra* note 76, at 176 (citing TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (2013)).

116. Taylor, *supra* note 76, at 177 (citing ISAIAH BERLIN, LIBERTY 166–217 (Henry Hardy ed. 1969)).

117. *Id.*

118. *General Comment No. 1*, *supra* note 27, ¶ 21.

119. Taylor, *supra* note 76, at 205.

120. *Id.* at 181 (citing Bolam v. Friern Hospital Management Committee, 2 All ER 118 (1957)).

121. *Id.*

122. *Id.* at 205.

123. *Id.* at 182 (citing Re E (Medical Treatment: Anorexia), EWCOP 1639 (COP) (2012)).

and "removing a young woman from her home in order to perform a therapeutic sterili[z]ation operation on her against her will."[124] *While these actions may be considered as the patient's best interest, they are not completely removed from the idea that they may be contrary to the patient's wills and preferences*. What happens therefore is that "the rights and interests of cognitively impaired individuals may continue to be compromised, with 'best interests' conflated with the clinician's evaluation of "best medical interests."[125]

For this reason, the Committee actively calls for the abolition of substitute decision-making regime and the shift from the best interests principle to the wills and preferences principle. The wills and preferences paradigm is to be understood "in the context of decision-making supports required under Article 12 (3) of the UNCRPD and the supported decision-making regime which General Comment 1 outlines."[126]

Under the wills and preferences paradigm, the person can express his/her wills and preferences through an advanced directive.[127] *Absent the capacity to express the wills and preferences, the supporter must still be able to exert significant effort in order to determine the person's wills and preferences*.[128] If after such significant effort, the wills and preferences of the person are still undetermined, the supporter may resort to the "best interpretation" of the wills and preferences as a standard.[129]

In essence, the UNCRPD is explicit in espousing the wills and preferences approach as it is deemed integrated in the supported decision-making regime. The wills and preferences paradigm encompasses the person's deeply held personal beliefs, values, and the personal conception of good which, when taken collectively, become solid bases for the best interpretation of wills and

124. *Id.* at 186 (citing The Mental Health Trust & Ors v. DD & Anor, EWCOP 4 (COP) (2015)).

125. Taylor, *supra* note 76, at 205.

126. Mary Donnelly, *Best Interests in the Mental Capacity Act: Time to Say Goodbye?*, 24 MED. L. REV. 318, 321 (2016).

127. *General Comment No. 1*, *supra* note 27, ¶ 21.

128. *Id.* (emphasis supplied).

129. *Id.*

preferences.[130] It is usually in the supported decision-making regime that the legal capacity of a person is not impaired on the basis of mental incapacity because a supporter's responsibility is to ascertain the wills and preferences of the individual.[131]

iv. Highest Attainable Standard of Health and Informed Consent

Informed consent is integral to the exercise of legal capacity. Persons whose legal capacity are restricted or diminished are usually found to be unfit to make sound decision, thereby placing them under a substitute decision-making regime or system, such as guardianship.[132] Upholding the right to health means upholding freedom and entitlements which include freedom from non-consensual treatment.[133] The UNCRPD is express in its pronouncement that the legal capacity of a person must always be upheld even during crisis situations.[134] This principle is also upheld to be consistent with the pursuit to highest attainable standard of health. For example, *a health-care provider may resort only to a life-saving emergency procedure, only in the absence of a clear prior or immediate indication of refusal of the patient, and the next-of-kin cannot consent on behalf of the patient but ought to be consulted for relevant, albeit non-binding, information that may illuminate the preferences of the patient.*[135] This is a good showing that the UNCRPD advocates against substitute decision-making and in favor of the wills and preferences model.[136]

The framework of the highest attainable standard of physical and mental health includes "participation in all health-related decision-making is critical

130. Paul Skowron, *Giving Substance to 'The Best Interpretation of Will and Preferences'*, 62 INT'L J.L. & PSYCHIATRY 125, 132 (2019).

131. *Id.*

132. *Id.* ¶ 17.

133. Committee on Economic, Social, and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, ¶ 8, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

134. *General Comment No. 1*, *supra* note 27, ¶ 42.

135. U.N. Secretary-General, *supra* note 113, ¶ 29 (citing Moore v. Webb, 345 S.W.2d 239 (1961) & *Re T* 4 All ER 649 (1992)).

136. *Id.* ¶ 27.

at the community, national[,] and international levels."[137] This is consistent with the idea that informed consent must incorporate a rights-based approach.[138] Thus, the decision-making of a person must always be upheld notwithstanding communication barriers.[139]

III. MENTAL HEALTH RIGHTS UNDER THE MENTAL HEALTH ACT

A. The Mental Health Act and the UNCRPD

The Philippines expressly bound itself to comply with the UNCRPD through Section 2 of the MHA.[140] Such act has legislative imprimatur which effectively transformed the provisions of the UNCRPD into domestic law.[141] Thus, the UNCRPD provisions are legally binding.

B. The Mental Health Act

1. Advance Directive

State Parties to the UNCRPD have gradually reformed their laws in order to implement the supported decision-making regime as obliged by the Committee, the Philippines included.[142] Some examples of supported decision-making regimes include "formal and informal networks, support agreements, independent advocates, peer support, advance directives[,] and personal assistance."[143]

Advance directives allows "individuals to express their will and preferences beforehand, so they can be followed at a time when they may not be in a position to communicate them."[144] The advance directive must contain the potential decisions of the PWD, and such PWD must have the right to decide when the

137. *Id.* ¶ 22.

138. *Id.* ¶ 26.

139. *Id.* ¶ 29.

140. The Mental Health Act, § 2.

141. *See* Wilson v. Ermita, G.R. No. 189220, 813 SCRA 103, 121 (2016).

142. Report on PWD Rights, *supra* note 25, ¶ 44.

143. *Id.*

144. *Id.* ¶ 44 (emphasis supplied).

advance directive enters into force and ceases to have effect.[145] In most State Parties, however, advance directives can be overruled and can only take effect when the person concerned is already legally incapacitated.[146] Thus, it has been suggested that the advance directive should not only take effect on the basis of the assessment of mental capacity.[147]

Based on the provision in the MHA, the service user is given the right to express his or her wills and preferences through an advance directive.[148]

The advance directive, however, is only limited to what kind of treatment may be administered to the patient. Neither the MHA nor its corresponding IRR provides for other information that may be included, such as when the advance directive may take effect or cease, or directives other than those related to treatment like the power of property administration or disposition and other legal actions.

2. Supporters and Legal Representatives

Aside from advance directives, the UNCRPD advocates for the establishment of a system where the person is given the right to choose support persons broad enough to encompass "informal and formal support arrangements, of varying types and intensity."[149]

Under the MHA, a service user may designate up to three supporters which includes the legal representative of the service user for purposes of the supported decision-making regime.[150] *This implies that the supporter is different from the legal representative.* Interestingly, the inclusion of the legal representative as one of the supporters is also expressly stated. The supporter's functions are limited to having "access [to] the service user's medical information; consult with the service user vis-à-vis any proposed treatment or therapy; and be present during a service user's appointments and consultations with mental health professionals, workers, and other service providers during the course of

145. *Id.* (citing *General Comment No. 1*, *supra* note 27, ¶ 17.).

146. Report on PWD Rights, *supra* note 25, ¶ 44.

147. *Id.*

148. *See* The Mental Health Act, § 9.

149. *Id.* ¶ 17.

150. *Id.* § 11.

treatment or therapy."[151] There are no other provisions which expressly enumerate the functions of a supporter.

Another crucial factor to the understanding as to whether the MHA is compliant with the UNCRPD is understanding the definition and responsibilities of a legal representative who is necessarily a supporter.[152]

Under Section 4, the legal representative is defined as someone who can act on behalf of the service user.[153] *Where the legal representative is necessarily a supporter, it may be assumed that the wording 'acting on behalf' of the patient may be tantamount to substitute decision-making. This contention is further proven by Section 10 (a) (2) which expressly states that a legal representative can act as a substitute decision-maker, even temporarily.*[154] Section 10 (a) (1) may further prove that a legal representative is endowed with substitute decision-making powers as he or she may "represent the interests" of the person concerned.[155] Again, the UNCRPD obliges State Parties to shift from the best interest paradigm, which is generally linked to substitute decision-making regimes, to the wills, and preferences paradigm.[156]

3. Supported Decision-Making

Section 4 (v) of the MHA defines supported decision-making.[157]

Based on its definition, however, supported decision-making is only implemented if the service user is not affected by impairment or temporary loss of decision-making capacity.[158] This implies that the mental capacity of a person may need to be assessed first and if such person is not found to be impaired or does not have any loss of decision-making capacity; only then can supported decision-making be implemented. *This presents a peculiar scenario*

151. *Id.*

152. *Id.* §§ 4 (i) & 10.

153. *Id.* § 4.

154. The Mental Health Act, § 10 (a) (2) (emphasis supplied).

155. *Id.* § 10 (a) (1).

156. Flynn & Arstein-Kerslake, *supra* note 110, at 84.

157. The Mental Health Act, § 4 (v).

158. *See id.*

because the very purpose as to why supported decision-making should replace substitute decision-making is precisely to preserve or retain a person's legal capacity when such person experiences impairment or is incapable of making decisions. Supported decision-making is encouraged by the UNCRPD to help and assist persons with mental illness decide regardless of the impairment or incapacity as they are presumed to always possess universal legal capacity.[159]

Lastly, what is noticeably missing in the MHA and the IRR is the definition of substitute decision-making. The only instance when substitute decision-making was mentioned is under the functions of a legal representative. Not having a definition nor scope may be dangerous because the implementation of actions constituting substitute-decision-making regime may be justified as supported decision-making regime.

4. Informed Consent

Decisions regarding a person's mental or physical integrity can only be taken with the free and informed consent of the person concerned.[160] Informed consent "is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making and assigning associated duties and obligations to health-care providers."[161] As free and informed consent is fundamental to legal capacity, substitute decision-making regimes which permit third parties to provide consent for treatment, or admission for treatment on behalf of the person concerned, is considered a violation of legal capacity. Thus, State Parties are urged to meet their obligations to safeguard informed consent through legislative, political, and administrative mechanisms.

The MHA included provisions regarding the right to informed consent.[162]

It can be implied that the informed consent envisioned under the MHA is limited to giving consent to a particular treatment. While there are no definite guidelines as to how informed consent is implemented, the wording of Section 4 (h) which requires that informed consent must be communicated in "plain

159. *General Comment No. 1*, *supra* note 27, ¶ 12.

160. *Id.*

161. U.N. Secretary General, *supra* note 113, ¶ 9.

162. *See* Mental Health Act, §§ 4 (h) & 8.

language,"[163] is silent as to how communication is conveyed, whether in a conventional or non-conventional manner. The form of communication is important because there are persons who may necessitate specialized forms of communications.

5. Exceptions to Informed Consent as Involuntary Treatment

Involuntary treatment is defined as "both the act of committing a person to a hospital or health institution by an order of the court or a decision by a doctor, without the free and informed consent of the person, as well as the compulsory treatment measures that take place within the facility."[164] Under the MHA, Section 13 provides that informed consent may not be necessary anymore for the restraint or confinement of a person which may be considered as involuntary treatment.[165]

Section 13 provides for two instances when involuntary treatment can be valid: (1) psychiatric or neurologic emergencies,[166] and (2) when there is impairment or temporary loss of decision-making capacity.[167] The provision allows treatment, confinement, and restraint whether physical or chemical.[168] The provision is silent, however, as to who may perform such treatment, restraint or confinement.[169]

The provision also establishes safeguards in applying the exceptions to informed consent.[170] Under Section 13 (a), it appears that the general rule is to honor the advance directives of the person concerned.[171] It comes, however,

163. *Id.* § 4 (h).

164. Science Direct, Involuntary Treatment, *available at* https://www.sciencedirect.com/topics/medicine-and-dentistry/involuntary-treatment (last accessed Apr. 30, 2023) [https://perma.cc/8JD6-35TF].

165. The Mental Health Act, § 13.

166. *Id.*

167. *Id.*

168. *Id.*

169. *See id.*

170. *See id.*

171. *See* The Mental Health Act, § 13.

with the qualification that an immediate risk or serious harm to the person concerned or to another person can override the advance directive.

i. Psychiatric or Neurologic Emergency

The first exception provided under Section 13 is that the treatment, confinement, or restraint of a person with mental illness need not require informed consent during psychiatric or neurologic emergency.[172]

This is subject to the qualification that there must be a serious and immediate threat to the health and well-being of a service user, persons affected by a mental health condition or any other persons that would require immediate intervention.

ii. Impairment or Temporary Loss of Decision-Making Capacity

The second exception provided under Section 13 is impairment or temporary loss of decision-making capacity.[173]

While the standards set in the provision are commendable, there are two important factors that must be ensured in order to make the safeguards stronger, namely: comprehension and retention.[174] Comprehension and understanding are not synonymous.[175] The PWD concerned must be able to comprehend which consists of the ability to discuss and relay in his or her own terms the nature of his or her mental health condition, decisions, or treatment.[176] The person must also be able to retain such information[177] because it is not unusual that the person understands information at a particular time but forgets it afterwards.

IV. THE SUPPORTED DECISION-MAKING REGIME

A. The Supported Decision-Making Regime as a Concept

172. *See id.* § 13 (a).

173. *Id.* § 13.

174. Interview *with* Ronaldo Elepaño III, Medical Doctor, Consultation-Liaison Psychiatry, The Medical City, *through* Zoom (Aug. 2, 2021).

175. *Id.*

176. *Id.*

177. *Id.*

1. Definition

Substitute decision-making refers to systems by which someone is appointed to make a decision on another person's behalf based on the latter's best interests.[178] On the other hand, supported decision-making refers to systems where "an individual with cognitive challenges is the ultimate decision-maker, but is provided support from one or more persons who explain issues to the individual and, where necessary, interpret the individual's words and behavior to determine his or her preferences."[179]

Supported decision-making is a regime that helps with "obtaining information relevant to a decision, explaining issues, identifying and analyzing options, interpreting words or behavior to determine the individual's preferences, and communicating decisions once made," which can also include assistance with personal or financial decisions.[180] The supported-Decision-Making regime allows individuals to seek assistance from others in order for them to decide most conformably with their wills and preferences which strengthens their perceived sense of control.[181]

The regime can be implemented in different forms, even if the MHA and its IRR failed to expressly provide for guidelines in implementing the supported decision-making. First, it may comprise of a single supporter system, where assistance or support is extended individually, or multiple supporter system, where individuals can collaborate as a group.[182]

Second, supported decision-making can also be informal or formal.[183] An informal system would entail an individual to "receive support in obtaining, analyzing, and communicating information without any explicit agreement

178. Rachel Mattingly Phillips, *Model Language for Supported Decision-Making Statutes*, 98 WASH. U. L. REV. 615, 622 (2020).

179. *Id.*

180. Nina A. Kohn, *Article Legislating Supported Decision-Making*, 58 HARV. J. ON LEGIS. 313, 316 (2021).

181. *Id.* (citing Nina A. Kohn, *Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney*, 59 RUTGERS L. REV. 1 (2006)).

182. Kohn, *supra* note 180, at 316.

183. *General Comment No. 1*, *supra* note 27, ¶ 17.

with the person providing that support."[184] On the other hand, a formal system is "formalized by an explicit agreement between the individual and the supporter or supporters"[185] where "such agreements can create an opportunity for dialogue between the individual being supported and the supporter about the types of decisions with which support is sought, and what types of assistance and behaviors the individual being supported would find helpful."[186]

184. Kohn, *supra* note 180, at 317.

185. *Id.*

186. *General Comment No. 1*, *supra* note 27, ¶ 17.

2. The Elements of Supported Decision-Making

Article 12.4 outlines the four basic elements that a support system must have to be valid: (1) proportional, (2) tailored to the person's circumstances, (3) applied for the shortest possible time, and (4) subject to review.[187]

A support system must be *proportional*, in the sense that support systems may inevitably intrude in the private aspects of a person's life so the measure must not be more than what is necessary to not outweigh its benefits.[188] Second, the support system must be *tailored fit to a person's circumstances*, as the law acknowledges that the human being is complex and every condition must be treated on a case to case basis.[189] Third, the measure should be *applied for the shortest time possible*, which does not necessarily mean that the measure should be minimal.[190] The underlying implication is that the system must be effective enough so as to lessen the need for support in the future.[191] Lastly, the system must be *subject to periodic review*.[192]

B. The Implementation of the Supported Decision-Making Regime

1. Supported Decision-Making Regime

There are no guidelines yet on how to properly implement the supported decision-making regime.[193] The lack of specific guidelines leaves the hospitals and medical institutions the prerogative to adopt their own internal policies or standards.

Supported decision-making usually starts with an assessment, although the importance of a person's voluntariness to treatment must be emphasized. In fact, the assessment of a person's mental capacity, which is usually a precedent

187. UNCRPD, *supra* note 21, art. 12.4.

188. Pujalte, *supra* note 65, at 5.

189. *Id.*

190. Pujalte, *supra* note 65, at 5.

191. *Id.*

192. *Id.*

193. *Id.*

to being admitted, is purely voluntary.[194] Without any assessment, the mental capacity of a person cannot be assessed hence there would be no basis for hospital admission.[195]

In all stages, the priority is placed in the wills and preferences of the patient, which is determined through the help of the family or the care provider.[196] Failure to arrive in the determination of the patient's wills and preferences, notwithstanding reasonable effort, validates involuntary admission.[197]

2. Substitute Decision-Making Regime

Under the law, impairment or temporary loss of decision making capacity, and psychiatric or neurologic emergencies, can be grounds for involuntary treatment.[198] In practice, involuntary treatment automatically triggers the implementation of a substitute decision-making regime.[199] When a patient is disturbed, suffers hallucinations, or false perceptions without stimuli, which leads to the patient's inability to understand the nature of the condition and the need for confinement, the doctor will readily admit such patient even without consent.[200]

The consent is given, not by the patient, but the nearest of kin or the nearest family member.[201] The initial consent is a continuous one, which will be effective until the discharge of the patient.[202] This is subject to the 15-day reassessment under the MHA; and if there is no noticeable improvement, the patient will be subject to extended confinement.[203] It is at this point when the

194. Interview *with* Elepaño, *supra* note 174.

195. *Id.*

196. *Id.*

197. *Id.*

198. The Mental Health Act, § 13.

199. Interview *with* Elepaño, *supra* note 174.

200. Interview *with* Rico J. Caraos, Medical Doctor, Lawyer, National Center for Mental Health, *through* Zoom (Aug. 4, 2021).

201. *Id.*

202. *Id.*

203. *Id.*

patient will have to stay in the hospital alone as the relatives would have already left.[204] Any decision as regards the treatment of the patient will be carried out by the family or relatives, and if they cannot be found, or it is found that the patient has been abandoned, the patient will now be under the custody of the hospital director, the head of the facility, or a social worker under the doctrine of *parens patriae*.[205]

3. The Supported-Decision-Making Regime in Foreign States

To analyze the provisions and the possible gaps under the MHA, this section shall be dedicated to the discussion and analysis of the different supported decision-making laws of the most innovative and recent legal reforms, namely: (1) Peru, (2) United Kingdom, (3) Argentina, (4) Ireland, and (5) United States. The analysis of these foreign laws that comply with the UNCRPD shall help in the formulation of the recommendations for amendments.

i. Peru

The Peruvian Civil Code, Civil Procedure Code, and the General Act on Persons with Disabilities are laws which are considered at the forefront of compliance with the UNCRPD.[206] In fact, Article 9 of the General Act provides that "persons with disabilities have legal capacity in all aspects of life on an equal basis with others [and] the Civil Code regulates the support systems and reasonable accommodations that they require for decision-making."[207] The Peruvian Government published Legislative Decree No. 1384 on 4 September 2018, which recognizes and regulates the legal capacity of individuals with disabilities[208]

According to Article 42 of the Peruvian Civil Code, all persons with disabilities have the full capacity to exercise their rights on an equal footing

204. *Id.*

205. *Id.*

206. Pujalte, *supra* note 65, at 15.

207. *Id.*

208. Decreto Legislativo que Reconoce y Regula la Capacidad Jurídica de las Personas con Discapacidad en Igualdad de Condiciones, Decreto Legislativo No. 1384 (2018) (Peru).

with others and in all spheres of life.[209] Only those in a coma, who have not previously designated a support person, may have their capacity limited pursuant to Article 44.9.[210]

The Peruvian Civil Code establishes a very broad and flexible model of assistance for the exercise of legal capacity, with the general rule being that assistance is chosen and arranged by the individual in need.[211] A person who has achieved the age of majority, with or without a disability, can enter into a support arrangement, whether formal or informal.[212] The Code defines supports as "forms of assistance freely chosen by a person of legal age to facilitate the exercise of their rights, including support in communication, in the understanding of legal acts and their consequences, and the expression and interpretation of the will of the one who requires the support."[213] The interpretation of the will is also expressly stated in the provision by which

> the criterion of the best interpretation of the will applies, taking into account the life trajectory of the person, previous expressions of will in similar contexts, the information provided by trusted people of the assisted person, the consideration of their preferences and any other consideration relevant to the specific case.[214]

The individual who chooses to enter into a supported decision-making agreement determines the agreement's form, identity, amount, effects, and extension, as provided under Article 659-C. The supporters, however, do not have representational roles, unless, the principal expressly specifies otherwise.[215]

Court-ordered provision of support is also provided for by the code, at the request of any person in extremely exceptional circumstances. This is

209. Decreto Legislativo No. 295 [CODIGO CIVIL DE PERU], art. 42 (2018) (as amended).

210. *Id.* art. 44.9.

211. Pujalte, *supra* note 65, at 16.

212. *Id.*

213. Pujalte, *supra* note 65, at 16.

214. *Id.* at 15 (citing CODIGO CIVIL DE PERU, art. 659-B (2018) (as amended)).

215. Pujalte, *supra* note 65, at 16 (citing CODIGO CIVIL DE PERU, art. 659-B (2018) (as amended)).

exclusive to persons with disabilities, who are unable to express their will, and for persons in a coma, who have not previously designated a supporter.[216]

ii. United Kingdom

The United Kingdom's Mental Capacity Act ("MCA") of 2005 has incorporated the "best interest" provision which establishes standards akin to that of the wills and preferences paradigm.[217] In fact, the provision consists of ascertaining the person's wishes and feelings, beliefs, and values and other factors that the supporter may consider, to carry out a decision as though it is the principal making the decision.[218]

The MCA also provides for a support system which allows the principal to participate in any decision as fully as possible in conformity with the advocacy of the UNCRPD. Article 4 (4) of the MCA provides that the supporter "must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him."[219]

iii. Argentina

Argentina's Código Civil y Comercial de la Nación contains provisions on legal capacity.[220]

Article 32 provides that

> the judge may restrict the capacity for certain acts of a person[,] over [13] years of age[,] who suffers from an addiction or a permanent or prolonged mental disorder, of sufficient severity, whenever he/she considers that the exercise of the individual's full capacity may result in damage to his/her person or property.[221]

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216. *Id.*

217. *See* Mental Capacity Act 2005, 53 Eliz. 6, c.9 § 4 (U.K).

218. *Id.* § 4 (6).

219. *Id.*

220. *See* CÓDIGO PROCESAL CIVIL Y COMERCIAL DE LA NACIÓN [CÓD. PROC. CIV. Y COM.], ch. 2 (2014) (Arg.).

221. *Id.* art. 32, para. 1.

The situation that results in the restriction of capacity is possible through the concurrence of two factors. First, the individual must have an addiction or a serious mental impairment that is permanent or prolonged, and there must be a risk of harm to the individual or her property if her full capacity to act is preserved.[222] Second, the restriction of capacity is agreed upon only in connection with certain acts specified by the court so as to uphold the general rule of presumption of capacity to act contrary to those acts not specifically mentioned in the judgment.[223] In fact, Article 38 provides "that personal autonomy be harmed as little as possible,"[224] which implies that restriction must be avoided, if possible.[225]

The provision on supported decision-making is also broad as Article 43 defines it as "any measure of a judicial or extrajudicial nature that facilitates the person who needs it decision-making to manage themselves, manage their assets or enter into legal acts in general."[226] The provision also presupposes that support should not be limited as long as it is needed by the principal. This system is safeguarded by Article 40 which "orders a periodic review of capacity restrictions, which can be requested at any time *by* the party concerned and must be carried out at least within three years."[227]

Lastly, the periodic review is within the powers of the judge and failure to do so would trigger the powers of the Public Ministry to urge the judge to conduct a periodic review.[228] Because of such review, the cessation of incapacity or restrictions of capacity may be decreed, the legal acts for which the capacity is restricted may be reduced, or other modifications regarding the support measures, their scope or effects may be made.

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222. *Id.*

223. *Id.*

224. *Id.* (citing CÓD. PROC. CIV. Y COM., art. 38).

225. *Id.*

226. Pujalte, *supra* note 65, at 8 (citing CÓD. PROC. CIV. Y COM., art. 40).

227. *Id.*

228. *Id.*

iv. Ireland

Ireland enacted the Assisted Decision-Making (Capacity) Act on 30 December 2015.[229] Section 17 of the Act provides for the co-decision-making agreement where a person, the co-decision-maker jointly makes decisions with another above 18 years old with regard to the personal and/or property matters referred to in the agreement.[230]

Under the Capacity Act, the co-decision maker must necessarily be someone the principal can trust.[231] Both the co-decision-maker and the principal must give consent.[232] Legal actions must also be consented by the co-decision-makers with both signatures present if formalized in a document.[233] It is also possible, however, for someone who has made no consent to become incapable of making decisions and, in this case, legal incompetence may be declared over such person with regard to one or more decisions concerning personal or property matters.[234]

The court may declare that a person lacks capacity, unless he or she is assisted by a co-decision maker, or that he or she lacks capacity, even if assistance from a co-decision maker is available.[235] Hence, the court will set a deadline for the party to adopt a co-decision-making agreement.[236] If the deadline passes without a co-decision-making agreement being concluded, the court will appoint a decision-making representative.[237]

Section 3 of the Act requires a functional assessment to determine a person's capacity to make a decision, specifically stating that a person is considered incapable of making a decision if he or she cannot comprehend the information relevant to the decision, retain that information long enough

229. Assisted Decision Making (Capacity) Act 2015, Act No. 64 (2015) (Ir.).

230. *Id.* § 17.

231. Pujalte, *supra* note 65, at 12.

232. *Id.*

233. Assisted Decision-Making (Capacity) Act 2015, § 17.

234. Pujalte, *supra* note 65, at 13.

235. *Id.*

236. *Id.*

237. *Id.*

to make a voluntary choice, use it as part of the decision-making process, or communicate their decision.[238] Section 41 creates another safeguard which provides that if a person is subject to a decision-making representative, his or her wills and preferences must still be the priority consideration.[239]

Another innovation found under the Assisted Decision-Making (Capacity) Act of 2015 is the right to lodge an administrative complaint against an assistant decision-maker.[240] This form of safeguard is espoused by the UNCRPD.[241]

v. United States of America

The *Supported Decision-Making Law of Alaska (Alaska Statutes)*, expressly provides that a decision or request communicated by the principal, through a supported decision-making regime, shall, for all intents and purposes of the law, be recognized as the decision of the principal, giving the supporter the power to enforce such decision.[242]

On the other hand, principals who enter into supported decision-making regimes are, just like other persons, entitled to their right to privacy and confidentiality.[243]

The responsibility of the supporter to keep the information regarding the principal private should not only be seen as a statutory mandate, rather, it should be seen in keeping with the person's fundamental right to privacy. It would seem that a supporter is more than just a person appointed for a job, so to speak. In other states such as Texas, the statute expressly requires a fiduciary level of care.[244]

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238. Assisted Decision-Making (Capacity) Act 2015, § 3.

239. Pujalte, *supra* note 65, at 13.

240. Assisted Decision-Making (Capacity) Act 2015, § 15.

241. Pujalte, *supra* note 65, at 13.

242. ALASKA STAT. ANN., § 13.56.130 (West 2016) (U.S.) & Kohn, *supra* note 181, at 332.

243. ALASKA STAT. ANN., § 13.56.120 & Kohn, *supra* note 181, at 329.

244. Gabrielle Bechyne, *Supported Decision-Making Agreements in Texas*, 13 EST. PLAN. & CMTY. PROP. L. J. 311 , 319 (2020).

Under the *Supported Decision-Making Agreement Law of Texas (Texas Estates Code)*, a supporter has the duty to "(1) act in good faith; (2) act within the authority granted in [the supported decision-making agreement]; (3) act loyally and without self-interest; and (4) avoid conflicts of interest."[245] In a sense, placing such qualifications would enhance the rights of the principles given that the supporter-principal relationship would go beyond a supported decision-making system. It would create a relationship of trust and confidence.

Aside from fiduciary relationships, the Texas Estates Code includes a system of

> prohibiting imposition of guardianship[,] unless alternatives to guardianship that would avoid the need for the appointment of a guardian have been considered and determined not to be feasible; and supports and services available to the proposed ward that would avoid the need for the appointment of a guardian have been considered and determined not to be feasible.[246]

A guardian may not be appointed if supported decision-making can address the individual's needs. This makes guardianship a measure of last resort.

Lastly, The Texas Estates Code also provides for two safeguards in case guardianship is inevitable. First, the current supporters of a principal are entitled to receive notice in guardianship proceedings.[247] This effectively allows any opposition from the supporters in order to render a judgement whether a guardianship is really a matter of necessity.[248] Principals are also not excluded from hearings, and they are given the right to be assisted by their supporters.[249]

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245. TEX. EST. CODE ANN. §§ 1357.056 (a) (1)-(4) (West, 2017) (U.S.).

246. *Id.* §§ 1101.101 (a) (1) (D)–(E).

247. Kohn, *supra* note 181, at 351.

248. *Id.*

249. *Id.*

V. ANALYSIS

A. The Philippines is Not Compliant with Article 12.1, 12.2, and 12.3 of the UNCRPD

1. PWDs Should Be Entitled to Universal Legal Capacity Even During Periods of Impairment, Loss of Decision-Making Capacity, or Emergency Situations in Order to Uphold Article 12.1 and Article 12.2 of the UNCRPD

There is non-compliance with Article 12.1[250] and 12.2[251] of the UNCRPD if legal capacity is restricted due to disabilities.

Under the MHA, a person's legal capacity is restricted by the institution of the substitute decision-making regime and involuntary treatment under Section 10 (a) (2)[252] and Section 13,[253] therefore violating Article 12.1[254] and 12.2[255] of the UNCRPD. Under Section 10 (a) (2) of the MHA, a legal representative is empowered to act as a substitute decision-maker during periods of impairment or loss of decision-making capacity.[256] Under Section 13, on the other hand, involuntary treatment is considered valid during the period of impairment or temporary loss of decision-making and psychiatric or neurologic emergencies.[257] Involuntary treatment automatically triggers substitute decision-making because the fact that a person is subject to forced medical intervention or treatment already limits his or her, legal capacity, or the ability to consent to medical treatment.

250. UNCRPD, *supra* note 21, art. 12 (1).

251. *Id.* art. 12 (2).

252. The Mental Health Act, § 10 (a) (2).

253. *Id.* § 13.

254. UNCRPD, *supra* note 21, art. 12.1.

255. *Id.* art. 12 (2).

256. The Mental Health Act, § 10 (a) (2).

257. *Id.* § 13.

Anent the first contentious provision of the MHA, a legal representative, who is empowered to act as a substitute decision-maker, acts on the service user's behalf and represents the service user's interests under Section 4 (i).[258]

While this does not exclude the possibility of the legal representative deciding on the basis of the service user's wills and preferences, the wills and preferences model is not provided by law, and the fact that the wording of the provision under Section 10 (a) (1) pertains to representing "interests" would make it more probable for the best interest paradigm to be followed.[259] The wills and preferences model is one of the safeguards mandated under Article 12.4 of the UNCRPD. *Its non-inclusion is, in effect, not compliant with Article 12.4,*[260] *as an absence of measure upholding legal capacity, Article 12.1,*[261] *and Article 12.2,*[262] *as a restriction on legal capacity.*

Further, a legal representative can be a substitute decision-maker if the service user experiences impairment or loss of decision-making capacity implying that impairment or loss of decision-making capacity is a sufficient ground for the implementation of substitute decision-making.[263] Looking into the definition of impairment or loss of decision-making capacity, it refers to a medically-determined inability due to mental health condition, to provide informed consent.[264] The provision states four (4) elements, which is summarized as the inability to understand: (1) one's mental health condition; (2) the consequences of one's actions; (3) the treatment proposed; and (4) the inability to communicate consent.[265]

The inability to understand, however, should not be an immediate ground for substitute decision-making. The law should be able to provide more flexible ways for the service user to exercise his or her legal capacity, such as

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258. *Id.* § 4 (i).

259. *Id.* § 10 (a) (1).

260. UNCRPD, *supra* note 21, art. 12 (4).

261. *Id.* art. 12 (1).

262. *Id.* art. 12 (3).

263. The Mental Health Act, § 10 (a) (2).

264. *Id.* § 4 (g).

265. *Id.*

supported decision-making regimes. This would uphold the legal capacity of service users even during impairment or loss of decision-making capacity in compliance with Article 12.1,[266] and 12.2 [267] of the UNCRPD.

On the other hand, Section 13 of the MHA provides that involuntary treatment or forced medical intervention is valid in two instances: (1) psychiatric or neurologic emergency, and (2) impairment or loss of decision making-capacity.[268] These two exceptions would validate a substitute decision-making regime and, necessarily, justify restriction on legal capacity because forced medical interventions and confinement are necessarily the decision of another on behalf of the service user.

While the standards of psychiatric or neurologic emergency are valid, given that they limit involuntary treatment to extreme cases, the Note argues that impairment and loss of decision-making capacity should not be a sufficient ground for involuntary treatment. The inability to understand can be addressed by resorting to supported decision-making regimes.

The term "psychiatric emergency" relates to an "acute disturbance of behavior, thought[,] or mood of a patient which[,] if untreated[,] may lead to harm"[269] while the term neurologic emergency refers to "a condition that is life-threatening or in which a patient is faced with poor functional recovery unless treated promptly."[270] These two concepts are not synonymous with impairment or loss of decision-making capacity. Thus, it is proposed that involuntary treatment based on impairment or loss of decision-making capacity may be valid if such impairment or loss of decision-making capacity presents a serious or imminent threat to one's health or well-being or to other person's health or well-being similar to the standard set under psychiatric or neurologic emergency. Accordingly, the MHA should be amended.

In essence, a person experiencing mental illness should never be deprived of his or her universal legal capacity, even during impairment. The deprivation

266. UNCRPD, *supra* note 21, art. 12 (1).

267. *Id.* art. 12 (2).

268. The Mental Health Act, § 13.

269. Col. S Sudarsanan, et al., *Psychiatric Emergencies*, MED. J. ARMED FORCES INDIA 59, 59 (2004).

270. HIROSHI SHIBASAKI & MARK HALLETT, THE NEUROLOGIC EXAMINATION 269 (2016).

of such contravenes Article 12.1,[271] and 12.2[272] of the UNCRPD, thereby warranting an amendment of the MHA.

2. The Supported Decision-Making Regime is a Measure of Support That Will Enable the PWD to Exercise Legal Capacity and Protect His or Her Wills and Preferences Even During Periods of Impairment, Loss of Decision-Making Capacity, or Emergency Situations in Conformity with Article 12.3 and 12.4 of the UNCRPD

Article 12.3 of the UNCRPD provides that State Parties must be able to enact appropriate measures so that persons with disabilities can exercise their legal capacity[273] in all stages of life.[274] Article 12.4[275] of the UNCRPD, on the other hand, provides that a safeguard must be enacted for the support measure under Article 12.3[276] to protect the wills and preferences of the PWD.

The supported decision-making regime provision under the MHA expressly states that it is only applicable if there is an absence of impairment or loss of decision-making capacity.[277] This runs afoul the very purpose of the decision-making regime because it should be implemented precisely as a measure to aid the service user in exercising his or her legal capacity most especially during periods of impairment or loss of decision-making capacity. This system of support enables the individual to exercise his or her legal capacity, even during periods of impairment or loss of decision-making capacity, because the supporter is tasked to communicate to the individual in the manner understandable to him or her. The supporter would assist in helping the individual understand the nature and consequences of certain decisions so that such individual is able to convey his or her decision as an exercise of his or her legal capacity. This is contrary to substitute decision-making regimes where the finding of impairment would automatically vest the right of decision-making in a third party, and such third party is empowered

271. UNCRPD, *supra* note 21, art. 12 (2).

272. *Id.*

273. *Id.* art. 12 (3).

274. *Id.* art. 12 (2).

275. *Id.* art. 12 (4).

276. *Id.* art. 12 (3).

277. The Mental Health Act, § 4 (v).

to decide even against the wills and preferences of the individual on the basis of best interests.

For this reason, the UNCRPD incorporated the "wills and preferences" paradigm in order to replace the "best interest" paradigm[278] as one of the measures that would serve to fulfill the obligations under Article 12.1[279] and 12.2.[280] The wills and preferences paradigm is best associated with the implementation of the supported decision-making regime. This is contrary to the best interest paradigm, which is usually associated with the substitute decision-making regime. The wills and preferences paradigm is preferred over the best interest paradigm because the latter runs the risk of deciding against the wills and preferences of an individual on the grounds of medical necessity or best clinical needs.

The best interpretation of a person's wills and preferences should take into account not only what the supporter thinks the principal would have wanted, but also the principal's beliefs, values and concept of right and wrong.[281]

The scope of the decisions of the individual based on his or her wills and preferences or the best interpretation thereof, should cover, as much as possible, all forms of decision, whether they be legal decisions or medical treatment. After the determination of the principal's wills and preferences, the next crucial matter is to have such decisions, based on the principal's wills and preferences, be recognized by third parties and considered legally binding. This decision is a product of the person's legal capacity, and must be respected whether conveyed and enforced by the supporter or not. If the decision is not respected, this would result in an absurd situation where the supporter would exert utmost effort to ascertain a person's wills and preferences to arrive at a particular decision, only to have such decision disregarded. If this were the case, support systems and upholding universal legal capacity in general would be futile.

As the Philippines is legally obligated under Article 12.3 to enact measures that would uphold a person's legal capacity in all stages of life,[282] and has a correlative duty to enact safeguards for such measure that would protect the

278. Committee on Economic, Social and Cultural Rights, *supra* note 132, ¶ 17.

279. UNCRPD, *supra* note 21, art. 12 (1).

280. *Id.* art. 12 (2).

281. Skowron, *supra* note 130, at 128.

282. UNCRPD, *supra* note 21, art. 12 (3).

person's wills and preferences,[283] the PWDs must be able to utilize the supported decision-making regime provision under the MHA, even during periods of impairment, or loss of decision-making capacity. This right is currently restricted by Section 4 (v),[284] Section 10,[285] Section 11,[286] and Section 13[287] of the MHA. Hence, the MHA must be amended.

3. Accordingly, the Substitute Decision-Making Regime Should Be a Measure of Last Resort in Conformity with Article 12.3 and 12.4 of the UNCRPD

Considering that the supported decision-making regime is a support measure under Article 12.3[288] that respects the PWDs wills and preferences under Article 12.4,[289] this Note recommends that the supported decision-making regime be implemented first before considering the application of the substitute decision-making regime. This is possible through the amendment the MHA which would enable the service user to exercise legal capacity, even during periods of impairment or loss of decision-making capacity.

The supported decision-making regimes should be considered first before appointing a legal representative for substitute decision-making or in cases of involuntary treatment. *Again*, *impairment or loss of decision-making capacity is not mutually exclusive with legal capacity*, *as the latter can still be exercised through supported decision-making regime*. A legal representative may not be needed anymore if a supporter can be appointed. Even during the periods of impairment, a substitute decision-maker would not be needed because the supporter can communicate with the service user using conventional or non-conventional forms of communication. This would help in ascertaining the wills and preferences of such service user.

283. *Id.* art. 12 (3).

284. Mental Health Act, § 4 (v).

285. *Id.* § 10.

286. *Id.* § 11.

287. *Id.* § 13.

288. UNCRPD, *supra* note 21, art. 12 (3).

289. *Id.* art. 12 (4).

Even if the wills and preferences of a service user cannot be ascertained by the supporter during the period of impairment, the best interpretation of the wills and preferences constitutes another layer of safeguard. The supporter is tasked to consider the previous wills and preferences, the beliefs and values, and life contexts, among many factors, in order to ascertain the person's wills and preferences. On the other hand, involuntary treatment and confinement are forms of substitute decision-making. While psychiatric or neurologic emergencies present a valid exception that would justify substitute decision-making, the same cannot be said for impairment or loss of decision-making capacity for the same reasons discussed above.

In sum, the periods of impairment, loss of decision-making capacity, absolute deprivation of reason, or will experienced by a person with mental illness are not sufficient and immediate grounds to deny legal capacity. Article 12.3[290] provides that it is the duty of the State Party to enact measures that would give access for support to PWDs so that they may be able to exercise their legal capacity in all stages of life. The measures of support must enable PWDs to exercise their legal capacity, even during periods of impairment. As the supported decision-making regime addresses these concerns, the MHA should require their exhaustion and implementation first before considering substitute decision-making regimes as a measure of last resort. Accordingly, the MHA should be amended.

B. The Philippines is Not Compliant with Article 12.4 of the UNCRPD Because the Safeguards of the Mental Health Act are Insufficient to Protect the Rights of PWDs

Aside from the measures that the State must implement, the Philippines also has a legal obligation to enact safeguards under Article 12.4[291] in order to ensure that these measures truly uphold the rights of a person with disability. The Note submits that the safeguards under the MHA are insufficient to protect the rights of PWDs.

First, advance directives are recognized measures which seek to uphold legal capacity. Under the MHA, the advance directive provision is only limited to which treatment may be administered.[292] General Comment No. 1 suggests that an advance directive must be comprehensive enough to include even other

290. *Id.*

291. *Id.* art. 12 (4).

292. The Mental Health Act, § 9.

forms of decisions that may be coursed through a supporter, if the times comes when a person would experience impairment or loss of decision-making capacity.[293]

This must include the right of the principal or service-user to limit which legal decisions must be respected and which decisions can be enforced by the supporter. This is in conformity with the safeguard on wills and preferences, proportionality, and the measure being tailor fit to the person's circumstances. As part of the person's freedom to decide, he or she must be able to decide when the advance directive shall take effect and when it shall cease, as well as the decisions that can be enforced by the supporter. Under the MHA, there are no provisions expressly stating when an advance directive may commence or cease.

Second, the provisions on supporters and legal representatives are two of the most crucial provisions under the MHA. As the supported decision-making regime was expressly included under the MHA, it is interesting why the term "supporter" was not included. The term was only mentioned once, stating that a service-user may appoint up to three supporters,[294] whereas there are no other provisions defining who a supporter is, his or her scope of responsibilities or powers, qualifications, restrictions, and other important matters. The legal representative, who is also a substitute decision-maker, is necessarily a supporter.[295] By definition, the legal representative has the right to act on behalf of the service user, represent his or her interests, and even assume the powers of a substitute decision-maker.[296] The fact that the legal representative can decide on the best interest of the service-user and become a substitute decision-maker is contrary to the objective of the UNCRPD to abolish the substitute decision-making regime, which the Philippines has a legal obligation to so. This would result in a conflicting situation because the supported decision-making regime is an alternative or even a replacement to the substitute decision-making regime and the purpose of a supporter is to assist the principal in deciding and not to decide on behalf of such principal, unlike a substitute decision-maker.

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293. Report on PWD Rights, *supra* note 25, ¶ 44.

294. The Mental Health Act, § 11.

295. *Id.*

296. *Id.* § 10.

Third, as explained in the previous section, the right to legal capacity includes the service user's right to make legal decisions and have such decisions recognized. A supporter, being granted the power to enforce, may need to obtain necessary information from the principal, in order to carry out such enforcement. Access to private and confidential information is not unusual especially if there is a fiduciary relationship between a PWD and the supporter. PWDs, however, are still entitled to the fundamental right to privacy and confidentiality under Article 22 of the UNCRPD which states that supported decision-making regimes must ensure full respect to the privacy of PWDs.[297]

Fourth, a legal representative cannot be appointed during the period of incapacity or loss of decision-making capacity. Does this mean that such legal representative may not be terminated during the period of incapacity as well? As the period of incapacity is a period of vulnerability for the service-user, given that his or her legal capacity is restricted, it can become a conduit for abuse. There are no provisions under the MHA that provide for any actions that may be filed against the supporter or the legal representative in order to contest their actions.

Lastly, one of the most important aspects of a supported decision-making regime is the creation of a fiduciary relationship. As the role of a supporter is crucial to carrying out and assisting the principle, the supporter must be a person that the principal is able to trust and the supporter must be able to follow a set of principles that would enable him or her to carry out the duties in good faith. There would still be instances, however, that a supporter may enforce a decision in violation of the safeguards under Article 12.4 (conflicting interest, undue influence, coercion, abuse), hence, the principal must be able to have a recourse or action against the supporter.[298] These are safeguards that are lacking under the MHA which the UNCRPD expressly provides.

C. Upholding the Universal Legal Capacity of PWDs Protects Liberty and Nurtures Prosperity Under the Rule of Law

As stated previously, the cost of mental health illness estimates to trillions of dollars. In the Philippines alone, multiple billions of pesos are lost due to loss of productivity brought about by mental health conditions.

In a recent study conducted by the DOH, investing in measures that protect a person's mental health "could result in 700,000 healthy life years

297. *Id.* art. 22.

298. *Id.* art. 12 (4).

gained and over 5,000 lives being saved in the Philippines, with economic benefits of ₱ 217 billion (4.3 billion USD) over the next 10 years."[299] Investing and putting primacy in favor mental health leads to an increase in productivity, and in turn, leads to economic prosperity.

What ties a nation together is the proper development of mental capital that promotes social cohesion and inclusion.[300] Mental health conditions are imminent and inevitable. The legal capacity of persons who suffer from mental health conditions should be upheld, as this signifies that they are no different from persons without disabilities, as they equally have the same potential to contribute greatly to society. Thus, when a society "gives PWD the opportunity to participate fully and equally in all spheres and stages of life, PWD can be contributing members of family, community[,] and society."[301] Ultimately, upholding the rights of PWDs does not only give them the opportunity to contribute to society, but it protects the very tenets of their humanity — their liberty and freedom to be recognized as a person under the law, and in law. PWDs are entitled to equal recognition who can make legally binding decisions no different from persons without disabilities, simply, by virtue of being human.

VI. CONCLUSION AND RECOMMENDATIONS

A. Conclusion

The Note submits that the Philippines is not compliant with its obligations under Article 12 of the UNCRPD. The Philippines is a State Party to the UNCRPD which makes its provisions legally binding.

Article 12.1 provides that persons with disabilities are entitled to equal recognition under the laws which means that all persons with disabilities possess legal personality, a prerequisite to legal capacity. Legal capacity, as provided under Article 12.2, is composed of two fundamental elements: (1)

299. World Health Organization, *supra* note 9.

300. *Id.*

301. Cassandra Chiu, To Enhance Economic Growth, Help People with Disabilities Get Back to Work. World Economic Forum on ASEAN, *available at* https://www.weforum.org/agenda/2017/05/to-enhance-economic-growth-help-people-with-disabilities-get-back-to-work (last accessed Apr. 30, 2023) [https://perma.cc/8JZT-DAGC].

legal standing, and (2) legal agency; and these elements cannot be separated from each other. The failure to fulfill one necessarily violates legal capacity. This is manifested through involuntary treatments, where a person is administered treatment or confined against his or her well, or through the substitute decision-making regime, where another person is appointed to make legally binding decisions on behalf of the patient. Both are present under Section 10 (a) (2) and Section 13 of the MHA.

Based on the previous discussions, it is possible to exercise legal capacity even during periods of incapacity or emergency situations. The State Parties can always enact measures and safeguards that would still enable persons with disabilities to be able to exercise legal capacity even during periods of incapacity, in conformity with Article 12.3 and 12.4 of the UNCRPD. Upholding legal capacity during impairment can be performed in several ways, such as advance directives, supported decision-making regimes, ascertaining the wills, and preferences of the person, etc. As such, the MHA must be amended in order to accommodate the possibility of resorting to supported decision-making regimes, even during periods of impairment or loss of decision-making capacity. This effectively places the substitute decision-making regime as a measure of last resort.

Because of these seemingly conflicting provisions and vague definitions under the MHA, coupled with the lack of resources when it comes to mental health care, the rights of PWDs are at a constant risk to violation and abuse. Failure to uphold the rights of PWDs restricts their freedom and liberty. Not being part of an inclusive society can lead to unwanted but exorbitant economic costs which bring about loss of lives and loss of productivity. Thus, this Note lays down the foundation for factual and legal bases in order for the State to take a more proactive approach in balancing conflicting rights, but ultimately prioritizing the legal capacity of persons with mental illness. After all, human beings are entitled to equal recognition under the law.

B. Recommendations

1. Amending the Mental Health Act

First, the legal capacity of the person experiencing mental illness should be expressly included. This removes the stigma implied by the MHA that a service-user is only limited to being defined as a person with mental condition. A good way to address this concern is to expressly state that every person is entitled to universal legal capacity, just like Article 42 of the Peruvian Civil

Code.[302] Thus, the instances when these rights are curtailed would be limited to being a last resort. The provision will also imply that a service user enjoys the presumption of capacity in line with the UNCRPD obligation.[303]

The provision on supported decision-making must also be amended in order to provide clearer and more specific standards through a comprehensive definition. It must provide that the decision-making regime is, first and foremost, freely entered into by the service user as the choice to enter or not to enter into a support system is also an exercise of legal capacity. The provision must encapsulate in its definition the fundamental elements of a supported decision-making regime, which is a form of assistance involving communication assistance, to aid the service user in the understanding of certain legal actions and the consequences of such actions. Most importantly, the supported decision-making regime should be made available even during the period of impairment or loss of decision-making in line with what is envisioned under Article 12.2;[304] that all persons are entitled to legal capacity in all aspects of life.[305]

The provision on supported decision-making must expressly incorporate the wills and preferences paradigm as provided under Article 12.4 of the UNCRPD.[306] A good model to be followed are the standards provided under the MCA,[307] and Ireland's Capacity Act.[308] This is important because the wills and preferences paradigm is one of the safeguards espoused by Article 12. This should also create a standard and a hierarchy when it comes to implementing

302. CODIGO CIVIL DE PERU, art. 42.

303. *See* An Act Amending Sections 4 (i), 4 (t); 5, 9, 11 Creating New Sections: 4 (vv), 11 (a), 11 (b), 11 (c), 11 (d), 11 (e), 11 (f), 11 (g), 11 (h) All Under Republic Act No. 11036, Otherwise Known as the Mental Health Act of 2018 [Supported Decision-Making Act of 2021], Republic Act No. _, § 4. Proposal to amend Section 4 (t) of the MHA. These proposals for amendments are located in the Annex of this Note.

304. UNCRPD, *supra* note 21, art. 12 (2).

305. Supported Decision-Making Act of 2021, § 5. Proposal to amend Section 11 of the MHA.

306. *Id.* art. 12 (4).

307. Mental Capacity Act 2005, § 4.

308. Assisted Decision-Making (Capacity) Act 2015, § 41.

the regime because it would expressly state that the wills and preferences of the person must be ascertained first. The second paragraph should focus on what should be the guiding principles or standards in determining the wills and preferences of the service user, akin to the provisions of MCA[309] and the Peruvian Civil Code.[310] Lastly, the law should not make a distinction between a person who is temporarily incapacitated or permanently incapacitated, as both are entitled to equal recognition under the law therefore, supported decision-making must be available to both.

Creating a fiduciary relationship is also important in any supported decision-making regime. The Texas Estates Code is a good model provision for this aspect.[311] With a set of principles, the supporter is aware of his or her responsibilities when assisting the service user. The proponent suggests that Subsection (a) of Section 11 on supported decision-making must provide for these principles.[312]

Noticeably, Section 11 (a) (4) of the provision expressly states that conflict of interest, abuse, and undue influence must be avoided, in consonance with the safeguards provided under Article 12.4 of the UNCRPD.

Sections 11 (b)-(f), meanwhile, are the provisions on supporters. Under Section 11 (b), the appointment of supporters must come with the scope or period of support, as well as the specific powers endowed in order to prevent abuse akin to Article 659-C of the Peruvian Civil Code.[313] Under Section 11 (d), the decisions of the service user conveyed to the supporter should also be legally binding and the supporter should have the power to enforce the powers specifically granted or approved by the principal. A good model provision for this is Section 13.56.130 of the Alaska Statutes.[314] This is in conformity to the principle of legal agency which is fundamental to legal capacity. The only exception is the operation of a supported decision-making regime akin to substitute decision–making as found in Section 4 (vv). These

309. Mental Capacity Act 2005, § 4.

310. CODIGO CIVIL DE PERU, art. 639-B.

311. TEX. EST. CODE ANN. §§ 1357.056 (a) (1)-(4).

312. Supported Decision-Making Act of 2021, § 2. Proposal to amend Section 11 of the MHA.

313. CODIGO CIVIL DE PERU, art. 659-C.

314. ALASKA STAT. ANN., § 13.56.130.

amendments also incorporate safeguards on confidentiality, as it is inevitable that the supporter may have access to important information in order to fully assist or support the service user. In the event that the supporter may abuse this power or may decide inimically against the service user, a formal complaint may be filed before the Internal Review Board of the hospital or mental institution concerned.

Lastly, the judge should also be empowered to appoint a supporter in the instance when a person's mental health condition poses a serious or immediate threat to his or her own health or well-being, or to other people's health or well-being. Under the Peruvian Civil Code, the judge is empowered to decide on behalf of the individual and place him or her under a substitute decision-making regime if the wills and preferences cannot be ascertained and that they have exhausted all forms of accommodates.[315] While the determination of the support person rests on the sound discretion of the judge, the proposed amendment provides for certain standards that should be considered, such as relationship, trust, friendship, care, or kinship. This is an exception to the general rule that it is ultimately the choice of the service user, whether or not he or she should enter into a supported decision-making regime.[316]

While the wills and preferences must be respected as much as possible, restricting the legal capacity of a person may be possible, but should only be treated with utmost caution under the police power of the state. Of course, this still comes with a hierarchy as the wills and preferences model and other supported decision-making mechanisms must be exhausted before arriving to this recourse.

Another alternative that can be considered and may be exhausted first is the concept of co-decision making under Ireland's Assisted Decision- Making Act.[317] For all intents and purposes of the law, a qualified person may be appointed by the principal as a co-decision maker who can make joint decisions that are also legally valid. This solves the problem on the limited enforcement of powers vested in a supporter, as the appointment of a co decision-maker is a positive choice of the individual who consents to be bound by the decisions of the co-decision maker.

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315. CODIGO CIVIL DE PERU, art. 696-E.

316. Supported Decision-Making Act of 2021, § 2. Proposal to amend Section 11 (g) of the MHA.

317. Assisted Decision-Making (Capacity) Act 2015, § 17.

As the supported decision-making regime is defined, it is also important to define the substitute decision–making regime as a remedy of last resort to differentiate the two.[318]

Under the proposed subsection, it is now clearer that the substitute decision-making regime is a measure of last resort only employed during emergency cases. As it stands, substitute decision-making was not defined under the MHA.[319] Nonetheless, its implementation may be implied from Section 13[320] which provides for the exceptions to informed consent automatically triggering substitute decision-making. Substitute decision-making is also implied under Section 10 (a) (2)[321] which provides that a legal representative can act as a substitute decision-maker during impairment or temporary loss of decision-making capacity. Thus, substitute decision-making may be implemented based on the current standards under the MHA only if supported decision-making has already been exhausted.

On the other hand, the provision on the legal representative should also be amended.[322]

To remedy the confusion regarding the coinciding powers of a supporter and a legal representative, a legal representative should be expressly defined as a substitute decision-maker whose powers are only limited to instances that call for substitute decision-making. Although these are umbrella terms, at the very least, it is clear that a supporter is referenced to the supported decision-making regime and the legal representative to the substitute decision-making regime.[323]

The service user must also be empowered to designate or terminate a support agreement or a substitute decision-making agreement in exercise of his or her individual autonomy and legal capacity. The exceptions are the causes which would call for the power of the court to appoint a supporter or a legal representative because of serious harm to the health or well-being of the

318. Supported Decision-Making Act of 2021, § 2. Proposal to amend § 4 (vv) of the MHA.

319. *See generally* The Mental Health Act.

320. The Mental Health Act, § 13.

321. *Id.* § 10 (a) (2).

322. Supported Decision-Making Act of 2021, § 2. Proposal to amend § 4 (i) of the MHA.

323. *Id.* § 3. Proposal to amend § 5 (o) of the MHA.

service user or other people because it would presume that the appointment of a substitute decision-maker is important in order to protect the general welfare of the public.[324]

Advance directives should also not be limited to decisions on treatment. It would be more convenient for the service user to be able to specify the powers he or she chooses to grant to the supporter or the legal representative in the same notarized document. This is akin to an enduring power of attorney. It is also important that the service user is able to decide on the effectivity and termination of the advance directive.[325]

As provided in the aforementioned amendments, the legal representative is a substitute decision-maker. The powers of a legal representative to decide on the best interest of the service user are only triggered based on the grounds found under Section 4 (vv). To repeat, intrusion on a person's autonomy and legal capacity should be a last resort so a substitute decision-maker such as the legal representative must still be able to exhaust the wills and preferences paradigm.[326]

In consonance with the other suggested amendments, involuntary treatment must also be treated as a last resort. Under the definition of psychiatric or neurologic emergency, there must be a finding that the condition of the service user would pose a serious harm and imminent threat to his or her health and well-being or of others. This standard should also be used if the case were to fall under the second exception which pertains to impairment or loss of decision-making capacity. In this way, the mere fact that the service user experiences impairment or loss of decision-making capacity would not automatically place him or her under substitute decision- making or involuntary treatment because supported decision-making can still be considered. Only when there is a serious or imminent threat can these measures be justified. Also, under Section 13 (C), the mandatory 15-day assessment may be dispensed with, as this could be very costly and unnecessary for a person who has permanent mental disability.

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324. *Id.* § 3. Proposal to amend § 4 (t) of the MHA.

325. *Id.* § 4. Proposal to amend § 9 of the MHA.

326. *Id.* § 6. Proposal to amend § 13 of the MHA.

ANNEX

Republic of the Philippines
Congress of the Philippines
Metro Manila

Eighteenth Congress
THIRD REGULAR SESSION

Begun and held in Metro Manila, On Monday the twenty-sixth day of July, two- thousand and twenty one.

[REPUBLIC ACT NO. _____]

AN ACT AMENDING SECTIONS 4 (i), 4 (t); 5, 9, 11 CREATING NEW SECTIONS: 4 (vv), 11 (a), 11 (b), 11 (c), 11 (d), 11 (e), 11 (f), 11 (g), 11 (h) ALL UNDER REPUBLIC ACT NO. 11036, OTHERWISE KNOWN AS THE MENTAL HEALTH ACT OF 2018.

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled:

SECTION 1. Short Title. — This Act shall be known as the "Supported Decision-Making Act of 2021."

SECTION 2. The definition of Service User and Legal Representatives shall be amended and a definition for Substitute Decision-Making shall be included under

SECTION 4. Definitions of R.A. 11036 to read as follows:

SECTION 4. Definitions

(i) Legal Representative refers to a person designated by the service user, appointed by a Court of competent jurisdiction for any of the causes found under Section 4 (VV), or authorized by this Act or any other applicable law, to act on the service user's behalf. The legal representative may also be a person appointed in

writing by the service user to act on his or her behalf through an advance directive.

...

(t) Service User refers to a person with lived experience of any mental health condition including persons who require, or are undergoing psychiatric, neurologic or psychosocial care. Service users are entitled to full capacity to act and treated on an equal basis with others in all aspects of life, regardless of whether they use or require treatment or support for the expression of their will.

(vv) Substitute Decision-Making. During psychiatric or neurologic emergency as defined under Section 4 (q) of this Act, or when the service user is assessed to be temporarily or permanently mentally incapacitated and such condition presents a serious and immediate threat to the health and well-being of the service user, or of the others, a legal representative previously appointed by the service user through an advance directive executed for the purpose or appointed by the court in consideration of the circumstances provided in this section, may decide on behalf of the service user.

Any form of substitute Decision-Making is prohibited unless alternatives such as supported Decision-Making regimes are readily available and such are determined to be feasible.

SECTION 3. Subsection (o) shall be amended under SECTION 5. Rights of Service Users of R.A. 11036 to read as follows:

SECTION 5. Rights of Service Users

(o) Designate, appoint or terminate a person of legal age to act as his or her legal representative or supporter in accordance with this Act in relation to the other provisions.

SECTION 4. The provision on advance directive shall be amended under SECTION 9. Advance Directives of R.A. 11036 to read as follows:

SECTION 9. Advance Directive. – A service user may set out his or her preference in relation to a treatment <u>or any legal decision</u> through a signed, dated, and notarized advance directive executed for the purpose. An advance directive may be revoked by a new

advance directive or by a notarized revocation. The period of effectivity, including the implementation and termination period of the advance directive, must be provided in the same document.

SECTION 5. Section 11 of R.A. No. 11036 is hereby amended to read as follows:

SECTION 11. Supported Decision-Making. – Supported Decision-Making is a form of assistance freely chosen by a person to facilitate the exercise of their rights, including support in communication, in the understanding of legal acts and their consequences, and the expression and interpretation of the will and preferences of the one who requires the support whether or not there is a presence of impairment or loss of decision-making capacity and whether or not such impairment or incapacity is temporary or permanent.

When the support requires interpreting the will of the person who is being assisted, the criterion of the best interpretation of the will and preferences applies, taking into account the life trajectory of the person, previous expressions of wills and preferences in similar contexts, the information provided by trusted people of the assisted person, the consideration of their preferences and any other consideration relevant to the specific case. The following factors may also be considered: (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he or she had capacity, and (c) the other factors that he or she would be likely to consider if he or she were able to do so.

(a) Fiduciary relationship. A supporter appointed by the service-user or the judge in cases under section must always: (1) act in good faith; (2) act within the authority granted in [the supported decision-making agreement]; (3) act loyally and without self-interest; and (4) avoid conflicts of interest, abuse or undue influence.

(b) Appointment of Supporters. A service user may designate a person of legal age and to act as his or her supporter through a notarized document executed for that purpose. The service-user shall:

(1) Determine the form, identity, scope, duration of the supported decision-making agreement and number of supporters. The support can fall on one or more natural persons, public institutions or non-profit legal entities, specialized both in the matter and duly registered.

(2) Designate up to three (3) persons or entities to act as "supporters," for the purposes of Supported Decision-Making.

(c) Role of the supporters. Appointed supporters shall have the authority to: access the service user's medical information; consult with the service user vis-à-vis any proposed treatment or therapy; and be present during a service user's appointments and consultations with mental health professionals, workers, and other service providers during the course of treatment or therapy.

(d) Recognition of decisions or requests. A person shall recognize a decision or request made or communicated with the decision-making assistance of a supporter under this subsection as the decision or request of the principal for the purposes of a provision of law, and the service-user or supporter may enforce the decision or request in law or equity on the same basis as a decision or request of the service-user. The support has no powers of representation nor enforcement except in cases where this is expressly established by decision of the person in need of support or by the judge in cases falling under Section 4(VV).

(e) Confidentiality in the handling and disposal of information. A supporter shall keep the information collected by the supporter on behalf of the principal under this chapter confidential, may not use the information for a use that is not authorized by the principal, shall protect the information from unauthorized access, use, or disclosure, and shall dispose of the information properly when appropriate.

(f) Complaints in relation to the supporters. A formal complaint may be filed before the Internal Review Board against the supporter based on the following grounds:

(1) that a supporter has acted, is acting, or is proposing to act outside the scope of his or her

functions as specified in the decision- making assistance agreement;

(2) that a supporter is unable to perform his or her functions under the decision-making assistance agreement;

(3) that fraud, coercion or undue pressure was used to induce the appointer to enter into the co-decision-making agreement

(g) Exception to the appointment of supporters. Exceptionally, the judge of the court of competent jurisdiction can determine the necessary support for persons with disabilities who are undergoing psychiatric or neurologic emergency as defined under Section 4 (q) of this act, or when the service user is assessed to be temporarily or permanently mentally incapacitated and such condition presents a serious and immediate threat to the health and well-being of the service user, or of the others. The judge determines the support person or persons taking into account the relationship of cohabitation, trust, friendship, care or kinship that exists between them and the person that requires support.

This measure is justified after having made real, considerable and pertinent efforts to obtain an expression of wills and preferences from the person or the best interpretation thereof, and having provided them with measures of accessibility and reasonable accommodations, and when the designation of supports is necessary for the exercise and protection of their rights.

(h) Co-Decision-Making. A service user may also appoint a suitable person who has attained the age of majority to jointly make with the service user one or more than one decision on the service user's personal welfare or property and affairs, or both.

1) A person is suitable for appointment as a co-decision-maker if he or she —

(a) is a relative or friend of the appointer who has had such personal contact with the appointer over such period of time that a relationship of trust exists between them, and

(b) is able to perform his or her functions under the co-decision- making agreement.

SECTION 6. Section 13 of R.A. No. 11036 is hereby amended to read as follows:

> SECTION 13. Exceptions to Informed Consent. — During psychiatric or neurologic emergencies, or when there is impairment or loss of decision-making capacity and supported decision-making regimes have been considered and are not found to be feasible and/or the condition presents a serious and immediate threat to the health and well-being of the service user, or of the others, treatment, restraint or confinement, whether physical or chemical, may be administered or implemented on the part of a service user pursuant to the following safeguards and conditions:
>
> (a) In compliance with the service user's advance directives, if available, unless doing so would pose an immediate risk of serious harm and immediate threat to the health and well-being of the service user, or of the others.
>
> (b) Only to the extent that such treatment or restraint is necessary, and only while a psychiatric or neurologic emergency, or impairment or loss of capacity, exists or persists;
>
> (c) Upon the order of the service user's attending mental health professional, which order must be reviewed by the internal review board of the mental health facility where the patient is being treated within fifteen (15) days from the date such order was issued, and every fifteen (15) days thereafter while the treatment or restraint continues unless the service-user has been assessed to be permanently mentally incapacitated; and
>
> (d) That such involuntary treatment or restraint shall be in strict accordance with guidelines approved by the appropriate authorities, which must contain clear criteria regulating the application and termination of such medical intervention, and fully documented and subject to regular external independent monitoring, review, and audit by the internal review boards established by this Act.

SECTION 7. Separability Clause. — If any part, section, or provision of this Act is declared invalid or unconstitutional, the other parts thereof not affected thereby shall remain valid.

SECTION 8. Repealing Clause. — All laws, acts, presidential decrees, executive orders, administrative orders, rules and regulations inconsistent with or contrary to the provisions of this Act are deemed amended, modified or repealed accordingly.

SECTION 9. Effectivity. — This Act shall take effect fifteen (15) days after completion of its publication in two (2) newspapers of general circulation.