

# Paternalism vs. autonomy? Substitute and supported decision-making in England and Hungary

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## ABSTRACT

This paper explores substitute and supported decision-making in the light of the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD, adopted by the UN General Assembly in 2006, introduces a ‘paradigm shift’ in the regulation of legal capacity by endorsing the idea of universal legal capacity, i.e. that everyone, including persons with disabilities ‘enjoy legal capacity on an equal basis with others’. After examining the conceptual and regulatory issues surrounding substitute and supported decision-making and the requirements of the CRPD and the first General Comment of the UN Committee on the Rights of Persons with Disabilities (GC1), the paper proceeds to examine the regulations of the Mental Capacity Act 2005 (England & Wales) and the Hungarian Civil Code and their (non-)compliance with the CRPD and GC1.

## KEYWORDS

substitute decision-making, supported decision-making, mental capacity, UN Convention on the Rights of Persons with Disabilities (CRPD), Mental Capacity Act 2005

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## 1. INTRODUCTION

This article explores the questions of substitute and supported decision-making in the light of the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD was adopted by the UN General Assembly in 2006 and it is widely considered as a progressive instrument in safeguarding the rights of persons with disabilities. Among other things, it introduces a ‘paradigm shift’ in the regulation of legal capacity; the CRPD adopts the idea of universal legal capacity, i.e. that everyone, including persons with disabilities ‘enjoy legal capacity on an equal basis with others’.<sup>1</sup> This implies a shift from substitute to supported decision-making, which, at the same time, imposes a significant duty on States Parties to harmonise their national legislation with this requirement.

The first European country to ratify the CRPD was Hungary, the United Kingdom joined the Convention two years later, in 2009. In the following pages, we examine the provisions of the CRPD, the Hungarian Civil Code and the Mental Capacity Act (MCA) 2005 (England & Wales). The central question is not whether the two countries comply with the requirements of the CRPD as interpreted by the UN Committee on the Rights of Persons with Disabilities – to date, there is no country in the world that has a regulation that fully satisfies the CRPD’s requirement to replace substitute decision-making with supported decision-making.<sup>2</sup> Rather, our goal is (1) to situate the two sets of regulations in the conceptual framework of substitute and supported decision-making, and (2) to evaluate these in light of the international normative framework provided by the CRPD. Thus, the primary aim of this article is not to compare domestic regulations in the ‘traditional’ sense of the word, e.g. by identifying and comparing functional equivalents in English and Hungarian mental capacity law.<sup>3</sup>

The conceptual framework of substitute and supported decision-making is complex and, partly due to this complexity, seems to be constantly evolving. Section 2 seeks to give a brief, but systematic overview of the different forms and standards of substitute decision-making, using English and Hungarian mental capacity law to explore and illustrate the different conceptual variations. Section 3 discusses the main justificatory approaches for substitute decision-making in moral philosophy set in the broader conceptual framework of paternalism. It intends to demonstrate how the normative perceptions of paternalism and substitute decision-making depend on the way certain underlying concepts such as ‘autonomy’ or ‘disability’ are conceptualized. The section briefly touches upon the emerging concept of relational autonomy, which seems to imply a shift from substitute to supported decision-making. Following this line of thought, Section 4 changes the focus of our analysis from substitute to supported decision-making, and presents the requirements of the CRPD with respect to the regulation of legal capacity. Section 5 examines the interpretation of the CRPD provided by the first General Comment (GC1) of the UN Committee on the Rights of Persons with Disabilities. Finally, Sections 6 and 7 consider the CRPD compliance of the MCA and the Hungarian Civil Code; even if GC1 and its ‘radical’ normative implications are disregarded, it is possible to highlight certain features of both regulations that may run counter to the requirements of the CRPD. By

<sup>1</sup>Article 12 (2) CRPD.

<sup>2</sup>Arstein-Kerslake (2017) 64; Halmos (2019) 24.

<sup>3</sup>Samuel (2014) 65–68.



juxtaposing these, we will see that there are ‘issues’ which can be ‘transferred’ from the English to the Hungarian context, but there are also some that are specifically related to just one of these jurisdictions.

## 2. SUBSTITUTE DECISION-MAKING

Substitute decision-making means, as the name suggests, that a decision is made on behalf of a person by someone else, in case the person is unable to make a decision on his or her own.<sup>4</sup> Theoretically, substitute decision-making is not confined to adults without mental capacity. It may take place in a parent-child relation, or even in cases where a fully competent person asks someone else to make a decision instead of him, because, for example, he is convinced that the other person will make a ‘better’ (i.e. wiser, more prudent) decision in the given situation. There are two main questions that should be addressed when dealing with substitute decision-making, namely (I) who should be the substitute decision-maker, and (II) on what basis should substitute decision-making take place.<sup>5</sup>

(I) It is possible to distinguish at least three ways of how a substitute decision-maker gets appointed.<sup>6</sup> There are (1) patient- and (2) court-designated ‘surrogates’, and in certain cases it is also possible that someone (3) becomes a substitute decision-maker *ex lege*. I explore these possibilities with respect to Hungary and England in the following paragraphs.

1. Someone with decision-making capacity may give an *advance directive*, in which he or she appoints an ‘agent’, or a ‘proxy’ who is entitled to make decisions on behalf of the appointing person in case the latter loses his or her capacity. In Hungary, advance directives are regulated by the Civil Code and the Act on Health. According to the new Civil Code adopted in 2013, every adult with decision-making capacity can name someone, whom he or she would prefer to have as a ‘conservator’ (i.e. guardian) in case he or she loses capacity.<sup>7</sup> The scope of the advance directives regulated in the Act on Health is more limited, because the ‘proxy’ appointed under this Act can only make decisions related to healthcare, i.e. give consent to or refuse treatment on behalf of the incapacitated person.<sup>8</sup> In England and Wales, the MCA regulates LPAs – a Lasting Power of Attorney is a document that allows an adult with mental capacity (the donor) to appoint someone else (the attorney) to make decisions on his or her behalf in case he or she lacks mental capacity in the future.<sup>9</sup> An LPA can authorize the attorney to make decisions with respect to the donor’s personal welfare (e.g. decisions on care, where to live, etc.) and/or property affairs (e.g. banking, selling property, etc.). Somewhat similarly to the Hungarian

<sup>4</sup>Surrogate decision-making seems to be another expression for substitute decision-making, although it is not entirely clear if the two expressions are interchangeable. The expression ‘surrogate decision-making’ appears e.g. in [Buchanan and Brock \(1990\)](#) and [Jaworska \(2017\)](#).

<sup>5</sup>[Jaworska \(2017\)](#).

<sup>6</sup>For a somewhat similar classification, see [Pope \(2012\)](#) 1074–75.

<sup>7</sup>Act V of 2013 on the Civil Code of Hungary, sect. 2:39.

<sup>8</sup>Act CLIV of 1997 on Health, sect. 16.

<sup>9</sup>[MCA \(2005\)](#) sections 9–14.



regulation in the Act on Health, the MCA also allows for advance decisions to refuse medical treatment.<sup>10</sup> Besides advance directives, it is necessary to consider another, perhaps less obvious case of patient-designated ‘surrogacy’, i.e. the possibility that someone without capacity can nevertheless appoint his or her substitute decision-maker.<sup>11</sup> To a limited extent, the Hungarian Civil Code seems to recognize this possibility when prescribing that ‘the person [...] named in the appointment procedure by the relevant person shall be appointed for the office of conservator, unless it expressly conflicts with his/her interest’.<sup>12</sup> The Civil Code also provides that ‘[a] person shall not be appointed conservator if [...] an objection to such person is expressly made by the person under conservatorship’.<sup>13</sup>

2. If there is no patient-designated proxy, it is usually the task of the courts to appoint a substitute decision-maker. In Hungary, the rules of guardianship apply to ‘persons of legal age’ whose ‘discretionary ability for conducting their affairs is – owing to their mental disorder – permanently or persistently diminished’.<sup>14</sup> In such cases, the civil court, following the procedure laid down in sections 2:28–30 of the Civil Code, decides about the placement under guardianship, and the ‘guardianship authority’ (*gyámhatóság*) appoints a guardian based on the court’s order.<sup>15</sup> If there is an advance directive, the authority must appoint the person designated in the directive; in the absence of such document, the incapacitated person’s spouse or domestic partner shall be appointed, and in the absence of a spouse or domestic partner, any other person, who, all things considered, appears competent to serve as the guardian of the legally incompetent (with a preference given to parents and other relatives, provided they are able and willing to provide care). If no guardian can be appointed following these rules, a ‘professional guardian’ shall be appointed.<sup>16</sup> Although it seems that the legislative intent was to give priority to family members in the process of appointment, more than forty percent of people under guardianship had professional guardians in 2017.<sup>17</sup> In England, section 16

<sup>10</sup>MCA (2005) sections 24–26.

<sup>11</sup>Kanter describes the Representation Agreement Act of British Columbia as an instrument that allows people with severe disabilities (who may be found to lack capacity) to enter into representation agreements by demonstrating ‘trust’ in the designated supporters. Kanter (2015) 270.

<sup>12</sup>Act V of 2013 on the Civil Code of Hungary, sect. 2:31 (3).

<sup>13</sup>Act V of 2013 on the Civil Code of Hungary, sect. 2:31 (2). The MCA does not specify who the court-appointed deputy should be; the Court of Protection has a discretion in this respect. *Re BM, JB v AG* [2014] EWCOP B20 para. 46. The extent to which an incapacitated person’s ‘wishes and feelings’ shall be considered when appointing a deputy remains unclear. See, in relation to the appointment of personal welfare deputies, *Re Lawson, Mottram and Hopton* [2019] EWCOP 22 paras. 22, 45, 52, 53.

<sup>14</sup>Act V of 2013 on the Civil Code of Hungary, sect. 2:19 (2).

<sup>15</sup>According to sect. 2:33 of the previous Civil Code that was accepted by the Hungarian Parliament but never came into force (Act CXX of 2009 on the Civil Code of Hungary), it was the task of the civil court to appoint a guardian simultaneously with the decision about guardianship. The current Civil Code preserves the old approach and separates the appointment of guardians from the decision about guardianship. Boros (2021) 116; Adámkó (2016) 23.

<sup>16</sup>Act V of 2013 on the Civil Code of Hungary, sect. 2:31 (3)–(5).

<sup>17</sup>In 2017, there was a total of 57,983 people placed under guardianship in Hungary. 23,888 people had ‘professional’, while 34,095 had ‘non-professional’ guardians. The rate of professional guardians shows a slightly increasing trend. Gulya and Hoffmann (2019) 27.



of the MCA authorizes the Court of Protection (COP) to appoint a person (a ‘deputy’) that can make decisions on behalf of the person who lacks capacity. The Court usually appoints a family member or a friend because they tend to be more familiar with the situation of the incapacitated person than professional deputies.<sup>18</sup> Although the Hungarian guardianship and English deputyship regulations are not directly comparable,<sup>19</sup> it is telling that there are almost the same number of people under guardianship in Hungary as under deputyship in England and Wales, with a population six times that of Hungary.<sup>20</sup>

3. It is also possible that someone becomes a substitute decision-maker ‘by virtue of law’, i.e. without being specifically appointed by someone else. Section 5 of the MCA gives ‘informal authority’ to carers in personal welfare and healthcare situations to carry out certain tasks without fear of liability.<sup>21</sup> For this, no appointment is needed; anyone ‘in connection with the care or treatment of another person’ can become an ‘informal’ substitute decision-maker if he or she complies with the requirements set forth in section 5. The aim of this regulation is to give legal backing to carers that do not have an ‘official’ authorisation (e.g. an LPA or a court order) to perform personal welfare or healthcare-related tasks.<sup>22</sup> In Hungary, the Act on Health specifies – in the absence of an advance directive – a statutory order in which family members become substitute decision-makers to refuse or give consent to medical treatment on behalf of the incapacitated person.<sup>23</sup>

Courts can also become substitute decision-makers by virtue of law. According to section 16 (2) of the MCA, the Court of Protection can, by making an order, make a decision on behalf of a person lacking capacity in relation to that matter. Moreover, the MCA also states that a court order is preferable to the appointment of a deputy. The statistics of the COP seem to reflect this requirement.<sup>24</sup> The COP issued 16,669 property and affairs and 835 health and welfare orders in 2012, while it appointed 12,563 property and affairs deputies and 101 health and welfare deputies in the same year. The number of court orders (17,504) is significantly higher than the number of deputies appointed (12,664), which shows that the Court of Protection plays an important role in substitute decision-making besides patient and court-appointed ‘surrogates’. The low number of health and welfare orders and deputies can be explained by the previously mentioned section 5 of the MCA that gives ‘informal authority’ to carers in personal welfare and healthcare situations.<sup>25</sup> In Hungary, direct court orders are rare, it is rather the guardianship authority that gets involved in the work of guardians.

<sup>18</sup>Re BM, JB v AG [2014] EWCOP B20, para. 46. See also [Lush \(2014\)](#) 144; MCA Code of Practice (2007) 147.

<sup>19</sup>Partly because there are other means of substitute decision-making in the MCA (e.g. informal authority in personal welfare and healthcare situations, direct court orders and LPAs).

<sup>20</sup>There were 60,793 deputyship orders in place in England and Wales in 2020, while the number of people under guardianship in Hungary was 58,153 in 2019. The Hungarian data is from the website of the Hungarian Central Statistical Office. For the English data, see [Office of the Public Guardian Annual report and accounts \(2019/2020\)](#) 13.

<sup>21</sup>[Lush \(2014\)](#) 137, 146.

<sup>22</sup>Section 6.4 of the MCA Code of Practice (2007) gives some examples, e.g. helping with washing, dressing, personal hygiene, eating and drinking, giving medication, etc.

<sup>23</sup>Act CLIV of 1997 on Health, sect. 16 (2).

<sup>24</sup>[Lush \(2014\)](#) 145.

<sup>25</sup>[Lush \(2014\)](#) 137, 146.



- (II) The second question concerning substitute decision-making is about the standard of decision-making, i.e. if there is a general rule or principle that should be respected when making decisions on behalf of an incapacitated person. To answer this, we need to take a closer look at the guiding values behind substitute decision-making. It seems that there are two values that play an essential part in determining how a decision is made on behalf of someone who lacks capacity: autonomy and welfare. The value of autonomy requires maximum respect for the autonomy of the incapacitated person, which practically means that choices made for this person must be in line with his or her previously expressed values, wishes and preferences. Autonomy, however, can come into conflict with the other major value, individual welfare. Protecting someone's welfare may require to go against that person's current or previously expressed preferences. Such paternalism, while not necessarily wrong in itself, must be cautiously exercised and always balanced against the value of respect for autonomy. The legal standards for substitute decision-making seem to reflect the normative implications of the above values.<sup>26</sup> The *substituted judgment standard*, based on the value of autonomy, requires the decision-maker to reconstruct what the incapacitated person would have wanted if he or she had capacity in the specific situation and to make a decision that corresponds to that hypothetical construct.<sup>27</sup> The *best interests standard*, emphasizing the welfare of the protected person, says that the decision-maker must choose what he or she thinks is best for the person without capacity. The advantage of this standard is that it can be applied when the substituted judgment standard fails, i.e. when the previous wishes and preferences of the incapacitated person are unknown. Different jurisdictions make use of these standards differently; it seems that often a certain 'mixture' of the two is adopted.<sup>28</sup> The English Mental Capacity Act adopts the best interests standard. Although there is no definition of best interests in the statute, section 4 contains a non-exhaustive list of factors that must be considered when determining someone's best interests, including the incapacitated person's 'past and present wishes and feelings' and the 'beliefs and values that would be likely to influence his decision if he had capacity'.<sup>29</sup> The notion of best interests is complex; the jurisprudence of the Court of Protection has significantly contributed to its development.<sup>30</sup> The principles of substituted judgment and best interests are somewhat 'foreign' to the conceptual framework of the Hungarian legal system. However, it seems that it is an objective best interests standard which

<sup>26</sup>Jaworska (2017); Beauchamp and Childress (1994) 170–181.

<sup>27</sup>Jaworska (2017).

<sup>28</sup>In relation to the United States, substituted judgment is sometimes portrayed as the 'primary' decision-making standard and best interests as a 'fallback' principle for cases in which the patient's previous wishes and preferences cannot be ascertained. Pope (2012) 1077; Dresser (2004) para. 4. Empirical analysis of state legislation does not entirely confirm this picture. The Uniform Probate Code, after the adoption of the 1997 Uniform Guardianship and Protective Proceedings Act, contains both standards but sets no priority between them. Of the 52 jurisdictions, only 24 have regulations that contain any decision-making standard for the guardians of incapacitated adults. Six states refer to best interests, four to substituted judgment, while 14 guardianship statutes contain both standards. Out of this 14, only six statutes set a hierarchy (with priority given to the substituted judgment standard). Frolik and Whitton (2012) 739–47. Arstein-Kerslake mentions the New York Surrogate's Court Procedure Act which uses the best interests standard. Arstein-Kerslake (2017) 78–79.

<sup>29</sup>MCA (2005) section 4 (6).

<sup>30</sup>For an overview of the development of the best interests standard, see e.g. Szerletics (2012).



mostly determines substitute decision-making in Hungary.<sup>31</sup> Although section 2:22 (3) of the Civil Code states that guardians – if possible – shall take into account the views of the person under guardianship, in practice they very often fail to do so.<sup>32</sup> Moreover, references to the interests of the incapacitated person appear repeatedly in the Civil Code, e.g. in relation to the appointment and removal of guardians or property management.<sup>33</sup>

### 3. THE PATERNALISTIC CHARACTER OF SUBSTITUTE DECISION-MAKING

It has already been mentioned that substitute decision-making is based on the values attributed to the welfare and the autonomy of the individual. The requirements of these values often conflict with each other. While respect for individual autonomy can be perceived as a general expectation of modern societies, substitute decision-making implies paternalism, i.e. going against the past or present wishes and preferences of the individual to promote his or her welfare. The question of paternalism is intensely controversial. Much ink has been spilled on the topic but there is no genuine consensus among philosophers about the conditions necessary to justify paternalistic interventions.<sup>34</sup> One strand of thought, based on consequentialist normative ethics, emphasize the consequences of paternalism: in short, it claims that a paternalistic intervention is justified if it leads to ‘good’ consequences. The other approach builds on deontological ethics and places a categorical duty, i.e. the respect for personal autonomy in the centre of attention. In this framework, paternalism is wrong insofar as it violates the paternalized person’s autonomy. However, the meaning of autonomy is unclear. It is an extremely complex concept, which means that the justification of a paternalistic intervention will largely depend on how someone understands the notion of autonomy. At first sight, decision-making capacity seems an integral part of personal autonomy, i.e. an individual who – for whatever reason – lacks decision-making capacity does not appear as an autonomous agent to others. Thus, paternalism in the deontological framework is justified if exercised over individuals who lack capacity. In line with this ‘traditional’ approach to autonomy, John Stuart Mill, a committed liberal, rejects paternalism in general but sees nothing wrong with paternalising ‘a child, or someone who is delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty’.<sup>35</sup> However, just because someone lacks the cognitive capacity to make a decision on his or her own, this does not necessarily mean that the person cannot be autonomous. If, for example, we accept

<sup>31</sup>Mental Disability Advocacy Center (2007) 81; Halmos (2019) 35–36.

<sup>32</sup>Fiala-Butora (2016) 131.

<sup>33</sup>Act V of 2013 on the Civil Code of Hungary, paras. 2:31 (2) b., 2:33 (2) c. and 2:35.

<sup>34</sup>Some of the most important contributions to the concept and/or to the justification of paternalism in moral and legal philosophy include Feinberg (1971); Dworkin (1972); Arneson (1980); Kleinig (1983); Sartorius (1983); Dworkin (1988); Feinberg (1989); Kultgen (1995); Zamir (1998); Shiffrin (2000); Pope (2004); Arneson (2005); Pope (2005); Coons and Weber (2013); Bullock (2015); Grill and Hanna (2018).

<sup>35</sup>Mill (1975) 11. Mill also allows paternalism in cases, where the lack of autonomy has an ‘external’ cause, e.g. lack of information. Consider his famous case of an unsafe bridge: ‘If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back, without any real infringement of his liberty; for liberty consists in doing what one desires, and he does not desire to fall into the river.’ Mill (1975) 89.





that autonomy is a relational concept,<sup>36</sup> i.e. that it largely depends on the social relations and that it can be developed through improving these relations, the possibility of a ‘clear’ or ‘objective’ threshold between decision-making capacity and incapacity becomes illusory. Relational autonomy implies that the ability to make a decision does not primarily depend on someone’s cognitive faculties but on the social relations of the individual, e.g. on a network of support surrounding the person. Exercising paternalism, i.e. substitute decision-making over someone who is, or could be, autonomous under a relational account of autonomy seems morally unjustified. This brings us to the idea of supported decision-making and hopefully illustrates why substitute decision-making is morally unjustified, at least in the cases of those individuals who are able to make their own decisions with adequate support.

Before examining the question of supported decision-making, I would like to briefly address the objection that the ideas of relational autonomy and supported decision-making are not as ‘intimately’ connected as pictured in the previous paragraph. Although supported decision-making is generally associated with relational autonomy,<sup>37</sup> it is possible to argue that supported decision-making can also be accommodated in the ‘traditional’ (i.e. ‘liberal’ or ‘individualistic’) conceptual framework of autonomy where support is considered to enhance an individual’s cognitive faculties and these enhanced faculties make the person autonomous. This approach reflects a predominantly internalist perception of autonomy.<sup>38</sup> External factors, e.g. enabling social relations are recognized as *causal* but not as *constitutive* elements of autonomy.<sup>39</sup> Autonomy ultimately remains with the individual, which seems more consistent with the medical model of disability that perceives disability and autonomy as intrinsic properties;<sup>40</sup> it also implies that a (medical) assessment of cognitive faculties is sufficient to determine autonomous agency. Although assessment procedures can, in principle, take into account enabling or disabling social relations, Series points out that regulations based on the mental capacity paradigm, like the MCA, struggle ‘to produce clear and consistent principles for accommodating the influences of others [...] on decision making’ and interventions aimed at enhancing individual decision-making ‘can be remarkably coercive’.<sup>41</sup> It is worth mentioning that the recognition of social relations as being *constitutive* of autonomy carries risks as well.<sup>42</sup> Substantive theories of relational autonomy hold that someone, irrespective of his or her individual make-up, cannot be considered autonomous unless certain social and relational conditions are satisfied.<sup>43</sup> These approaches have been criticized for their paternalistic implications and lack of value neutrality.<sup>44</sup> Sticking to ‘traditional’ theories of autonomy (at least to those that are

<sup>36</sup>For an overview of the concept of relational autonomy, see e.g. Mackenzie and Stoljar (2000) 3–31.

<sup>37</sup>See e.g. Arstein-Kerslake (2017) 62–63; Halmos (2019) 23; Gooding (2013) 435; Peterson et al. (2021) 7; Series (2015) 81.

<sup>38</sup>For the distinction between internalist and externalist accounts of autonomy, see Ashley (2012) 11–13; Series (2015) 82.

<sup>39</sup>Stoljar (2018) ch. 3; Mackenzie and Stoljar (2000) 22; Series (2015) 81; Holroyd (2009) 323.

<sup>40</sup>Peterson et al. (2021) 6.

<sup>41</sup>Series (2015) 81.

<sup>42</sup>Arstein-Kerslake (2017) 63.

<sup>43</sup>Series (2015) 81.

<sup>44</sup>Series (2015) 81; Holroyd (2009) 321.





procedural in nature, i.e. focus on the process of preference formation and not the content of preferences) could be a way to preserve neutrality.<sup>45</sup> However, relational autonomy is not a monolithic concept; besides its substantive accounts, there are procedural versions which seem to be content neutral as well.<sup>46</sup>

#### 4. SUPPORTED DECISION-MAKING AND THE REQUIREMENTS OF THE CRPD

Supported decision-making came into the forefront of attention with the adoption of CRPD. According to its advocates, supported decision-making represents a paradigm shift in mental capacity legislation.<sup>47</sup> Contrary to substitute decision-making, it does not involve the substitution of someone's judgment for the judgment of the person with impaired decision-making ability; rather, it means that the person is enabled to make his or her own decisions through adequate support.<sup>48</sup> Support can come in many different forms. It can mean, for example, assistance in exploring and understanding the choices available for someone.<sup>49</sup> It can also mean helping other people recognize the 'personhood' of the disabled person, i.e. that he or she is someone with a 'history, interests and aims in life'.<sup>50</sup> Countries that introduced supported decision-making did it in different ways.<sup>51</sup> Sections 6 and 7 will briefly touch upon the regulation of supported decision-making in England and Hungary.

The central idea behind supported decision-making is the idea of universal legal capacity. It means that all human beings enjoy legal capacity on an equal basis, irrespective of disabilities – what is different for each person is the amount of support needed to exercise this capacity.<sup>52</sup> The question here is not whether someone has capacity, but what supports are necessary to enable the person to exercise this capacity.<sup>53</sup> It is obvious that everybody needs some form of support to make decisions in life. For example, if someone wants to buy a new car, he may need the help of

<sup>45</sup>Mackenzie and Stoljar (2000) 13–19.

<sup>46</sup>Stoljar (2018) ch.3.

<sup>47</sup>Bach and Kerzner (2010) 9.

<sup>48</sup>Davidson et al. (2015) 61.

<sup>49</sup>United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities (2007) 90.

<sup>50</sup>United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities (2007) 90–91.

<sup>51</sup>Canada was one of the first countries that recognized the importance of supported decision-making. The province of British Columbia, for example, moved in the direction of supported decision-making with the adoption of the Representation Agreement Act in 1996. Section 7 (1) of the Act allows for the creation of representation agreements by which someone can appoint a representative to help him or her make decisions, or to make decisions on his or her behalf. Although the Act recognizes supported decision-making, it also lets the representative to make decisions on behalf of the represented person similarly to a power of attorney. The Adult Guardianship Act of British Columbia also retains the possibility of substitute decision-making. *Devi et al.* (2011) 255; *Arstein-Kerslake* (2017) 190; *Gordon* (2000) 69; *Bach and Kerzner* (2010) 53; *Kanter* (2015) 270; *Arstein-Kerslake and Flynn* (2016) 478 and fn. 44.

<sup>52</sup>Flynn and Arstein-Kerslake (2014a) 90.

<sup>53</sup>Flynn and Arstein-Kerslake (2014a) 90.



a car mechanic to advise him on the reliability of the chosen model.<sup>54</sup> The person may also want to consult his friends, his family, or a financial advisor before making the purchase. Thus, we all make choices based on the model of supported decision-making, and it is possible to argue that the CRPD only recognizes this basic fact of life when making the move from the substitute to the supported decision-making paradigm.

The idea of universal legal capacity, just as the whole approach of the CRPD, is informed by the social model of disability that perceives disability as a social construct.<sup>55</sup> Proponents of the social model argue that disability is not a medical condition; people with mental and physical impairments are ‘disabled’ because the world is arranged in a way to fit the needs of the majority constituted by able-bodied men.<sup>56</sup> Thus, the social model focuses on removing disabling social barriers instead of ‘curing’ or ‘normalizing’ people with impairments.<sup>57</sup> The idea of supported decision-making fits well here. Moreover, the social model can also imply that the whole concept of mental capacity needs to be abandoned because, similarly to disability, it is also a social construct that cannot be objectively established.<sup>58</sup> Mental capacity in the prevailing medical model is primarily seen as a cognitive ability to make rational decisions, an objective medical fact, which is, however, discriminatorily applied to people with cognitive impairments. It is often the stigma of mental disability that leads people to hastily conclude that the given person lacks capacity or that his or her decision-making capacity needs to be medically assessed.<sup>59</sup> Article 12 of the CRPD, at least in its ‘radical’ interpretation, aims to break with this discriminatory practice by completely abolishing substitute decision-making and giving up the idea of distinguishing between people that have and do not have legal capacity based on their disabled status and/or lack of mental capacity.

## 5. THE INTERPRETATION OF THE CRPD

According to Article 12 (2) of the CRPD, ‘States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others’. The meaning of the term ‘legal capacity’ is somewhat vague, especially in civil law jurisdictions, where legal capacity can refer both to the ‘passive’ ability of (all) human beings to hold rights and duties (*jogképeség* in Hungarian, *Rechtsfähigkeit* in German) and the ‘active’ capacity to exercise these rights and to undertake duties (*cselekvőképesség* in Hungarian, *Geschäftsfähigkeit* in German). It is generally accepted that ‘legal capacity’ in the CRPD refers to both concepts; accordingly, the official Hungarian translation of the Convention uses both terms when translating ‘legal capacity’.<sup>60</sup>

<sup>54</sup>Mental Disability Advocacy Center (n.d.) 7.

<sup>55</sup>Kanter (2015) 8, 235; Halmos (2019) 5–7; Arstein-Kerslake (2017) 72.

<sup>56</sup>Arstein-Kerslake (2017) 71.

<sup>57</sup>Arstein-Kerslake (2017) 70–71.

<sup>58</sup>Hall (2012) 63, 71; Arstein-Kerslake (2017) 71–72; Halmos (2019) 27.

<sup>59</sup>Kanter (2015) 241; Halmos (2019) 27.

<sup>60</sup>It needs to be noted that the official Hungarian translation uses the word ‘illetőleg’ to join the two expressions. This word can be interpreted as meaning ‘and’ or ‘or’ depending on context. If interpreted as ‘or’, it allows for a category of people who have the passive ability to hold rights but lack the active capacity to exercise rights or undertake duties. Gombos and Könczei (2009) 10–15, fn. 11. It is also worth pointing that the use of the word ‘illetőleg’ is now forbidden when drafting new legislation. See Section 7 (4) of the 61/2009. (XII. 14.) Decree of the Minister of Justice on Legislative Drafting [61/2009 (XII. 14.) IRM rendelet a jogszabályszerkesztésről].



Translating the term ‘legal capacity’ is not merely a question of semantics. Substitute decision-making regimes, e.g. guardianship regimes characteristic to countries in Continental Europe, while do not affect the status of the individual to hold rights and duties, they do restrict the active capacity to exercise rights and undertake duties, leading to the ‘civil death’ of the person.<sup>61</sup> If the CRPD’s requirement to provide legal capacity to everyone on an equal basis refers to both parts of the concept, then it can be plausibly argued that States Parties are expected to abolish ‘traditional’ regimes of substitute decision-making. The requirement to move towards supported decision-making becomes more explicit in Article 12 (3), which requires that states ‘provide access by persons with disabilities to the support they may require in exercising their legal capacity’. It is possible to argue, however, that the text of the CRPD does not contain a direct obligation to abolish substitute decision-making;<sup>62</sup> it is only the first General Comment (GC1) of the UN Committee on the Rights of Persons with Disabilities, adopted in 2014, which clearly states that the Convention’s new model of disability ‘implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making’.<sup>63</sup> GC1 also makes it clear that the Convention requires the abolition of substitute decision-making; maintaining substitute decision-making and parallelly introducing alternatives of supported decision-making is not sufficient to comply with Article 12. Critics are quick to point out, however, that the Committee is ‘merely’ a body of independent experts with the task of monitoring the implementation of the Convention; its interpretation of the Convention is ‘authoritative’ but not legally binding on States Parties.<sup>64</sup>

GC1 gives a controversial reading of Article 12 of the CRPD. Some praise it as brave step in the direction of establishing legal capacity on an equal basis to all, including persons with disabilities.<sup>65</sup> Others claim that it is too radical, and its implementation raises many practical problems.<sup>66</sup> Besides the complete abolition of substitute decision-making, GC1 also requires that the objective ‘best interests’ paradigm be replaced with the ‘will and preference’ paradigm. Paragraph 29 (b) of the General Comment states that ‘all forms of support in the exercise of legal capacity [...] must be based on the will and preference of the person, not on what is perceived as being in his or her objective best interests’. Although the exact meaning of this requirement is left unclear, the Committee seems to prefer the will and preference model, because it respects individual autonomy, while the best interests standard often imposes ‘external’ values and preferences on the person with impaired decision-making. However, maximizing autonomy

<sup>61</sup>Mental Disability Advocacy Center (2013) 9.

<sup>62</sup>Essex Autonomy Project (2014) 12–13. The ‘silence’ of the CRPD can be interpreted oppositely as well. It is possible to argue that Article 12 rejects the possibility of substitute-decision making because it makes no explicit reference to it. Kanter (2015) 264; Halmos (2019) 27.

<sup>63</sup>UN Committee on the Rights of Persons with Disabilities (2014) section I.3.

<sup>64</sup>Keller and Grover (2012) 129; Essex Autonomy Project (2014) 12–13; Szmukler (2015) e29; Essex Autonomy Project (2016) 54–58; Arstein-Kerslake (2017) 27–28; Halmos (2019) 26. However, this does not mean that states can easily dismiss GC1. They ‘must attach great weight’ to its interpretation of the CRPD, especially that the Committee will use GC1 as a yardstick when monitoring the implementation of Article 12. Szmukler (2015) e29; Arstein-Kerslake (2017) 28.

<sup>65</sup>See e.g. Arstein-Kerslake and Flynn (2016) 485–86.

<sup>66</sup>See e.g. Freeman et al. (2015) 844–45.



sometimes requires going against the individual's actual will and preferences; consider the example of treating someone suffering from anorexia nervosa against his or her will.<sup>67</sup>

Another problem that comes up in relation to supported decision-making is the question of those severely disabled individuals, who, despite all kinds of support, are unable to make decisions on their own. Although only around five percent of people with impaired decision-making capacity belong to this group,<sup>68</sup> the 'will and preferences' paradigm cannot adequately handle these cases, because these people are unable to form or express their will and preferences at all. Substitute decision-making based on the assessment of 'objective' best interests seems inevitable in such cases – however, section 28 of GC1 makes it clear that 'hybrid models' of supported and substitute decision-making are not compliant with the requirements of the CRPD. Instead, GC1 recommends using the 'best interpretation of will and preferences' in cases where it is impossible to determine the actual will and preferences of an individual. This is called facilitated decision-making: the support person does not substitute his own judgment to the judgment of the supported person but facilitates the supported person's decision by trying to ascertain, by any means possible, the person's wishes and preferences. If the person is completely unable to communicate, the 'support person must search for indications of the individual's will and preferences – including speaking to those who know the person well, considering the person's values and belief systems, and taking into account any previous expressions the person may have made about her wishes'.<sup>69</sup> Facilitated decision-making was conceptualized by Bach and Kerzner as a 'last resort' in those cases, where no amount of support is enough to discover the actual will of the individual.<sup>70</sup>

It seems that currently there is no country in the world that fully complies with the requirements of Article 12 of the CRPD as interpreted by the Committee in GC1.<sup>71</sup> Even the most progressive countries, such as Canada, have been criticized by the Committee for upholding their guardianship-style regulations in parallel with the introduction of supported decision-making.<sup>72</sup> I briefly examine the English and the Hungarian statutory frameworks in the following chapters; it seems pretty clear that neither of them complies with the radical interpretation of the CRPD since both preserve substitute decision-making besides introducing mechanisms for supported decision-making. However, a less radical interpretation of the CRPD would allow to distinguish between people with and without capacity, provided that the distinction is based on objective criteria and does not discriminate against people with mental disabilities. It is possible to argue that the English and Hungarian regulations comply with such an interpretation; however, there are concerns that certain elements in the wording and the application of these statutes are still discriminatory to people with mental disabilities.

<sup>67</sup>Essex Autonomy Project (2014) 37–38.

<sup>68</sup>Glen (2015) 12.

<sup>69</sup>Glen quoting Flynn and Arstein-Kerslake (2014b) 131–32. See Glen (2015) 12.

<sup>70</sup>Flynn and Arstein-Kerslake (2014a) 95–96.

<sup>71</sup>Arstein-Kerslake (2017) 64; Halmos (2019) 24.

<sup>72</sup>Arstein-Kerslake and Flynn (2016) 478, fn. 44; UN Committee on the Rights of Persons with Disabilities (12 April 2017) section 27. The 'hybrid' regulation of British Columbia is briefly discussed in fn. 51 above.



## 6. THE CRPD AND THE MENTAL CAPACITY ACT

The Mental Capacity Act creates a model of substitute decision-making based on the concept of best interests. It represents a functional approach which gears an individual's legal capacity to mental capacity, the presence of which is determined by tests aimed at measuring cognitive functioning, e.g. whether the person understands the meaning and consequences of his or her decision.<sup>73</sup> The functional approach is generally considered to be more progressive than the status approach which connects the lack of legal capacity to the mentally disabled status of the individual. The status approach is unacceptable because 'the fact of having a disability alone does not necessarily lead to incompetence';<sup>74</sup> it is discriminatory to take away someone's legal capacity on the sole basis of having been diagnosed with mental disability.<sup>75</sup> Capacity in the functional approach seems to rest on (allegedly) objective criteria, i.e. on cognitive faculties that can be measured by medico-scientific means.<sup>76</sup> Moreover, the functional approach also recognizes that mental capacity is not an 'abstract' concept and always needs to be assessed in relation to a specific decision. Thus, the MCA focuses on someone's ability to perform a particular task and it examines whether the person can 'understand the meaning and consequences of the decision at issue'.<sup>77</sup> This is expressed in section 2 (1) of the MCA, which states that 'a person lacks capacity *in relation to a matter* if at the material time he is unable to make a decision for himself *in relation to the matter* because of an impairment of, or a disturbance in the functioning of, the mind or brain'.<sup>78</sup>

Although the MCA can be praised for introducing a functional approach to legal capacity, there are two major problems that can render the MCA incompatible with the CRPD, even if one does not adopt the 'radical' interpretation of GC1 that requires States Parties to completely abolish substitute decision-making. (1) As discussed in chapter 2, the MCA uses the best interests standard as the standard for substitute decision-making. However, GC1 explicitly calls for the replacement of the 'best interests' paradigm with the 'will and preferences' paradigm. Of course, it is possible to point out that state regulations, like the MCA, are expected to comply with the text of the Convention, and not with GC1; general comments are authoritative but not legally binding sources of interpretation.<sup>79</sup> Even if we disregard GC1, it seems that the best interests standard is still incompatible with Article 12 (4) of the Convention, which requires 'appropriate and effective safeguards' 'to ensure that measures relating to the exercise of legal

<sup>73</sup>Flynn and Arstein-Kerslake (2014a) 86.

<sup>74</sup>Devi et al. (2011) 253.

<sup>75</sup>Statutory reforms during the late twentieth century pushed the status approach into the background. Today, the dominant legislative approach to substitute decision-making is functional, although there are still a few statutes that seem to follow the status approach. The New York Surrogate's Court Procedure Act and the Irish 'ward of court' system are mentioned as potential examples. Arstein-Kerslake (2017) 66, 69, 77–84. Flynn and Arstein-Kerslake (2014a) 86.

<sup>76</sup>The functional approach seems to be informed by the medical model of disability. For the social model of disability and its take on mental capacity, see the last paragraph of Section 4.

<sup>77</sup>Flynn and Arstein-Kerslake (2014a) 86.

<sup>78</sup>Emphasis added.

<sup>79</sup>In support of this claim, see the sources specified in fn. 64.



capacity respect the rights, will and preferences of the person'. It is very well possible that the decision which is in the best interests of someone is not the same as the decision dictated by this person's 'will and preferences'. Although the MCA requires that the best interests decision-maker *considers* the incapacitated person's 'past and present wishes and feelings' and the 'beliefs and values that would be likely to influence his decision', the decision-maker is not bound by these considerations, and can override these, if the 'overall' best interests of the person so dictates.<sup>80</sup> The requirement of the Convention, i.e. respect for the individual's will and preferences, would be met by the MCA if it was amended in a way that gave *precedence* to the person's wishes and feelings over other elements of the best interests standard.<sup>81</sup>

(2) It is possible to argue that the regulation of mental capacity in the MCA, even though based on the seemingly objective functional approach, still discriminates against people with mental disabilities.<sup>82</sup> Establishing the lack of capacity consists of two steps in the MCA. (i) According to the functional test, it needs to be shown that the person is unable to make a specific decision at the time of capacity assessment. Section 3 of the MCA further elaborates on this requirement; it states that a person is unable to make a decision if he is unable to understand, retain, or use or weigh the information relevant to his decision, or if he is unable to communicate his decision. (ii) However, section 2 (1) of the MCA contains an additional requirement, namely that the inability to make a specific decision must be caused by 'an impairment of, or a disturbance in the functioning of, the mind or brain'. This so-called 'diagnostic threshold' can be criticized for being discriminatory on the basis of mental disability: lack of capacity can only be established, and, as a result, substitute decision-making can only be imposed on those people who suffer from some kind of cognitive 'impairment'. The Code of Practice makes it clear that 'impairment' does not only mean mental disabilities, but also includes, for example, delirium, concussion following head injury or the symptoms of alcohol or drug use.<sup>83</sup> However, some argue that the diagnostic threshold is still discriminatory because it 'automatically' selects people with mental disabilities for the functional test, while those without mental disabilities (and without 'impairments') will not be required to prove that they are able to understand, retain, or use or weigh the information relevant to their decisions, even if their decisions seem manifestly unwise.<sup>84</sup> This contradicts Article 5 (2) of the CRPD which prohibits all discrimination on the basis of disability. Theoretically, it would be possible to simply omit the diagnostic threshold from the MCA, but such a remedy is far from being unproblematic.<sup>85</sup>

It is necessary to mention that the idea of supported decision-making also appears in the MCA. LPAs, advance decisions to refuse treatment and IMCAs (Independent Mental Capacity Advocates) can all be considered as instruments facilitating supported decision-making.<sup>86</sup> Moreover, section 1 (3) prescribes that '[a] person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'.

<sup>80</sup>Essex Autonomy Project (2014) 39–40.

<sup>81</sup>Essex Autonomy Project (2014) 47–52.

<sup>82</sup>Arstein-Kerslake (2017) 87–88; Flynn and Arstein-Kerslake (2014a) 87; Essex Autonomy Project (2014) 31–36.

<sup>83</sup>MCA Code of Practice (2007) 44, section 4.12.

<sup>84</sup>Arstein-Kerslake (2017) 91–93; Flynn and Arstein-Kerslake (2014a) 87.

<sup>85</sup>Essex Autonomy Project (2014) 44–47.

<sup>86</sup>Essex Autonomy Project (2016) 23–33, 78–83.



However, as the report of the House of Lords Select Committee points out, supported decision-making is rarely seen in practice.<sup>87</sup> The MCA is mainly regarded as an instrument of substitute decision-making: family members and professional carers, prefer to make decisions, rather than provide support, on behalf of people deemed to lack capacity. This was a major concern for the Committee on the Rights of Persons with Disabilities as well. In its ‘Concluding observations’ on the initial report of the UK, the Committee voiced its concerns about the prevalence of substituted decision-making and urged the UK ‘to speed up the development of supported decision-making regimes’.<sup>88</sup> To be sure, the weak presence of supported decision-making in practice cannot be solely attributed to the shortcomings of the legislative framework. It is also the mentality of people that needs to change, from a protective and paternalistic approach to an enabling and empowering culture of support.<sup>89</sup>

## 7. THE CRPD AND THE HUNGARIAN CIVIL CODE

Although the new Civil Code, adopted in 2013, contains a partial reform of Hungary’s mental capacity legislation, the new regulation fails to meet the requirements of Article 12 of the CRPD. At least five general problems can be identified. (1) The Civil Code introduces the possibility of supported decision-making, but it does not abolish substitute decision-making. The new Act preserves the models of plenary and partial guardianship as instruments of substitute decision-making. Although GC1 was not yet adopted in 2013, the requirement to abolish substitute decision-making was clearly articulated by the CRPD Committee in its review of the Hungarian legislation in 2012. In section 26 of its ‘Concluding observations’, the Committee ‘recommends that the State party [i.e. Hungary] use effectively the current review process of its Civil Code and related laws to take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making’.<sup>90</sup> (2) The present Hungarian system of guardianship distinguishes between legal capacity (*cselekvőképesség*) and mental capacity (*belátási képesség*); legal capacity is contingent on a ‘more or less’ functional assessment of mental capacity.<sup>91</sup> The Civil Code in section 2:19 (2) states that ‘the Court shall place an adult under guardianship partially limiting his capacity to act, if, due to his *mental disorder*, his *ability required to take care of his own affairs is significantly reduced*, permanently or in a temporarily recurring manner’.<sup>92</sup> Two problems arise at this point. (2/a) Similarly to the MCA, the Hungarian regulation seems to contain a ‘diagnostic threshold’ as it requires that the lack of mental capacity be caused by a mental disorder (*mentális zavar*). Mental disorder is left undefined in the Civil Code; critics point out that it is an overly vague term that either needs to be specified or preferably omitted from the wording of the statute.<sup>93</sup> Omitting this

<sup>87</sup>House of Lords Select Committee (2014) 41–43; Beadle-Brown (2015) 25.

<sup>88</sup>UN Committee on the Rights of Persons with Disabilities (29 August 2017) section 31.

<sup>89</sup>Beadle-Brown (2015) 26.

<sup>90</sup>UN Committee on the Rights of Persons with Disabilities (17–28 September 2012) section 26.

<sup>91</sup>The requirement that the lack of mental capacity must be caused by a mental disorder can be interpreted as a ‘remnant’ of the status approach. Halmos (2019) 31.

<sup>92</sup>Emphasis added.

<sup>93</sup>Gurbai et al. (2012) recommendation no. 4.





requirement seems a better solution because even if mental disorder is defined in a *prima facie* neutral manner (i.e. as a concept that does not only include mental disabilities but also other conditions, similarly to the concept of ‘impairment’ in the MCA), it can be applied in a discriminatory way to people with mental disabilities. (2/b) Unlike the MCA, the Civil Code does not define mental capacity.<sup>94</sup> Consequently, it is unclear how the functional assessment of capacity shall happen, i.e. exactly what shall be assessed and who shall perform the capacity assessment. According to relevant judicial practice, a medical diagnosis of mental disorder *per se* is not enough for placing someone under guardianship,<sup>95</sup> it is also necessary that the person’s mental capacity, i.e. his ability required to take care of his own affairs is ‘significantly reduced’ or ‘completely and permanently’ missing. There is, however, no further legal guidance here. Halmos argues that although the decision-making ability relevant to mental capacity is essentially a factual question that can be measured by scientific means, Hungarian judicial practice rarely makes use of expert evidence based on modern psychological methods available for the assessment of capacity.<sup>96</sup> Fiala-Butora points out that in the absence of a statutory definition, forensic experts can arbitrarily determine how they understand mental capacity and by which standard they measure it.<sup>97</sup> (3) A further point of concern is that the regulation of the Civil Code does not sufficiently recognize the situation-specific character of mental capacity. Although in the case of partially limiting guardianship it is necessary to indicate those ‘categories of affairs’ in which the person is deemed to lack capacity, these categories seem to be too wide. For instance, deciding about ‘financial affairs’ implies many different decisions; someone might be able to make some of these, while unable to make others.<sup>98</sup> (4) The regulation of supported decision-making in section 2:38 of the Civil Code is very rudimentary compared to the detailed regulation of guardianship.<sup>99</sup> Although there is a separate Act on supported decision-making,<sup>100</sup> the regulation remains quite superficial, perhaps because supported decision-making was always intended to be merely ‘secondary’ or ‘supplementary’ to guardianship. One problematic issue is that the regulation does not require a relationship of trust between the supported person and the person providing support.<sup>101</sup> Although the Act on supported decision-making prohibits the appointment of a support person against the will of the supported person,<sup>102</sup> this does not necessarily ensure a relationship of trust between the two individuals, which seems essential to the functioning of supported decision-making regimes. Concerns were also raised about the role of the guardianship authority in appointing the support person and the high maximum number of supported individuals a professional support person can look after (30; or 45 in case of public servants).<sup>103</sup> Professional support persons are usually professional guardians who

<sup>94</sup>Fiala-Butora (2019) 16.

<sup>95</sup>Halmos (2019) 32.

<sup>96</sup>Halmos (2019) 32–33.

<sup>97</sup>Fiala-Butora (2019) 16.

<sup>98</sup>Fiala-Butora (2019) 17.

<sup>99</sup>Gurbai et al. (2012) recommendation no. 17.

<sup>100</sup>Act CLV of 2013 on supported decision-making (2013. évi CLV. törvény a támogatott döntéshozatalról).

<sup>101</sup>Mental Disability Advocacy Center (2013) 55. Gazsi (2016) 75.

<sup>102</sup>Act CLV of 2013 on supported decision-making, sect. 2 (3).

<sup>103</sup>Act CLV of 2013 on supported decision-making, sect. 7 (5)–(6).



receive a short training in supported decision-making; their attitude to support is probably determined by their previous experiences as substitute decision-makers.<sup>104</sup> (5) Article 12 (2) of the CRPD requires that ‘measures relating to the exercise of legal capacity respect the rights, will and preferences of the person’. The Civil Code contains no provision with respect to the standard of supported decision-making.<sup>105</sup> Substituted decision-making, as discussed in chapter 2, mostly happens on an objective best interests basis; it is possible to argue that this makes the Hungarian regulation incompatible with the requirements of the CRPD, similarly to the MCA.<sup>106</sup>

## 8. CONCLUSIONS

What conclusions can we draw from the analysis of the English and the Hungarian mental capacity legislations? Firstly, we can establish that neither legislation complies with the requirement of the CRPD as interpreted by GC1 to fully abolish substitute decision-making. Although both jurisdictions recognize supported decision-making, it remains underdeveloped in law and in practice as well. Substitute decision-making dominates the legal landscapes and even though both countries seem to adopt a mostly functional approach to mental capacity, it is possible to argue that mental capacity assessments have the potential to be discriminatorily applied to people with mental disabilities. The seemingly neutral diagnostic threshold of the MCA, similarly to the ‘mental disorder’ expression in the Hungarian Civil Code, seems to ‘single out’ people with mental disabilities. The much-criticized institution of plenary guardianship, i.e. guardianship that completely replaces someone’s legal capacity, remains an option in Hungarian law, even after the adoption of the new Civil Code in 2013. Although partially limiting guardianship tries to confine the limitation of legal capacity to ‘categories of affairs’, these categories are too wide and cannot guarantee that only non-capacitous decisions will be denied legal effect. The MCA seems more progressive in this respect because it recognizes that mental capacity manifests itself in relation to a specific matter and depends very much on the person’s specific situation. This results in a regime that is allegedly less restrictive of personal autonomy than ‘traditional’ guardianship regimes. However, this does not change the fact that both jurisdictions paternalize people with disabilities by allowing that decisions are made for them by someone else.

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