Mental Health, Law and Creating Inclusive Workplaces

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Abstract

A growing body of research has drawn attention to the high levels of disadvantage encountered by people with mental health problems in the labour market. This takes a variety of forms, including higher rates of unemployment and sickness absence, as well as individual experiences of discrimination often linked to the stigmatisation of mental illness. This article explores the role that law can play in creating inclusive workplaces. It reflects on the values that should guide legal intervention, taking its inspiration from the UN Convention on the Rights of Persons with Disabilities and the principles found in capabilities theory. Drawing upon both, the article contends that law can be galvanised to make a more effective contribution, in particular through greater emphasis on the role for positive action and the rights of persons with disabilities to individual and collective participation.

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Introduction

There is increasing public debate on how the state and society respond to mental health problems. International organizations and national governments have identified mental health as a major economic and social challenge. The World Health Organisation (WHO) estimates that 'during their entire lifetime, more than 25% of individuals develop one or more mental or behavioural disorders'.[1] While some argue that the prevalence of mental health problems may be even greater,[2] the '1 in 4' statistic leaves no doubt as to the extensive ramifications of mental health problems.

Public debate often medicalises mental health issues by focusing on questions such as the proportion of the healthcare budget spent on mental health, the quality and adequacy of emergency mental health facilities, or barriers to accessing talking therapies. These are all important themes, but they need to be complemented with a wider vision of how people with mental health problems are treated in other aspects of social life, such as work, housing or education. In a similar vein, law on mental health has traditionally concentrated on issues such as legal capacity in decision-making or the legal framework governing voluntary or involuntary hospital admission. Although disability equality law applies to both mental and physical impairments, Bartlett has noted that there is relatively limited literature on questions such as reasonable accommodation for those with mental health problems.[3]

There are signs that policymakers are increasingly engaging with mental health in a broader horizon. Since the mid to late 1990s, European employment policy has concentrated on increasing the proportion of the population participating in employment.[4] While the economic crisis has made this goal more difficult to attain, the pressure on public finances has incentivised states as they search for ways to move individuals out of welfare dependency and into the labour market. The Organisation for Economic Co-operation and Development (OECD) has urged states to place a spotlight on those with mental health problems, identifying this as the major cause of exit from the labour market due to incapacity and subsequent dependence on disability welfare benefits.[5] For example, it found that around 70% of new disability benefit claimants in the 20-34 year age range were people with mental health problems.[6] A range of policy interventions designed to include (and retain) people with mental health problems in employment can be identified. For example, one response in recent years has been public information campaigns aimed at destigmatising mental health problems.[7] While not exclusively directed at working life, such initiatives aim to change attitudes amongst employers and co-workers, thereby fostering a more supportive environment where individuals feel able to disclose mental health problems. This article examines the role for law within the

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[1] WHO, 'The World Health Report 2001. Mental Health: New Understanding, New Hope' (WHO 2011) 23.

[2] F. Callard, N. Sartorius, J. Arboleda-Flórez, P. Bartlett, H. Helmchen, H. Stuart, J. Taborda and G. Thornicroft, *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (John Wiley & Sons 2012) 79; M. De Lorenzo, 'Employee Mental Illness: Managing the Hidden Epidemic' (2013) 25 *Employee Responsibilities and Rights Journal* 219, 221.

[3] P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 *Modern Law Review* 752, 760.

[4] D. Ashiagbor, *The European Employment Strategy: Labour Market Regulation and New Governance* (OUP 2005) ch 4.

[5] OECD, 'Sickness, Disability and Work: Breaking the Barriers. A Synthesis of Findings Across OECD Countries' (OECD, 2010) 50-51.

[6] Ibid 63.

[7] eg Time to Change: <http://www.time-to-change.org.uk> accessed 17 May 2016; See Change: <http://www.seechange.ie> accessed 17 May 2016.

policy toolbox. It argues that law can make a positive contribution to rendering the workplace more inclusive. This is not simply a question of increasing the number of people with mental health problems who are in work; it concerns also the quality of their labour market experiences and ensuring that a supportive working environment exists. To this end, it reflects on what rationales should underpin legal interventions in this field, taking its lead from the principles found in the UN Convention on the Rights of Persons with Disabilities (CRPD). It links these to the 'capabilities approach' to human development advanced by, in particular, Amartya Sen and Martha Nussbaum. The final section of the article draws upon this theoretical framework to consider the possible implications for law reform of adopting an approach based on the values found in the CRPD. It looks at several examples from current employment law and considers how these might change if the CRPD was fully embraced. Before turning to these issues, section 1 begins by garnering a better appreciation of mental health and work.

1. Painting a Picture of Mental Health and Work

a. Mental Health: Definitions and Debates

The boundaries of mental health, and the most appropriate language to adopt, remain highly contested. Definitions of mental health can be contingent upon time and culture. Some human conditions that were regarded as mental illnesses in the past are no longer viewed as such today, notably homosexuality. The most prominent points of reference within psychiatry for cataloguing mental health problems are the WHO's International Classification of Diseases (ICD)[8] and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).[9] These catalogues provide a framework of reference for psychiatric diagnosis, but their role remains a point of controversy. Critics have argued that 'the DSM has promoted the medicalization of everyday life'[10] and that the expanding list of conditions found therein has facilitated the commercial interests of the pharmaceutical industry through growth in the use of prescription medicines for mental health problems.[11] This reflects a more fundamental debate around how mental health is understood. A rich spectrum of views exists, which can only be touched upon in the context of this article. Some see mental health problems as predominantly having a biological basis, while others place more emphasis on the social and environmental factors that impact on mental health. The appropriate response to mental health problems will reflect, to some extent, the view of the underlying causes. Biological psychiatry tends to favour pharmaceutical treatments and other medical interventions,[12] whereas psychotherapeutic treatments (such as talking therapies) imply causes beyond biology. Whether the emphasis is on psychiatry or psychotherapy, both are premised

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[8] WHO, 'International Statistical Classification of Diseases and Related Health Problems' 10th Revision: <http://apps.who.int/classifications/icd10/browse/2015/en> accessed 17 May 2016. Chapter V covers 'mental and behavioural disorders'.

[9] The fifth edition (DSM-5) was published in 2013. See further: <http://www.dsm5.org/Pages/Default.aspx> accessed 17 May 2016.

[10] J. Cromby, D. Harper, and P. Reavey, *Psychology, Mental Health and Distress* (Palgrave Macmillan 2013) 5.

[11] A. Rogers and D. Pilgrim, *Mental Health and Inequality* (Palgrave Macmillan 2003) 195; S. Fernando, *Mental Health Worldwide: Culture, Globalization and Development* (Palgrave Macmillan 2014) 90.

[12] Rogers and Pilgrim, ibid 203.

on the notion that mental health problems need 'treatment' and there is, at least, the potential for recovery.[13] More radical critiques challenge the very notion of mental illness, questioning the construction of certain human experiences as 'disorders'. These challenges have been found within academic and practitioner commentary, such as the 'anti-psychiatry' critiques since the 1960s,[14] as well as movements representing those who have 'survived' the psychiatric system.[15]

It is beyond the confines of this article to reach any conclusions on these meta-narratives in the world of mental health. Yet it is important to be conscious of the slippery nature of mental health as a concept given that law often begins with a search for definitions. Even if the focus is the workplace rather than healthcare, questions arise about what constitutes a psychosocial occupational risk or when a person with mental health problems should be regarded, in law, as having a disability. The enduring debate around mental health is reflected in the lack of consensus on the most suitable terminology to be used. Some favour the terms 'psychosocial condition'[16] or 'psychosocial disability'.[17] The UN Committee on the Rights of Persons with Disabilities has used the latter,[18] although it is not found in the text of the CRPD. These terms emphasise the social construction of mental health and draw attention to the social and environmental barriers that people with such conditions encounter.[19] In a similar vein, Cromby et al prefer the term 'distress' as a means of reflecting the impact of 'history, place and culture' on how behaviour is interpreted and the impossibility, in their view, of drawing a clear line between 'normal' and 'abnormal' experiences.[20] In contrast, psychiatric epidemiology is more likely to adopt the language of 'mental illness' or 'mental disorder',[21] which arises from a medical diagnosis. While there is little consensus, many advocacy groups continue to use the term 'mental health problems', which was also the language used by the EU Fundamental Rights Agency in its study of anti-discrimination law in this field.[22] Given its common currency, this is the label that will be mostly used in this article, while acknowledging the ongoing conversation amongst activists on this point. In some contexts, 'mental disability' is a label that primarily refers to the experiences of people with intellectual disabilities, such as those with Down Syndrome. This article does not use the term 'mental health problem' as a synonym for intellectual disability, but it is important to recognise that people with intellectual disabilities may also experience mental health problems.

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[13] Ibid 224.
[14] Cromby et al (n10) 4. eg T. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (Secker & Warburg 1962).
[15] Cromby, ibid 140.
[16] A. Lawson, 'People with Psychosocial Impairments or Conditions, Reasonable Accommodation and the Convention on the Rights of Persons with Disabilities' in B. McSherry (ed), *International Trends in Mental Health Laws* (Federation Press 2008) 62, 81.
[17] The Mental Disability Advocacy Centre defines this as: 'those who experience mental health issues or mental illness, and/or who identify as mental health consumers, users of mental health services, survivors of psychiatry, or mad': <http://www.mdac.info/en/books/glossary-0> accessed 17 May 2016.
[18] eg para. 9, General Comment No. 1 (2014), 'Article 12: Equal Recognition Before the Law', Committee on the Rights of Persons with Disabilities, 11th session, CRPD/C/GC/1.
[19] Callard et al (n2) 14.
[20] Cromby et al (n10) 9.
[21] Rogers and Pilgrim (n11) 11.
[22] European Union Agency for Fundamental Rights (FRA), 'The Legal Protection of Persons with Mental Health Problems under Non-Discrimination Law – Understanding Disability as Defined by Law and the Duty to Provide Reasonable Accommodation in European Union Member States' (FRA 2011) 7.

b. Mental Health and Employment

The WHO describes mental health as a 'state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to his or her community.'[23] It is notable that work is placed at the heart of this definition and there is a consensus that, in general, being out of work is negative for mental health.[24] Paradoxically, this does not mean that being in employment is always conducive to mental well-being. The OECD concluded that 'poor-quality jobs can be detrimental for mental health',[25] while some research indicates an association between job insecurity and mental health.[26] It is, though, a complex picture. For example, Clarke et al interviewed 82 workers in precarious employment.[27] They found that the impact on the individual's mental health depended on the degree of insecurity in the job, but also the individual's own aspirations. The strongest association with ill-health was amongst those who wanted secure employment, but for some time had been unable to find permanent, full-time work.[28] Therefore, it is important to consider not only the question of access to the labour market for people with mental health problems, but also the experience of those who find employment. Negative conditions may be detrimental to health, thereby increasing the risk of labour market exit in the long-run.

There is consistent evidence that those with mental health problems are less likely to be in employment. The OECD distinguished between those with 'common mental disorders', such as mild or moderate depression or anxiety, and those with 'severe mental disorders', such as schizophrenia.[29] It concluded that around three quarters of those affected have 'common' mental disorders, and their employment rate was 10-15 percentage points lower than those without a mental disorder; in contrast, the gap was around 25 percentage points for those with severe mental disorders.[30] There is also evidence that the employment participation rate of those with mental health problems is lower than that of people with physical disabilities, such as visual or hearing impairments.[31] At the same time, it may be artificial to erect a rigid dichotomy between physical and mental disabilities as research has indicated that many people with mental health problems also experience other types of disability.[32]

Mental health is a leading cause of absence from work. In the UK, data from general practitioners indicate that, between 2012 and 2014, 60% of certified days of

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[23] WHO, 'The World Health Report 2001. Mental Health: New Understanding, New Hope' (WHO 2001) x.
[24] OECD, 'Sick on the Job? Myths and Realities about Mental Health and Work' (OECD 2011) 203; M. Henderson and I. Madan, 'Mental Health and Work' in S. Davies (ed.), *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence* (Department of Health 2014) 160; Rogers and Pilgrim (n21) 18.
[25] ibid.
[26] Henderson and Madan (n24) 159.
[27] M Clarke, W Lewchuk, A de Wolff, and A King, '"This just isn't sustainable": Precarious Employment, Stress and Workers' Health' (2007) 30 *International Journal of Law and Psychiatry* 311.
[28] Ibid 321.
[29] OECD (n24) 201.
[30] Ibid 202.
[31] N. Coleman, W. Sykes, and C. Groom, 'Barriers to Employment and Unfair Treatment at Work: a Quantitative Analysis of Disabled People's Experiences' Research Report 88 (Equality and Human Rights Commission 2013) Tables 2.1 and 2.14.
[32] D Watson and B Maître, 'Emotional, Psychological and Mental Health Disability' (Economic and Social Research Institute/National Disability Authority 2014) 19.

sickness absence were due to mental ill-health.[33] Moreover, between 2009 and 2013 the number of days off work due to stress, depression and anxiety increased by 24%.[34] The 2013 EU Labour Force Survey found that these were the most commonly reported forms of work-related health problem in the UK.[35] Earlier European research identified stress, depression and anxiety as giving rise to longer absences from work than other forms of ill-health: 32.2% experiencing these conditions had been off work for over one month in the past year.[36] Research on depression found that 10% of European workers had taken time off as a result, with the average time lost per episode being 36 days.[37]

While mental health problems frequently lead to absence from work, there is also evidence of presenteeism amongst those affected. Research suggests that workers are frequently reluctant to inform their employers that they need time off due to mental health problems.[38] This leads workers who are unwell to continue attending the workplace. Consequently, a hidden cost of mental health problems is the reduction in productivity experienced by those who are at work, but unwell.[39]

The intersection between work and mental health also reflects the latter's point of onset. As many mental health problems only emerge later in life,[40] the individuals affected are often already in the labour market. As noted above, work can play a positive role in maintaining good mental health, but adverse circumstances in the workplace can also be a trigger for mental health problems. In the UK, data from general practitioners on the causes of mental ill-health cited 'factors intrinsic to the job' in 41% of cases (eg workload), and 'changes at work' in 12% of cases (eg new management).[41] Clarke et al found stress-related health problems were connected to experiences of precarious employment.[42] Their participants reported difficulties with long working hours coupled with job (and income) insecurity, which meant that such workers were reluctant to take the risk of turning down work. The unpredictability of when work would be offered meant that it became problematic to combine work with family/social commitments.

Some data indicate that experience of mental health problems is not spread evenly across workers. In the EU Labour Force Survey, when asked to identify their most serious work-related health problem during the past 12 months, over 25% of those with a higher level of education cited stress, depression or anxiety, but the

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[33] Health and Safety Executive (HSE), 'THORGP01-Ill-health: number of diagnoses and associated sickness absence by diagnostic category, 3 year average': <http://www.hse.gov.uk/Statistics/tables/index.htm#thor> accessed 17 May 2016.
[34] Henderson and Madan (n24) 158.
[35] Of those reporting work-related health problems, 41.8% in the UK cited stess, depression or anxiety: EU Labour Force Survey, 'Accidents at Work and Other Work-Related Health Problems' (2013) lfso_13: available at: <http://ec.europa.eu/eurostat/web/lfs/data/database> accessed 17 May 2016. See Table hsw_pb5: 'Persons reporting a work-related health problem by sex, age and type of problem'.
[36] The figure was 25.3% for those with back problems: A. Venema, S. van den Heuvel and G. Geuskens, 'Health and Safety at Work. Results of the Labour Force Survey 2007 ad hoc module on accidents at work and work-related health problems' (TNO 2009) 66.
[37] HR Leadership Forum to Target Depression in the Workplace, 'Depression in the Workplace in Europe: A Report Featuring New Insights from Business Leaders', 3: <http://targetdepression.com> accessed 19 March 2015.
[38] De Lorenzo (n2) 224.
[39] OECD (n24) 203; HR Leadership Forum (n37) 3.
[40] Watson and Maître (n32) 17.
[41] HSE, 'THORGP14 - Mental ill-health by precipitating event, 3 year aggregate total': <http://www.hse.gov.uk/statistics/tables/index.htm#thor> accessed 17 May 2016.
[42] Clarke et al (n27).

corresponding figure was less than 10% for those with a lower level of education.[43] There is also evidence that professional/management employees are over-represented amongst those with mental health problems who bring litigation alleging disability discrimination.[44] Of course, the significance of litigation data must be balanced by an acknowledgement that high income employees are better placed to embark upon legal proceedings. Moreover, the overall picture is one where 'higher prevalence rates for a range of mental health problems are found amongst those in the lowest social classes'.[45]

c. Mental Health and Stigma

Goffman's classic work on stigma opens by defining this as 'the situation of an individual who is disqualified from full social acceptance'.[46] This is due to possession of 'an attribute that is deeply discrediting'.[47] Mental health is surrounded by stereotypes of dangerousness and deviance, with a history of social responses often based on detention and social segregation. Attitudinal studies offer some insight into whether, and to what extent, people continue to view mental health as discrediting. The annual 'Attitudes to Mental Illness' survey in the UK suggests that stigma may have declined. In 2013, 10% of people agreed with the statement: 'people with mental illness should not be given any responsibility', whereas this figure had been 20% in 1995.[48] Nevertheless, there remains evidence of persistent stereotypes; for example, 32% said that usually someone who is mentally ill 'is prone to violence'.[49] Studies elsewhere also reveal evidence of the effects of stigma within the labour market. For example, Scheid's research in the USA found that employers were less comfortable with recruiting an employee with a record of mental health problems than, by comparison, employees who had dropped out of high school or who had no prior work experience.[50]

The experience of stigma can be distinguished between 'enacted' and 'felt' stigma.[51] Thornicroft defines enacted stigma as 'episodes or events of discrimination against people who are considered unacceptable'.[52] There is significant evidence to confirm that people with mental health problems regularly encounter enacted stigma.[53] A survey of 732 people with a diagnosis of schizophrenia across 27 countries found that 29% linked their diagnosis to difficulties in finding or keeping a

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[43] Venema (n36) 66.
[44] G. Lockwood, C. Henderson and G. Thornicroft, 'Mental Health Disability Discrimination: Law, Policy and Practice' (2014) 14 *International Journal of Discrimination and the Law* 168, 172; T. Scheid, 'Stigma as a Barrier to Employment: Mental Disability and the American with Disabilities Act' (2005) 28 *International Journal of Law and Psychiatry* 670, 673.
[45] Rogers and Pilgrim (n21) 18.
[46] E. Goffman, *Stigma – Notes on the Management of Spoiled Identity* (Penguin 1963) 9.
[47] Ibid 13.
[48] TNS BRMB, 'Attitudes to Mental Illness 2013 Research Report' (2014), 9: <http://www.mind.org.uk/news-campaigns/news/survey-shows-greatest-improvement-in-public-attitudes-to-mental-health-in-20-years/#.VQq-xMZOKS1> accessed 17 May 2016.
[49] Ibid 24.
[50] 43.1% were uncomfortable with employing someone receiving treatment for depression: Scheid (n44) 681. For further international research on mental health and stigma, see the overview in G. Thornicroft, *Shunned: Discrimination Against People with Mental Illness* (OUP 2006) 175.
[51] Thornicroft, ibid 156.
[52] Ibid.
[53] Ibid 51. See also, H. Stuart, 'Mental Illness and Employment' (2006) 19 *Current Opinion in Psychiatry* 522.

job.[54] A major study in the UK found that 18.6% of people using mental health services had experienced discrimination in finding a job, while the corresponding figure was 16.6% for keeping a job.[55]

The prevalence of enacted or experienced stigma is correlated to the existence of 'felt' stigma, also referred to as 'self stigma' or 'anticipated discrimination'. Thornicroft defines this as including 'the experience of shame of having a condition, and the fear of encountering enacted stigma'.[56] He cites an interview where a man speaks vividly about feeling '"branded" mentally ill for life'.[57] Goffman argued that the nature of stigma was such that 'shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being a defiling thing to possess'.[58] The demoralisation inherent in felt stigma may lead individuals to experience lower self-esteem and to expect discrimination from others.[59] The corollary of such sentiments is that individuals may seek to isolate themselves from the risk of encountering discrimination, for example, by withdrawing from the labour market.[60] Comparative research on people with schizophrenia recorded that 69% anticipated discrimination in finding or keeping employment.[61] Research in England has also uncovered this phenomenon: a 2011 study found that 46% of mental health service users reported not looking for work due to anticipated discrimination.[62]

To be clear, the argument is not that people with mental health problems are generally uninterested in finding work; this is contradicted by evidence showing a strong interest in labour market participation.[63] Yet the process of (re)entering the labour market creates a jeopardy. If the individual discloses their record of mental health problems, then they may encounter discrimination, which could deepen the adverse effects of previous instances of enacted stigma. Alternatively, the individual may seek to 'pass',[64] by concealing this information. This may, however, generate anxiety about the risk of this information being disclosed at a later point in time, and the anticipation of discrimination as a result (felt stigma). In short, stigma can become a major factor in shaping labour market experience and behaviour.

While stigma is a significant dimension to mental health, its role remains a point of debate. There has been criticism that a focus on stigma can obscure the role played by discrimination.[65] A narrow view of stigma could see this as a problem of attitudes that can be corrected by changing public opinion. If society were better

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[54] G. Thornicroft, E. Brohan, D. Rose, N. Sartorius, and M. Leese, 'Global Pattern of Experienced and Anticipated Discrimination Against People with Schizophrenia: a Cross-Sectional Survey' (2009) *The Lancet* 408, 410.

[55] E. Corker, S. Hamilton, C. Henderson, C. Weeks, V. Pinfold, D. Rose, P. Williams, C. Flach, V. Gill, E. Lewis-Holmes and G. Thornicroft, 'Experiences of Discrimination Among People Using Mental Health Services in England 2008-2011' (2013) 202 *The British Journal of Psychiatry* s58, s61.

[56] Thornicroft (n50) 156.

[57] Ibid 153.

[58] Goffman (n46) 18.

[59] Scheid (n44) 673.

[60] Thornicroft (n50) 161.

[61] Thornicroft et al (n54) 412.

[62] G. Thornicroft, S. Evans-Lacko, and C. Henderson, 'Stigma and Discrimination' in S. Davies (ed.), *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence* (Department of Health 2014) 179, 180. See also, L. Sayce, 'Stigma, Discrimination and Social Exclusion: What's in a Word?' (1998) 7 *Journal of Mental Health* 331, 334.

[63] See research cited by Thornicroft (n50) 51.

[64] '… the management of undisclosed discrediting information about self': Goffman (n46) 58.

[65] eg Sayce (n62); L. Mac Gabhann, R. Lakeman, P. McGowan, M. Parkinson, M. Redmond, I. Sibitz, C. Stevenson, and J. Walsh, 'Hear My Voice: The Experience of Discrimination of People with Mental Health Problems in Ireland' (Dublin City University 2010) 7.

informed about mental health issues, then it would adopt a more enlightened outlook. In turn, this would improve the self-esteem of those encountering mental health problems and enable them to overcome felt stigma. To some extent, this philosophy can be traced in the public education and awareness-raising campaigns on mental health. While there is evidence of the potential contribution that these can make,[66] there are shortcomings in viewing stigma as mainly about outlook. First, it presupposes that greater familiarity with mental health will change attitudes. Various commentators have questioned this hypothesis, pointing out that the evidence suggests a more complex relationship between awareness and attitudes to mental health.[67] Secondly, by concentrating on attitudes, it neglects the importance of behaviour. Discrimination in employment, for example, is manifested through behaviour, such as not appointing someone due to their mental health history or sidelining an employee when she returns to work after an absence related to mental health. The experience of other equality characteristics illustrates that mere familiarity with the 'other' does not necessarily lead to the disappearance of discrimination. Moreover, some forms of discrimination do not appear to be caused by stigma. In particular, discrimination that arises from a failure to provide reasonable accommodation may be due to a variety of factors, such as resistance to organisational change on the part of management or co-workers. Thornicroft has tried to redress these gaps by defining stigma as:

> '1. problems of knowledge (ignorance)
> 2. problems of attitudes (prejudice)
> 3. and problems of behaviour (discrimination).'[68]

He has also drawn attention to the role of 'environmental factors', such as the organisation of work.[69]

d. Mental Health and Work: A Summary

This section has reviewed a range of statistical data and academic literature relating to mental health and work. This provides evidence that some people leave employment due to the severity of their health problems, while others are excluded due to discrimination. The stigmatisation of mental health reinforces social exclusion, sometimes leading people to avoid labour market engagement due to the anticipation of discrimination. There is a twofold challenge: (1) to increase the number of people with mental health problems in employment, and (2) to make the working environment more supportive in order that work is a positive experience conducive to maintaining good mental health. The question explored in this article is the role that law can play in promoting an inclusive labour market, both in terms of getting a job and also the experience of working life. The next section examines this question from a theoretical perspective by exploring what rationales should underpin legal intervention.

2. Identifying Principles To Guide Legal Intervention

When approaching issues surrounding mental health and work, it must be acknowledged that law has the capacity to exercise both a positive and a negative

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[66] eg Thornicroft et al (n62) 182-186.
[67] Sayce (n62) 338; Mac Gabhann (n65) 9; Thornicroft (n50) 186.
[68] Thornicroft, ibid 182.
[69] Ibid.

influence. Historically, law has often been used as an instrument to constrict the social opportunities of those with a record of mental health problems, for example, through disqualification from holding certain occupations.[70] Although mandatory exclusions from the workplace are no longer common (at least in the UK), there remains the potential for risk regulation to be deployed in a manner that generates discrimination related to mental health. For example, in the wake of the Germanwings air crash, concerns were expressed that this could provoke unjustified negative treatment of those with depression due to safety concerns.[71] It is, therefore, necessary to reflect on the principles that guide the intervention of law to ensure that the foundation is one that fosters social inclusion. This section argues that such principles can be found today in the CRPD and that its provisions chime with an approach grounded in human capabilities theory. To this end, it begins by examining the Convention and then turns to explore its theoretical underpinnings.

a. Mental Health and the CRPD

Since its adoption in December 2006, the CRPD has rapidly become the global point of reference for contemporary understanding of disability rights. At the time of writing, it has been ratified by over 160 states from a broad spectrum of legal and social traditions,[72] indicating its transcendence of national diversity. The Convention recognises the evolving ways in which disability is understood and accommodates this standpoint through a non-exhaustive definition of disability.[73] Article 1 states:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

This is accompanied by paragraph (e) in the preamble: 'disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'. Importantly, the CRPD thus includes mental impairments in the same manner as other forms of impairment, a point that generated resistance from some states during its negotiation.[74]

Various commentators have viewed the (partial) definition of disability in Article 1 CRPD as reflecting a shift away from a medical model of disability, and its replacement by an embrace of the social model.[75] There is an extensive body of

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[70] e.g. s.3 Mental Health (Discrimination) Act 2013 repealed provisions that permitted a company directorship to be terminated on grounds of mental health.

[71] 'Don't stigmatise depression after Germanwings crash, says top doctor', *The Observer*, 28 March 2015, available at: <http://www.theguardian.com/world/2015/mar/28/germanwings-plane-crash-alps-depression-doctor> accessed 17 May 2016.

[72] <https://www.un.org/development/desa/disabilities/resources/united-nations-enable-newsletter.html> accessed 17 May 2016.

[73] G. Szmukler, R. Daw, and F. Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37 *International Journal of Law and Psychiatry* 245, 246.

[74] G. de Búrca, 'The European Union in the Negotiation of the UN Disability Convention' (2010) 35 *European Law Review* 174, 190.

[75] e.g. L. Waddington, 'A New Era in Human Rights Protection in the European Community: The Implications of the United Nations' Convention on the Rights of Persons with Disabilities for the European Community', Maastricht Working Papers, 2007-4, Maastricht University, Faculty of Law, 4; E. Flynn, 'Ireland's Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?' (2009) 31 *Dublin University Law Journal* 357; Bartlett (n3) 758. For a more critical perspective on CRPD's concept of disability, see R. Kayess and P. French, 'Out of Darkness Into Light? Introducing the Convention on the Rights of Persons with Disabilities?' (2008) 8 *Human Rights Law Review* 1, 21.

academic literature debating the parameters of the social model, and variants thereto.[76] Without delving into that (heated) conversation, for current purposes it is sufficient to identify the particular value for mental health of the Convention's shift away from medicalisation. As mentioned earlier, mental health is a field where there continues to be great contestation of categorization and diagnosis. An approach to disability rights that rested upon clinically recognised mental health impairments could easily get mired in controversies over whether an individual's experience fits within the confines of a psychiatric disorder.[77] While the Convention's text presupposes some concept of what constitutes a long-term mental impairment, the disability arises from the interaction of this impairment with social/environmental barriers. Therefore, the focal point of disability is no longer exclusively personal medical history; rather it means identifying the inequalities and exclusions that are generated by the combination of impairment and barriers. The lower significance of medical diagnosis is underscored by the reference in the preamble to 'attitudinal' barriers. As discussed in the first part of this paper, some forms of discrimination experienced by people with mental health problems are caused by stigma; for example, a reluctance to hire someone who previously had time off work for mental health reasons. Where disability stems from attitudinal barriers, then it becomes evident that the precise nature of the impairment should be less important.[78] Greater difficulty may arise from the reference in Article 1 CRPD to the 'long-term' nature of the impairment. Mental health can fluctuate over time; for example, depression may be episodic for some people. Kelly points out that temporary mental illnesses risk falling outside the CRPD.[79]

b. Orienting Law and Policy Under the CRPD

In exploring how the CRPD can guide interventions on mental health at work, it is helpful to begin with consideration of its horizontal provisions, reserving more detailed analysis of Article 27 on work and employment to the third section of this article. Of particular note is Article 3, which identifies eight principles that animate the Convention. They are:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
(b) Non-discrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
(e) Equality of opportunity;
(f) Accessibility;

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[76] An overview can be found in D. Hosking, 'A Critical Study of European Union Law and Policy Related to Disability' (2012) Ph.D. thesis, University of Leicester, ch 3. Available at: <http://hdl.handle.net/2381/10377> accessed 17 May 2016. See further: T. Shakespeare, *Disability Rights and Wrongs Revisited* (2nd edn, Routledge 2014) ch 2; S. Mitra, 'The Capability Approach and Disability' (2006) 16 *Journal of Disability Policy Studies* 236.

[77] cf. the requirement for a diagnosable psychiatric disorder in personal injury claims: J. Ahuja, 'Liability for Psychological and Psychiatric Harm: the Road to Recovery' (2015) 23 *Medical Law Review* 27. Originally, the Disability Discrimination Act 1995 included a requirement that mental impairments be 'clinically well-recognised', but this was subsequently repealed: see further, G. James, 'An Unquiet Mind in the Workplace: Mental Illness and the Disability Discrimination Act 1995' (2004) 24 *Legal Studies* 516, 523.

[78] E. Emens, 'The Sympathetic Discriminator: Mental Illness, Hedonic Costs, and the ADA' (2005-2006) 94 *Georgetown Law Journal* 399, 486.

[79] B. Kelly, *Dignity, Mental Health and Human Rights: Coercion and the Law* (Ashgate 2015) 95.

(g) Equality between men and women;
(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

In her analysis of the drafting of the CRPD, de Búrca notes that the EU initially favoured an approach centred on non-discrimination, which reflected its own legislation, rather than the guaranteeing of substantive rights.[80] It was, though, a vision of the latter that won through. As a consequence, the CRPD is premised upon a broad understanding of what equality entails. The framework of values found in Article 3 reveals a vision that intertwines the realisation of equality with 'respect for difference'. The CRPD is unequivocal that equality for persons with disabilities goes beyond a narrow concept of formal equal treatment based upon sameness; instead, it embraces the idea that disability equality often involves change to the standard way of doing things.[81] This is reinforced by Article 5 on 'equality and non-discrimination', which incorporates a duty to provide reasonable accommodation, as well as endorsing the legitimacy of positive action. Article 5(4) states: 'specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.' In contrast, the equivalent provisions in the UN Conventions on Discrimination Against Women[82] and Racial Discrimination[83] characterise special measures as only temporary in duration.

It is clear, therefore, that the concept of equality found in the CRPD implies considerable social and institutional change.[84] The substantive articles of the Convention provide more guidance on what this transformation might entail for specific areas of social life, such as education, healthcare and work. Given that responding to, and respecting, difference is at the heart of disability equality, this poses the challenge of ensuring that any diversity of treatment or provision does not perpetuate inequality. For example, an employment scheme for persons with disabilities that reinforced segregation from the open labour market might conflict with the goals of equality even though it could be superficially depicted as responding to the needs of those experiencing labour market exclusion. Critically, the principles found in Article 3 help to navigate this terrain by providing a set of values that can be used to interrogate whether different treatment favours equality. In particular, dignity, autonomy and independence provide yardsticks through which to evaluate the appropriateness of special measures for persons with disabilities. Their focus on enabling individuals to have a range of valuable choices in life, for example, with regard to one's career, give substance to the meaning of equality. This has led several authors to draw a link between the concept of equality in the CRPD and the 'capabilities approach' to human development.[85]

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[80] de Búrca (n74) 188.
[81] S. Fredman, 'Disability Equality: A Challenge to the Existing Anti-Discrimination Paradigm?' in A. Lawson and C. Gooding (eds), *Disability Rights in Europe: From Theory to Practice* (Hart Publishing 2005) 203; Kayess and French (n75) 8.
[82] Art 4(1), Convention on the Elimination of All Forms of Discrimination Against Women.
[83] Art 1(4), Convention on the Elimination of All Forms of Racial Discrimination.
[84] A. Broderick, *The Long and Winding Road to Equality and Inclusion for Persons with Disabilities* (Intersentia 2015) 139.
[85] Broderick, ibid 28. E. Albin, 'Universalising the Right to Work of Persons with Disabilities: An Equality and Dignity Based Approach' in V. Mantouvalou (ed), *The Right to Work: Legal and Philosophical Perspectives* (Hart Publishing 2015) 61; C. Harnacke, 'Disability and Capability: Exploring the Usefulness of Martha Nussbaum's Capabilities Approach for the UN Disability Rights Convention' (2013) 41 *Journal of Law, Medicine & Ethics* 768; B. Clough, '"People Like That": Realising The Social Model in Mental Capacity Jurisprudence' (2015) 23 *Medical Law Review* 53; K.

c. The Capabilities Approach

The capabilities approach is most prominently connected to the writings of Amartya Sen and Martha Nussbaum. This section reflects on what it entails and how this dovetails with the CRPD.

The capabilities approach stems from a critique of comparative measures of human development. A commonly used indicator of relative economic circumstances is Gross National Product (GNP) per capita. Yet this reveals very little about the distribution of resources within a particular country, nor what those resources permit individuals to accomplish.[86] Even if GNP is relatively high in a particular state, this may conceal great internal disparities in the distribution of wealth. A more penetrating critique challenges the assumption that equality would be achieved if all persons in the country enjoyed a similar level of income. Sen has pointed out that this fails to acknowledge the different resources needed by individuals to accomplish the same tasks.[87] For example, some conditions mean that individuals avoid close physical contact with other people. If public transport is underfunded and this leads to overcrowding, then such individuals might decide that the only way they can travel to work is via private car. In this case, the resources required to go from home to work for a disabled person are greater than those needed by a person without a disability. Indeed, there is evidence that, in general, the living costs of disabled people are frequently higher due to factors such as healthcare expenses, or additional outlay in managing the home environment.[88] Therefore, an arithmetically even distribution of resources to all people will not produce equal opportunities in life activities; some need more resources to accomplish the same outcomes.[89]

The capabilities approach offers an alternative vision of 'equality as a political goal'.[90] Nussbaum has offered the following summary:

> Instead of asking "How satisfied is person *A*," or "How much in the way of resources does *A* command," we ask the question: "What is *A* actually able to do and to be?" In other words, about a variety of functions that would seem to be of central importance to a human life, we ask: Is the person capable of this, or not?[91]

Nussbaum has been willing to offer a catalogue of ten 'central human capabilities', which she views as 'requirements of a life with dignity'.[92] These include the principle of 'affiliation', under which she places 'being able to be treated as a dignified being whose worth is equal to that of others'.[93] In the context of this article, Principle 10 can be underlined as this includes control over one's material environment, further specified to include 'the right to seek employment on an equal basis with others …

Whalley Hammell, 'Quality of Life, Participation and Occupational Rights: a Capabilities Perspective' (2015) 62 *Australian Occupational Therapy Journal* 78.

[86] M. Nussbaum, *Women and Human Development – The Capabilities Approach* (Cambridge University Press 2000) 60.

[87] A. Sen, *Inequality Reexamined* (OUP 1995) 148.

[88] T. Burchardt, 'Capabilities and Disability: the Capabilities Framework and the Social Model of Disability' (2004) 19 *Disability & Society* 735, 747; S. Mitra, 'The Capability Approach and Disability' (2006) 16 *Journal of Disability Policy Studies* 236, 245.

[89] M. Nussbaum, 'Capabilities and Human Rights' (1997-1998) 66 *Fordham Law Review* 273, 284.

[90] M. Nussbaum, 'Capabilities as Fundamental Entitlements: Sen and Social Justice' (2003) 9 *Feminist Economics* 33.

[91] Nussbaum (n89) 285.

[92] Nussbaum (n90) 40. The ten categories are: life; bodily health; bodily integrity; sense, imagination, and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment. The list is not intended to be static and Nussbaum expressly leaves space for national deliberation on more precise delineations.

[93] ibid 42.

being able to work as a human being, exercising practical reason, and entering into meaningful relationships of mutual recognition with other workers'.[94]

The capabilities approach implies that resources need to be mobilised to ensure that all people possess the central human capabilities, such as being able to engage in dignified work. It differs, though, from an approach based on equality of outcomes or results. This rests on the distinction drawn between *capabilities* and *functionings.* Sen describes the latter as 'beings and doings', such as 'being adequately nourished, being in good health'.[95] The onus is on the state to ensure that people are placed in a position where they enjoy the full range of capabilities, but it is a matter of choice as to how individuals exercise these 'abilities to function'.[96] Nussbaum provides the example of the capability to 'play', which includes enjoying recreational activities.[97] Notwithstanding the capability to play being secured to all, there might be individuals who are so passionate about their work that they choose not to engage in leisure pursuits. Likewise, the capabilities approach allows for the possibility that some people, even though capable of undertaking full-time, paid employment might make other choices in life. This poses a challenge to some aspects of contemporary employment policy, which has often been based around maximising labour market participation. While this is frequently linked to equality objectives, such as increasing the proportion of women, older people and people with disabilities in employment, critics have queried the devaluation of other life choices, such as voluntary work or combining work with other valued activities like study or pastimes.[98]

Perhaps the most troublesome aspect of the capabilities approach is how to ascertain when individuals enjoy the full set of capabilities, yet freely make choices with regard to their functioning that might raise doubts over whether equality has been secured. The data cited in the first section of this report indicates that many people with mental health problems are not currently in employment. The capabilities approach indicates that we need to understand the reasons for this in order to grasp if this is problematic. If individuals are denied the capability to pursue employment because of barriers such as discrimination, or the way in which work is currently organised, then more action is required to realise this capability for all. Yet there may be others for whom not engaging in employment cannot be attributed to such obstacles. For example, the National Disability Survey in Ireland asked whether individuals who were not currently in employment were 'interested in employment'.[99] Almost half of those with emotional, psychological and mental health (EPMH) disabilities responded that they were not interested in employment.[100] This may be linked to state of health as the majority of those with such disabilities responded that they were 'unable to work because of illness or disability'.[101] If the capabilities approach implied that we view the latter group as simply having 'chosen' not to work, and hence not requiring any further intervention, then that would be problematic. It

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[94] ibid.
[95] Sen (n87) 38.
[96] Albin (n85) 74.
[97] Nussbaum (n86) 80.
[98] M. Orton, 'Flourishing Lifes: the Capabilities Approach as a Framework for New Thinking about Employment, Work and Welfare in the 21st Century' (2011) 25 *Work, Employment and Society* 352, 354; A. Somek, *Engineering Equality: An Essay on European Anti-Discrimination Law* (OUP 2011) 9.
[99] D Watson and B Maître, 'Emotional, Psychological and Mental Health Disability' (Economic and Social Research Institute/National Disability Authority 2014) 58.
[100] 47% of male respondents and 48% of female respondents, ibid.
[101] ibid 56.

does not, though, take a simplistic view of how human choice is exercised. It insists on an interrogation of the conditions necessary for exercising free choice.

Nussbaum draws attention to 'the many ways in which habit, fear, low expectations, and unjust background conditions deform people's choices and even their wishes for their own lives'.[102] Likewise Sen evokes the idea of those who come to view deprivation with 'non-grumbling resignation'.[103] This phenomenon, summed up in the notion of 'adaptive preferences',[104] can be applied to the situation of those with mental health problems. As discussed in the first section of this article, one of the effects of stigma can be that individuals choose not to engage in employment due to fears of anticipated discrimination and dilemmas around whether and when to disclose a record of mental health problems. Being cognisant of the impact of stigma, labour market 'choices' demand a critical evaluation. For example, considering the results of the National Disability Survey cited above, there is a need to probe why half of those with EPMH disabilities were uninterested in work. While this might be a personal choice for some, for others it might reflect the perceived inaccessibility of the type of work available in the labour market. In a follow-up question, 52% of those with EPMH disabilities said 'flexible work arrangements' would be necessary to enable someone with such a disability to take up employment.[105] As mentioned above, Nussbaum refers to the capability of 'being able to work as a human being'.[106] This reminds us of the twofold dimension to including people with mental health problems in the labour market. It is not simply a question of being able to find a job, but attention is also needed to the experience of the working environment. If people with disabilities are unable to locate jobs that are conducive to maintaining mental health, then real choice and autonomy may be missing.

d. Mental Health and the Capabilities Approach

Having outlined the broad contours of the capabilities approach, the question arises whether this offers an appropriate theoretical framework for advancing disability rights, and specifically the rights of people with mental health problems. This is a legitimate question because initially the capabilities approach did not pay special attention to disability.[107] Indeed, some of its early propositions were troubling. For example, writing in 1997, Nussbaum said that she was focusing on 'adults who have full mental and moral powers' in relation to the choices that individuals made once they acquired the full set of capabilities.[108] In later work, however, she expanded her horizons to acknowledge mental disability.[109] In 2003, she recognised 'many types of dignity in the world, including the dignity of mentally disabled children and adults'.[110] She argued for a 'human lifecycle' perspective based around the heightened dependency on others that many people experience at some point in life.

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[102] Nussbaum (n86) 114.
[103] Sen (n87) 55.
[104] Nussbaum (n89) 283.
[105] Watson and Maître (n99) 59.
[106] Nussbaum (n90) 42.
[107] Sen does recognize that mental disability is amongst the reasons that can lead an individual to need greater resources in life to undertake the same activities as those without disability: (n87) 148.
[108] Nussbaum (n89) 291. Specifically, she was distinguishing adults from children in this paragraph. See also, Nussbaum (n86) 90.
[109] See, in particular, M. Nussbaum, *Frontiers of Justice – Disability, Nationality, Species Membership* (Harvard University Press 2007).
[110] Nussbaum (n90) 54.

Based on this observation, she incorporated 'care for physical and mental dependency needs' as a necessary element of securing the central human capabilities to all.[111] Nevertheless, Vorhaus draws attention to the underpinning premise in Nussbaum's work that human dignity is only realised when an individual is provided with the resources necessary to exercise each of the central human capabilities.[112] He argues that this provides an insufficient response to those with profound disabilities. Even if some of the central human capabilities may be unattainable (irrespective of the support provided), this should not preclude the idea that life can be lived with dignity.[113]

In a meta-level critique, Dean argues that the capabilities approach is inherently constrained because it is a liberal theory that fails to challenge the fundamentals of a capitalist economic system, such as the commodification of labour.[114] He queries the individualistic leanings of the capabilities approach, notably its emphasis on choice with regard to how individuals use their capabilities. From a different angle, Fredman has also queried the role ascribed to individual choice.[115] She suggests that this neglects the relational dimension to a flourishing life, giving the example of caring, which may be performed as a responsibility flowing from affective bonds, rather than a freely exercised choice. In response to Dean's critique, it must be accepted that the capabilities approach does not bring into question the market economy *per se*, but instead it attempts to tackle some its limitations. In this regard, Albin highlights the space within the capabilities approach for valuing forms of employment other than paid work.[116] This is particularly relevant in the context of those with serious mental health problems, who may be the furthest away from inclusion in mainstream employment. For example, Simon et al conducted research with over 300 people who, in the recent past, had been involuntarily detained in hospital under the Mental Health Act 1983;[117] a mere 1% were in regular paid employment. A market economy perspective might lead to the conclusion that the costs entailed in providing an occupation for such persons outweigh any productivity gains that might be derived. In contrast, the capabilities approach demands that the state devotes the resources required to provide opportunities for dignified employment for all. Nussbaum argues that broader social advantages can be derived, even if these are not evident in narrow terms of economic productivity.[118] This means that the state cannot 'write off' individuals as unsuitable for the employment, even where this might entail creating alternatives to jobs in the open labour market.[119]

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[111] Ibid 55.

[112] J. Vorhaus, 'Capabilities, Human Value and Profound Disability: Capability Theory and its Application to Theatre, Music and the Use of Humour' (2015) 30 *Disability & Society* 173. In contrast, Sen does not view all capabilities as equally significant: (n87) 46.

[113] In *Frontiers of Justice*, Nussbaum seems to acknowledge this critique, accepting that for some individuals the goal should be to secure as many capabilities as possible even though all are not attainable: (n109) 193.

[114] H. Dean, 'Critiquing Capabilities: the Distractions of a Beguiling Concept' (2009) 29 *Critical Social Policy* 261, 267.

[115] S. Fredman, *Human Rights Transformed: Positive Rights and Positive Duties* (OUP 2008) 15-16.

[116] Albin (n85) 72.

[117] J. Simon, P. Anand, A. Gray, J. Rugkåsa, K. Yeeles, and T. Burns, 'Operationalising the Capability Approach for Outcome Measurement in Mental Health Research' (2013) 98 *Social Science & Medicine* 187, 189.

[118] Nussbaum (n109) 129.

[119] Townsend poses the question of providing occupational activity for those hospitalized or incarcerated: E. Townsend, 'Boundaries and Bridges to Adult Mental Health: Critical Occupational and Capabilities Perspectives of Justice' (2012) 19 *Journal of Occupational Science* 8, 17.

With regard to the criticisms of the stress placed on individual choice in the capabilities approach, Burchardt identifies this as advantageous from a disability perspective.[120] Behaviour driven by paternalism, medicalisation, or welfarism has frequently denied people with mental health problems the autonomy to make decisions about how to live their lives. At the same time, the capabilities approach recognises that enabling choice demands resources; poverty, in interaction with impairment, can restrict opportunities.[121] In a similar vein, Sen argues that being able to enjoy 'genuine choice with serious options' enriches life,[122] while at the same time acknowledging that too much choice can ultimately 'bemuse and befuddle'.[123]

e. The Capabilities Approach and the CRPD

The potential application of the capabilities approach to disability rights has been strengthened by its apparent congruence with the CRPD. As mentioned above, the Convention espouses a substantive concept of equality that implies a need for social change to reflect the specific situation of persons with disabilities. It is explicit about the need for states to mobilise resources to realise the Convention's rights. Article 4 on General Obligations requires states to adopt measures necessary for the implementation of the CRPD, including the mainstreaming of disabled people's human rights into 'all policies and programmes'.[124] With regard to economic, social and cultural rights, there is a duty on each state 'to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights'.[125] This chimes with the capabilities approach, which places responsibility on the state for redistributing resources in order to achieve social justice.[126] Nussbaum argues that guaranteeing the central human capabilities justifies 'spending unequal money on the disadvantaged, or creating special programs to assist their transition to full capability'.[127] The capabilities approach treats such measures as inherent in the pursuit of equality, rather than temporary derogations thereto. As mentioned earlier, the CRPD provides firm authority for the legitimacy of positive action as an instrument for advancing disability rights.[128]

The capabilities approach combines support for positive action with a distinctive emphasis on enabling individual choice with regard to functioning and its embrace of the possibility that individuals will make a variety of choices on how they use their capabilities. This resonates with the CRPD's strong commitment to autonomy and participation by people with disabilities in decision-making. As mentioned earlier, Article 3 on General Principles includes 'the freedom to make one's own choices', an aspiration that has clear echoes of the capabilities approach. Moreover, Article 4(3) stresses the need for participation in the formulation of national law and policy: 'States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations'.

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[120] Burchardt (n88) 742.
[121] Mitra (n88) 242.
[122] Sen (n87) 41.
[123] ibid 59.
[124] Art 4(1)(c).
[125] Art 4(2).
[126] Albin (n85) 76.
[127] Nussbaum (n89) 295.
[128] Art 5(4) CRPD.

With regard to mental health, Article 12 on 'equal recognition before the law' forms a particularly important contribution to ensuring that individual freedom of choice is both protected and facilitated. People with mental health problems, especially where these are severe, have been historically vulnerable to a loss of autonomy where they are deemed to lack decision-making capacity. Article 12 has featured prominently in analysis of the Convention by mental health specialists.[129] Notably, it starts from the premise that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. It also requires states to take steps to assist individuals to be able to make decisions: 'States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.' While it is beyond the confines of this article to explore the potential implications of Article 12 for decision-making in areas like healthcare, its aspiration fits with the priority attached to enabling free choice within the capabilities approach, and the devotion of the resources necessary to make that a reality.

In summary, this part of the article has examined what principles can provide a framework for using law to advance the creation of inclusive workplaces for people with mental health problems. It identified the CRPD as a contemporary benchmark for the rights of persons with disabilities. More profoundly, the CRPD reveals a philosophical orientation that shares many characteristics of the capabilities approach. While the latter may possess certain shortcomings, it can provide an intellectual foundation for pursuing disability equality. Importantly, its emphasis on choice underscores the need to consider both access to work *and* the quality of the working experience. A truly inclusive labour market will ensure that people with mental health problems have meaningful choices when pursuing their careers. The third part of this article takes these principles and applies them to rights in the workplace.

3. Mental Health, Work and the CRPD

The final section of this article applies the framework of values found in the CRPD, with its underpinning in capabilities theory. It takes three examples of contemporary issues in employment law in order to consider how the vision found in the CRPD might lead us in the direction of law reform. The objective is not to provide a comprehensive prescription of detailed revisions that should be made to legislation or through case-law. Instead, this section seeks to illustrate how a full embrace of the CRPD might lead us to reconsider aspects of the current legal framework. The starting point for this analysis is Article 27 CRPD on 'The Right to Work':

> 1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:

[129] e.g. Bartlett (n3); Szmukler et al (n73); Kelly (n79); G. Richardson, 'Mental Disabilities and the Law from Substitute to Supported Decision-Making' (2012) 65 *Current Legal Problems* 1; T. Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' (2007) 34 *Syracuse Journal of International Law and Commerce* 405, 408; M. Keys, 'Emerging Issues in the Law Within a Changing Human Rights Framework' in A. Higgins and S. McDaid (eds), *Mental Health Law in Ireland: Policy, Practice & Law* (Gill & Macmillan 2014) 207, 209.

> (a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
> …
> (g) Employ persons with disabilities in the public sector;
> (h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
> (i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
> …

Starting from Article 27, this section explores the potential for change in relation to: the duty to provide reasonable accommodation; the role for positive action; and rights to participation.

a. The Duty to Provide Reasonable Accommodation

Article 27(1)(i) obliges states to ensure that reasonable accommodation is provided;[130] its denial is explicitly recognised in the Convention as a form of discrimination.[131] Article 2 CRPD defines reasonable accommodation as:

> necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Stereotypical images of reasonable accommodation often reflect physical disabilities, such as providing a ramp in a doorway to enable access by wheelchair users. Yet evidence indicates that reasonable accommodation is also central to the inclusion of people with mental health problems. Henderson et al conducted research from 2006 to 2010 involving around 500 employers in the UK.[132] They found a rapid increase in the prevalence of accommodations for employees with mental health problems. Amongst the most common practices were:

- Reduced workload/working hours (86%);
- Increased supervision (66%);
- Adjustment to role (80%);
- Access to counselling (71%);
- Option to work from home (46%).[133]

A survey of over 2000 staff in higher education who had experienced mental health difficulties found that 74% of those who received workplace adjustments found these positive or very positive.[134] The adjustments mentioned included practices around 'work management support' (especially clear definition and planning of tasks); changes to working hours (including flexibility on when work was performed); and changes to work location.[135]

The duty to provide reasonable accommodation is a familiar element of contemporary disability law. It has been present in British law since the Disability Discrimination Act 1995 and is now found in the Equality Act (EA) 2010.[136] The

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[130] See also, Art 5(3) CRPD.
[131] Art 2 CRPD.
[132] C. Henderson, P. Williams, K. Little, and G. Thornicroft, 'Mental Health Problems in the Workplace: Changes in Employers' Knowledge, Attitudes and Practices in England 2006-2010' (2013) 202 *British Journal of Psychiatry* s70.
[133] ibid s73.
[134] Equality Challenge Unit (ECU), 'Understanding Adjustments: Supporting Staff and Students Who Are Experiencing Mental Health Difficulties' (ECU 2014) 12.
[135] ibid 15.
[136] s.20 EA provides the general definition.

question arises, therefore, whether the CRPD has anything additional to contribute, at least in relation to states like the UK where the duty is well-established. Reconsidering the approach to reasonable accommodation in the light of the CRPD can, arguably, yield insights into ways in which the current legal framework has shortcomings for those with mental health problems. Several examples can be provided.

The first point is that it is a pre-requisite for the individual to demonstrate that she falls within the protected class of persons with disabilities, before being entitled to reasonable accommodation. In Britain, this means that the circumstances of an individual complainant must fall within the definition of disability found section 6 EA. As discussed in section 1 of this article, diagnosis of mental health problems remains a contested field. Section 2 highlighted the benefits of the CRPD approach to disability with its non-exhaustive definition. Notably, this includes recognition of disability arising from the interaction of impairments with attitudinal barriers, such as stigma. Nevertheless, the definition of disability in the EA focuses on the individual's impairment rather than the barriers to participation arising from other factors. Section 6(1)(b) requires evidence that the 'impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities'. This can result in protracted scrutiny of personal medical histories, such as in *J v DLA Piper UK LLP*.[137] In that case, a job offer was withdrawn following the applicant mentioning a history of depression. Yet the litigation turned on whether, at the relevant time, the applicant had experienced a re-occurrence of previous episodes of depression, or whether her symptoms were those of low mood. Taking into account the stigma surrounding mental health problems, it seems reasonable to assume that some individuals will be deterred by the prospect of litigation raking over their state of health, often in an adversarial and contentious manner. Writing on similar dilemmas in US law, Emens points out the paradox of having to show that your impairment is sufficiently serious to qualify as a disability, yet then needing to argue that you remain capable of performing the job if accommodations are provided.[138] The CRPD offers a better approach to defining disability by reducing the emphasis on individual impairment and recognising the disabling effects of attitudinal barriers.

A second observation is that the definition of reasonable accommodation in the Convention may offer greater clarity than that found in the EA 2010. The latter has several strands, but the most frequently contested element is section 20(3):

> The first requirement is a requirement, where a provision, criterion or practice of A's puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage …

This creates a number of hurdles for complainants, such as the need to define the 'provision, criterion or practice' and to show that this creates 'substantial disadvantage' for disabled persons in comparison to non-disabled persons. These requirements, and the literal way in which they have been interpreted, generate difficulties for people with mental health problems.[139] For example, tribunals have taken the view that the duty in section 20(3) is focused on achieving a particular end-

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[137] [2010] IRLR 936 (EAT).

[138] E. Emens, 'Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act' (2012) 60 *American Journal of Comparative Law* 205, 216.

[139] I have explored this in more depth elsewhere: M. Bell, 'Mental Health at Work and the Duty to Make Reasonable Adjustments' (2015) 44 *Industrial Law Journal* 194.

result; that is, the person's continued participation in employment.[140] A doctrinaire reading of the law has resulted in some tribunals denying that the duty contains any obligations concerning the *process* of assisting someone to resume work; in other words, the employer's approach to searching for a reasonable adjustment cannot, *per se*, constitute a breach of section 20(3). In *Smith*,[141] the Employment Appeals Tribunal went further, holding that a phased return to work or a career break did not constitute reasonable adjustments:

> Adjustments that do not have the effect of alleviating the disabled person's substantial disadvantage … are not reasonable adjustments within the meaning of the Act. Matters such as consultations and trials, exploratory investigations and the like do not qualify.[142]

In contrast, Lawson argues that reasonable accommodation should entail a 'procedural component', which she describes as 'the necessity for an employer to interact and enter into dialogue with a disabled employee or applicant'.[143] This seems consonant with the outlook of the CRPD and its strong emphasis on the participation of disabled people in making choices affecting their lives. Paragraph (o) in the preamble of the Convention states:

> persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them.

This resonates with Nussbaum's capability of 'control over one's material environment' with its references to 'being able to work as a human being, exercising practical reason'. It seems inimical to this idea that reasonable accommodation does not entail any duty on the employer to interact, in a dignified manner, with the person who will be most affected by the outcome of the deliberation on possible changes to their way of working. More generally, the obligation in Article 27 CRPD to create work environments that are open, inclusive and accessible calls for a purposive reading of the duty to provide reasonable accommodation rather than the literal outlook on statutory interpretation that sometimes prevails in relation to the EA 2010.

b. The Role for Positive Action

In keeping with the capabilities approach, Article 27 is premised on the idea that it is a state responsibility to equip all persons with the right to work and that this work should be performed in a dignified environment. As the right to work is extended to all, this implies that the capability to work needs to be secured by removing barriers to participating in the open labour market, but also taking measures to support those who are furthest away from the labour market and where mainstream employment might not, at least temporarily, be attainable.[144] Insofar as Article 27 focuses on prohibiting discrimination, including a duty to provide reasonable accommodation, it resembles the existing legal instruments found in many EU states. Yet its distinctiveness lies in the firm recognition of the inadequacy of relying purely on litigation by individuals as a model for achieving change. Instead, states are obliged

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[140] para. 12, *Royal Bank of Scotland Plc v Ashton* [2011] ICR 632 (EAT). A recent decision of the Court of Appeal adopts a more flexible approach to the interpretation of the duty to make reasonable adjustments, in particular with regard to identifying when a disabled person is placed at a substantial disadvantage and what constitutes a 'step' for the purposes of the duty: *Giffiths v The Secretary of State for Work and Pensions* [2015] EWCA Civ 1265.

[141] *Salford NHS Primary Care Trust v Smith* [2011] EqLR 1119 (EAT) [11].

[142] ibid para 49.

[143] A. Lawson, 'People with Psychosocial Impairments or Conditions, Reasonable Accommodation and the Convention on the Rights of Persons with Disabilities' in B. McSherry (ed), *International Trends in Mental Health Laws* (Federation Press 2008) 62, 69.

[144] Albin (n85) 81.

both to employ persons with disabilities in the public sector *and* to take measures to promote their employment in the private sector. With regard to the latter, Article 27 endorses 'affirmative action programmes'. In the context of mental health, the strong emphasis on promoting the employment of persons with disabilities in Article 27 is particularly valuable given the obstacles to enforcement via individual litigation. The effects of stigma, both experienced and anticipated, mean that individuals are often reluctant to disclose mental health problems to their employers and colleagues. Those who experience episodic mental health problems may be inclined to persevere in silence, hoping that the situation will improve without any need to acquire a record of having had a mental health problem. While research on staff in UK higher education institutions revealed that many of those who received accommodations found these beneficial, only 1 in 500 (0.2%) staff had disclosed a mental health condition to their university.[145] More generally, a 2013 public opinion survey in the UK recorded that 49% would be uncomfortable talking to an employer about their mental health.[146] This picture has been echoed elsewhere; for example, a European survey of 7,000 workers found that only one-third of those with depression revealed this to someone at work.[147] Such data illustrate that a reactive approach to mental health that relies on individuals asserting their rights is unlikely to be sufficient. Lawson argues that reasonable accommodation will only be effective if it forms part of a coordinated strategy on mental health, including measures to give people the confidence to seek accommodations.[148]

The obligations on states found in Article 27 might be aligned with the trajectory in anti-discrimination law to complement individual litigation rights with positive duties to promote equality. Within the UK, this approach has grown since the late 1990s and it is now consolidated in the public sector equality duty found in section 149 EA.[149] Yet the CRPD brings added value by explicitly tying these obligations to *private* sector employment. The EA requires private sector organisations to refrain from discrimination, but it stops short of placing upon such employers any general duty to adopt measures to promote equality. The Act provides legal protection for organisations that choose to take positive action in order to overcome disadvantage and to tackle under-representation,[150] but recourse to such measures is voluntary and at the discretion of the employer.

Hepple identified a long-standing discourse by successive governments that, in relation to the private sector, 'only if voluntary methods do not work will legislation be considered at a "later date"'.[151] He argued that the experience of decades of equality legislation showed that this outlook was 'profoundly mistaken'.[152] The CRPD poses a challenge, therefore, in placing a spotlight on employment in the private sector and identifying state responsibility for bringing about change in this field. Once again, this is in line with the capabilities approach. Nussbaum recognises that the goals of social justice may curtail private property rights or commercial freedoms, but she defends this a necessary part of securing the central human capabilities.[153]

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[145] ECU (n134) 1.
[146] TNS BRMB (n48) 40.
[147] HR Leadership Forum (n37) 17.
[148] Lawson (n143) 78.
[149] See further, S. Fredman, 'The Public Sector Equality Duty' (2011) 40 *Industrial Law Journal* 405.
[150] ss.158-159.
[151] B. Hepple, *Equality: The Legal Framework* (2nd edn, Hart Publishing 2014) 223.
[152] ibid.
[153] Nussbaum (n90) 44-45.

c. Rights to Participation

Article 3(d) CRPD lays down the general principle of 'full and effective participation' by people with disabilities. This is reinforced by a duty on states in Article 4(3) to 'closely consult with and actively involve persons with disabilities' in the development and implementation of legislation and policies designed to give effect to the CRPD. As discussed above, participation has an individual dimension in terms of being involved in decisions that affect oneself, such as negotiations over the provision of reasonable accommodation. Participation can also assume a collective character. Article 27(1)(c) requires states to 'ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others'. This connects the CRPD to the collective representation of workers and prompts reflection on how such mechanisms include the voices of workers with disabilities. This ties with Nussbaum's identification of human capabilities as including the capability to form 'meaningful relationships of mutual recognition with other workers'.[154]

In terms of anti-discrimination legislation, there has been relatively little weight given to the idea of collective participation with the predominant influence being the individual character of enforcement via litigation. A notable innovation was the Disability Equality Duty, introduced by the Disability Discrimination Act 2005. This imposed a general duty on public authorities to have due regard to promoting equality of opportunity between disabled persons and other persons.[155] The general duty was fleshed out in specific duties. Notably, these required public authorities to involve persons with disabilities in the preparation of their Disability Equality Scheme (which explained the steps that the authority intended to take in order to comply with the general duty).[156] The EA 2010 led to the replacement of the pre-existing race, disability and gender duties with the introduction of a new public sector equality duty applying across a range of protected characteristics.[157] In respect of England, this provided an opportunity for the government to change the earlier regulatory approach, leading to a radical thinning of the specific duties placed on public authorities.[158] In this drive to reduce perceived 'bureaucracy', the requirement for the involvement of persons with disabilities was deleted. In contrast, stronger obligations for the involvement of affected persons continue to be found in the specific duties on public authorities in Scotland and Wales.[159]

The limited emphasis on worker participation within anti-discrimination legislation contrasts with other branches of employment law where this remains central to the regulatory model. Hepple drew attention to occupational safety and health,[160] where, *inter alia*, employers are obliged to consult 'in good time' Safety

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[154] Nussbaum (n86) 80.
[155] s.49A(1), Disability Discrimination Act 1995 (as amended).
[156] Para. 2, Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005, SI 2005/2966.
[157] s.149 EA.
[158] Equality Act 2010 (Statutory Duties) Regulations 2011, SI 2011/2260. See further, Government Equalities Office, 'Equality Act 2010: the Public Sector Equality Duty: Reducing Bureaucracy' (2011) available at: <https://www.gov.uk/government/publications/equality-act-2010-the-public-sector-equality-duty-reducing-bureaucracy-policy-review-paper> accessed 17 May 2016.
[159] Para. 5, Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011, SI 2011/1064; para. 4(2), Equality Act 2010 (Statutory Duties) (Scotland) Regulations 2012, SI 2012/162.
[160] Hepple (n151) 214.

Representatives appointed by a recognised trade union.[161] The latter are entitled to paid time off to perform their duties, which include investigating potential hazards and making representations to the employer or inspectors of the Health and Safety Executive.[162] Although there has been growth in the numbers of workplace 'Equality Representatives', this is a voluntary initiative by trade unions.[163] Such representatives are not conferred with specific legal rights or protections, so any entitlements (such time off for these duties) are, in principle, at the discretion of the employer.

The CRPD does not provide a precise recipe for how to ensure the full and effective participation of persons with disabilities in the workplace. By drawing attention to the value of participation in decision-making, it renders visible deficiencies in the current legal framework. This could lead law reform in several directions. For example, one response could be to re-examine the scope for incorporating participation rights into the legal framework on anti-discrimination. This might involve a duty to inform and consult workers on equality policies, including workplace procedures for providing reasonable accommodation. The CRPD also encourages a reflection on whether existing methods of worker participation in other branches of employment law give sufficient weight to ensuring that the voices of workers with disabilities are heard. As mentioned above, worker participation is one strand to the enforcement model in occupational safety and health law. This touches upon the psychosocial risks present in the working environment, which can be a factor in triggering or exacerbating mental illness amongst workers. It is, therefore, relevant to consider ways in which the experiences and perspectives of workers with mental health problems can be incorporated within the system of worker participation already applying in this field. Better participation from workers with a diversity of disabilities might assist in ensuring that occupational safety and health measures give sufficient attention to psychosocial risks to workers' health and avoid a narrow focus on risks to physical health.

4. Conclusions

Section 1 of this article illustrated the wide-ranging evidence of labour market disadvantage experienced by persons with mental health problems. This has social and economic costs both for the individuals affected and society as a whole. Inevitably, any response must be multifaceted, but this article has concentrated on the potential role for law in promoting an inclusive labour market and working environment. Existing legal instruments already make a contribution; in particular, the duty to provide reasonable accommodation. Yet the enforcement infrastructure rests mainly on individuals asserting their rights, ultimately via litigation. This is valuable for those who fall within the statutory definition of disability and who enjoy the financial, emotional and information resources necessary to pursue the enforcement of their rights. The evidence presented in this article suggests that the deep forms of disadvantage experienced by people with mental health problems means that many are not in a position to use the law to maximum effect. Stigma inhibits individuals from speaking about mental health at work and accessing supports that may be

[161] Reg 4A, Safety Representatives and Safety Committee Regulations 1977, SI 1977/500. Separate measures exist for workplaces without a recognised trade union: Health and Safety (Consultation with Employees) Regulations 1996, SI 1996/1513.
[162] Reg 4, ibid.
[163] T. Wright, H. Conley, and S. Moore, 'Addressing Discrimination in the Workplace on Multiple Grounds: the Experience of Trade Union Equality Representatives' (2011) 40 ILJ 460.

available. In some cases, the experience of discrimination in the past and anticipation of future stigma leads to a withdrawal from labour market participation. Furthermore, the introduction of Employment Tribunal fees in 2013 has resulted in a sustained reduction in the number of claims being brought of disability discrimination; the drop in the number of claims remains over 50%.[164]

In thinking about how the law might enhance the contribution that it makes, the CRPD provides a touchstone for contemporary reflection on the values that should guide legal evolution. Building upon the insights of capabilities theory, the CRPD brings to the fore the need for persons with disabilities to be able to make their own choices in life and to be involved in decisions that affect them individually and collectively. The CRPD places a duty upon states to mobilise the resources necessary to ensure that persons with disabilities can participate in decent work, through action in both the public and private sectors of employment. On the whole, the CRPD does not provide tight prescriptions of what these objectives require in the context of an individual state. While the UK's legal framework on disability equality has been with us for over two decades, this article contends that there are opportunities to learn from the values and vision embedded within the CRPD and that this could lead to significant law reform. Some changes might lie in the detail of doctrinal law, such as how the duty to provide reasonable accommodation is interpreted by courts. Others might entail a more ambitious reorientation of the focus of law, such as moving towards duties to engage in positive action or new rights to ensure participation in workplace decision-making by persons with disabilities. By engaging in a serious reflection on how the CRPD might refashion our response to the issue of mental health and work, the law has the potential to play a strong role in realizing more effectively the capability for all to engage in dignified work.

[164] Comparison of the number of claims lodged of disability discrimination in the first quarter of 2013 (before the fees were introduced) and the first quarter of 2015: Ministry of Justice, 'Tribunal and Gender Recognition Statistics Quarterly: October to December 2015', Annex C: <https://www.gov.uk/government/statistics/tribunal-and-gender-recognition-statistics-quarterly-october-to-december-2015> accessed 17 May 2016.