The United Nations Convention on the Rights of Persons with Disabilities and Mental Health in Australia

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Abstract

This thesis examines whether or not current Australian mental health legislation complies with the Convention on the Rights of Persons with Disabilities (the CRPD) which Australia ratified on 17 July 2008. It analyses the meaning of specific provisions of the CRPD that are most relevant to persons with psychosocial disabilities. It assesses whether mental health legislation should be abolished or reformed. It argues that Australian mental health acts conflict with the CRPD and should be abolished. Given Australia's interpretative declaration on ratifying the CRPD that the CRPD allows for the involuntary detention and treatment of persons with mental disabilities, it is unlikely that mental health legislation will be abolished in Australian jurisdictions. However, this thesis argues that the CRPD provides a new and tangible normative framework for the reform of mental health laws and this thesis sets out the steps that need to be taken to ensure that persons with psychosocial disabilities have equal standing in society and are protected from being subject to differential treatment in law and practice.

The legislation in this thesis is as at 1 July 2011.
Declaration

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(Annegret Kämpf)
Acknowledgements

I sincerely thank my supervisor Professor Bernadette McSherry for her trust and friendship beyond her invaluable support, guidance and patience.

I dedicate this thesis to my mother and the memory of my uncle, Harald Huber.
Related Publications

Chapters Two, Three, Four, Five and Ten of this thesis incorporate material that the author published in the following book chapters:


## Abbreviations

<table>
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<th>Definition</th>
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<tr>
<td>CAT</td>
<td>Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment</td>
</tr>
<tr>
<td>CAT-OP1</td>
<td>Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<tr>
<td>CERD</td>
<td>International Convention on the Elimination of All Forms of Racial Discrimination</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<tr>
<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>CRPD-OP</td>
<td>Optional Protocol to the Convention on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICCPR-OP1</td>
<td>Optional Protocol to the International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICCPR-OP2</td>
<td>Second Optional Protocol to the International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>MI Principles</td>
<td>Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care</td>
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<tr>
<td>Siracusa Principles</td>
<td>Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant of Civil and Political Rights,</td>
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<tr>
<td>Standard Rules</td>
<td>Standard Rules on the Equalization of Opportunities for Persons with Disabilities</td>
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<tr>
<td>Tallinn Guidelines</td>
<td>Tallinn Guidelines for Action on Human Resources Development in the Field of Disability</td>
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<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UN Charter</td>
<td>Charter of the United Nations</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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INTRODUCTION

1 A New Convention on the Rights of Persons with Disabilities

When the United Nations adopted the *Convention on the Rights of Persons with Disabilities (CRPD)* on 13 December 2006, the United Nations Secretary-General Kofi Annan referred to that day as the “dawn of a new era – an era in which disabled people will no longer have to endure the discriminatory practices and attitudes that have been permitted to prevail for all too long”. Within the international human rights framework, differential treatment solely based on a person’s disability has long been recognised as constituting discrimination, comparable to discrimination based on criteria such as a person’s race, colour, sex, language, religion, national or social origin, property or birth. However, persons with disabilities have continued to experience wide-ranging and systematic discrimination, despite moves to abolish discriminatory practices based on disability.

The experience that disability is a matter of marginalisation and invisibility

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3 The meaning of the word ‘solely’ will be discussed in sections 5.3 and 8.4.3.1 below.
has been central to ongoing discrimination. Many persons with disabilities have been placed under guardianship and have lived in institutions or other care settings where human rights violations occurred unnoticed by society at large. When persons with disabilities lived in such settings and under the direction of others, human rights violations could continue on a routine basis because persons with disabilities have faced significant barriers in drawing attention to their human rights situation, let alone in claiming their rights. Many persons with disabilities who have lived their lives out of sight of society at large, have experienced their worth and skills being undervalued by mainstream society. Society has perceived disability as an impairment of the individual rather than as a matter of exclusion through the design of facilities, products or services that could be changed to accommodate for diverse abilities. This experience of social exclusion has reinforced the idea that persons with disabilities cannot live independently and need the direction or help of others. As a result, disability has been widely accepted as an overall and de facto hindrance to self-determination and equal participation in society.

The CRPD now clarifies in unprecedented detail what changes are necessary in order to prevent the discriminatory treatment of persons with disabilities and to ensure that persons with disabilities enjoy their human rights


7 See, for example, Mike Clear, Promises Promises: Disability and Terms of Inclusion (Federation Press, Leichhardt, 2000), 106 ff.


9 See ibid, 11 f. See also, for example, Melinda Jones and Lee Ann Basser Marks, Disability, Divers-ability and Legal Change (Martinus Nijhoff Publishers, The Hague, 1999).


and fundamental freedoms on an equal basis with others. This thesis argues that in comparison to pre-existing international human rights treaties of the United Nations, the CRPD is unique as it reaches well beyond inspirational guidance. The CRPD explains the interpretation and application of well-established human rights in the context of disability. It requires States Parties to take measurable efforts towards improving the human rights situation of persons with disabilities. Most fundamentally, the CRPD stresses the equality and the respect for the inherent dignity of each human being. The detailed provisions of the CRPD clarify what this means in respect to realising well-established human rights and fundamental freedoms, such as the right to liberty, the right to equal recognition before the law and the right to the highest attainable standard of health. Thus, this thesis argues that the CRPD provides a new normative framework for evaluating what measures States Parties have to take in order to ensure that persons with disabilities have equal standing in society and are protected from being subject to differential treatment in law and practice.

1.1 Human Rights and Psychosocial Disability

This thesis examines whether the current mental health legislation in Australia complies with the CRPD. Australia signed and ratified the CRPD and is thus obliged to give effect to the human rights standards set out in it. This thesis focuses on the situation of persons with psychosocial disabilities because the new human rights standard of the CRPD calls for unprecedented scrutiny of the use and design of mental health legislation.

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15 Australia signed the CRPD on 30 March 2007 and ratified it on 17 July 2008. Further details will be discussed in section 7.1 below.
1.2 The Term Psychosocial Disability

This thesis uses the term ‘psychosocial disability’ to address those individuals who traditionally have been referred to as persons with mental illness because the term ‘psychosocial disability’ seems to reflect the ideology of the CRPD in the following ways.

First, the term ‘psychosocial disability’ addresses disability beyond diagnostic criteria and acknowledges that social aspects can contribute to disabling factors. Article 1 of the CRPD states that “[p]ersons 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”.\(^\text{17}\) The Preamble of the CRPD recognises “that disability is an evolving concept and that 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”.\(^\text{18}\) Thus, the CRPD stresses the links between individual impairment, social responses to individual impairment and human rights realisation. The term ‘psychosocial disability’ reflects the idea that the ‘disabling effect’ of an individual’s mental condition needs to be understood in its social context.

Second, the CRPD uses the term ‘disabilities’ broadly. It does not adopt a strict differentiation between disability, which may be understood as a permanent impairment, and illness, which may be understood as a condition that may be alleviated through treatment.\(^\text{19}\) Rather, the CRPD covers persons with a “long-term”\(^\text{20}\) impairment. This includes those individuals whose condition may be alleviated through recurrent treatment or treatment for an extended period of time. The CRPD defines disability through the lived experience of the individual, rather than the individual’s medical diagnosis and prognosis. Thus, the CRPD applies to

\(^{17}\) Emphases added.  
\(^{19}\) See, for example, the Disability Services Act 1986 (Cth), s 8(1). This Act incorporates such kind of differentiation when it defines ‘disability’ restrictively and applies to persons whose conditions are “permanent or likely to be permanent”.  
some kinds of illnesses, depending on the question whether or not the individual experiences long-term impairments because of his or her condition in body and mind. The term ‘psychosocial disability’ reflects this understanding of impairment better than the terminology of ‘mental illness’.

Third, organisations of persons with disabilities have adopted the motto “Nothing about Us, Without Us”. The negotiations on the formulation of the CRPD responded to this claim and revolved around the participation and the views of persons with disabilities, including representatives of the World Network of Users and Survivors of Psychiatry. They use the terminology of psychosocial disability, rather than mental disability or mental illness when they express their views on the CRPD. Their voice guides the use of terminology in this thesis.

However, in the discussion of legal provisions or policy documents, the thesis uses the language of the relevant documents in order to be precise.

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22 Accreditation and Participation of Non-Governmental Organizations in the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 56th sess, UN Doc A/56/510 (26 July 2002); Participation of Persons with Disabilities in the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 56th sess, UN Doc A/DEC/56/474 (23 July 2002) See section 4.4.3 below. See also section 2 below which clarifies that it is legitimate to use the background information on the negotiation of a United Nations international human rights treaty as a guide to its interpretation and application.


1.3 The Focus on Psychosocial Disability

The thesis focuses on psychosocial disability because the CRPD incorporates specifications that pose the following challenges to the current Australian mental health acts.

1.3.1 The Justifications for Mental Health Legislation

First, this thesis argues that the CRPD challenges the traditional justifications for mental health legislation which impose special restrictions on the rights and freedoms of persons with psychosocial disabilities because of their psychosocial disability, even if other considerations apply to limit the application of the mental health legislation only to those persons with psychosocial disabilities who are at risk of harming themselves or others. This thesis argues that the requirements for the involuntary treatment and detention of persons with psychosocial disabilities, as set out in the current domestic mental health legislation reflect some of the reasons why the CRPD challenges a separate legislative regime. While some consumer groups, scholars and mental health professionals have long debated and challenged the existence of mental health legislation and the requirements for involuntary treatment and detention in mental health care, this thesis argues that the debate has gained momentum with the adoption of the CRPD.

Thus, one major theme of this thesis assesses whether or not mental health legislation should be abolished in light of the new human rights standard of the CRPD. Persons with psychosocial disabilities are one group of persons that are subject to differential treatment, not only in practice, but also by law. Prior to the CRPD, authoritative guidance on the interpretation and application of international human rights treaties allowed for special interventions into the human rights of persons with psychosocial disabilities. This position was based on the rationale that the nature of psychosocial disability renders persons with psychosocial disabilities too ill to look after themselves and that mental health specific interventions were necessary to protect them from detrimental behaviour against

\[25\] See sections 3.7.6 below.
\[26\] See sections 2.1.7, 5.1 and 6.2.1 below.
themselves or others.\textsuperscript{27}

This thesis argues that the \textit{CRPD} overrides the pre-existing interpretative guidance on international human rights standards. It reassesses the debate on the justification for mental health legislation. It argues that the \textit{CRPD} has extended its full protection to persons with psychosocial disabilities and requires States Parties not to subject persons with psychosocial disabilities to legislation that restricts their rights and freedoms on the ground of their psychosocial disability. It argues that this applies even if other modifiers apply to limit the scope of application to those who are at risk of harming themselves or others. It also argues that the \textit{CRPD} takes a precautionous stance towards assumptions into the effect of disability on the lives of persons with disabilities and the assessments of their need for protection. Thus, this thesis argues that the \textit{CRPD} scrutinises the use of psychosocial disability as a primary criterion for differentiation to an unprecedented degree.

\subsection*{1.3.2 Uniform Incapacity Legislation}

Second, prior to the \textit{CRPD}, there were claims that differential treatment should only be justified on the ground of decision-making incapacity and other criteria which can be applied to persons with or without disabilities alike.\textsuperscript{28} Thus, the second major theme of this thesis discusses the question whether or not the \textit{CRPD} supports the claim to replace mental health legislation with uniform incapacity legislation. It argues that the \textit{CRPD} aims to delink any justification for interventions from the existence of psychosocial disability in order to ensure that persons with or without disabilities are subject to the same, high level of scrutiny for justifying why interventions may be necessary. It assesses the proposal of using a person’s incapacity as primary criterion for differentiation and discusses the advantages and disadvantages of adopting capacity-based legislation in light of the human rights standard of the \textit{CRPD} and the current mental health acts of the Australian States and Territories. It points out that the \textit{CRPD} adopts a new understanding of protecting the legal capacity of persons with disabilities which needs to be reflected in any legislative framework that responds to persons with psychosocial disabilities.

\begin{itemize}
\item \textsuperscript{27} See section 3.4 below.
\item \textsuperscript{28} See Chapter Nine below.
\end{itemize}
1.4 Structure of the Thesis

As international human rights commitment requires States Parties to bring their domestic laws in line with international human rights standards,29 this thesis predominantly focuses on a ‘black letter’ analysis of the current domestic mental health legislation. The thesis adopts the following approach to assessing whether or not the mental health legislation complies with the CRPD.

First, Chapters Two to Seven provide the background information that guides the interpretation and application of the CRPD and Australian mental health legislation. Chapters Eight and Nine analyse whether or not the justifications for mental health legislation are compatible with the CRPD and whether or not the current requirements for involuntary treatment and detention as set out in domestic mental health legislation comply with the CRPD. Chapter Ten summarises the findings and elaborates further on the consequences of the findings of the previous Chapters. Chapter Ten interprets the CRPD as requiring that mental health services focus on respecting the human dignity and equal worth of persons with psychosocial disabilities.

The following paragraphs set out the issues to be addressed in more detail.

1.4.1 The Background to the CRPD

Chapters Two and Three clarify the background to the CRPD and assess the international human rights protection of persons with disabilities prior to the CRPD. The background to the CRPD is explored in detail because “the preparatory work of the treaty and the circumstances of its enactment”30 are supplementary means of interpreting a treaty to confirm the meaning of its provisions. The evaluation of the human rights standard of persons with psychosocial disabilities prior to the CRPD identifies to what extent the international human rights framework has traditionally differentiated persons with psychosocial disabilities from other persons, including those with physical disabilities. It also explains the rationale for such differentiation.

29 See section 1.1 above and section 7.1 below.
Chapter Two first assesses the pre-existing United Nations treaty law and its protection of the human rights of persons with disabilities. It explains the evolving understanding of disability as human rights issue and identifies the shortcomings in the pre-existing human rights protection. The identification of these shortcomings is important for the subsequent assessment of the rationale and content of the CRPD. Chapter Two highlights some specific considerations on the human rights of persons with psychosocial disabilities, but it argues that the treaty law prior to the CRPD provided miniscule guidance on the interpretation and application of human rights to the situation of persons with psychosocial disabilities.

Chapter Three analyses other international human rights instruments prior to the adoption of the CRPD which complement the United Nations treaty law. This assessment serves to show that the international human rights debate has increasingly acknowledged disability as human rights issue. These developments have emphasised that the human rights realisation of persons with disabilities requires States Parties to become proactive in ensuring their substantial equality and the respect for their human dignity. However, Chapter Three points out that the most detailed human rights instrument on psychosocial disability has been less inspirational than the human rights instruments which address physical disabilities. It argues that the human rights guidance on psychosocial disability set out a minimum standard of protection that has shown some inconsistencies with the interpretation of the treaty law and that these shortcomings may have contributed to ongoing shortcomings in the human rights realisation of persons with psychosocial disabilities.

1.4.2 The New Human Rights Standard of the CRPD

Chapters Four and Five assess the nature, rationale and content of the CRPD. Chapter Four first clarifies how the CRPD fits into the international human rights scheme of the United Nations and provides an overview of the CRPD. It assesses the development of the CRPD and argues that the CRPD adds new features to the human rights discourse in response to pre-existing inconsistencies, challenges and shortcomings as identified in Chapters Two and Three. It argues that these new features aim to ensure that States Parties’ obligations to promote, respect
and fulfil the human rights of persons with disabilities result in measurable outcomes which reflect the paradigm shift of the CRPD.

Chapter Four analyses in particular the CRPD's emphasis on the equality and non-discrimination of persons with disabilities. It argues that the CRPD's understanding of respecting persons with disabilities as equal subjects of rights revolves around the social model of disability which places the individual's abilities, will and preferences at the heart of any decision-making that affects his or her human rights, while the pre-existing human rights standard focused on protecting the interests of the individual as they could be defined by others. Chapter Four also argues that the CRPD substantiates the non-discrimination of persons with disabilities with the States Parties' obligation to ensure the social inclusion of persons with disabilities and to provide for their equal opportunities to exercise their rights. It argues that the CRPD is remarkably precise and proactive in identifying what measures States Parties have to take in order to ensure the human rights realisation of persons with disabilities.

Chapter Five explores how the substantive provisions of the CRPD relate to psychosocial disability. In light of the CRPD's Preamble and Articles 1 and 5, this Chapter argues that the CRPD extends its full protection to persons with psychosocial disabilities and challenges the idea of differentiating persons with psychosocial disabilities because of their disability. It also argues that the CRPD protects persons with psychosocial disabilities from the assumption that the nature of their disability has a particularly disabling effect on their abilities to exercise their rights. Rather, this Chapter argues that the CRPD emphasises that persons with psychosocial disabilities who are impaired in making decisions must be provided with reasonable accommodation to exercise their rights.

Chapter Five then addresses Article 12, the CRPD's provision on the equal recognition before the law and identifies the reasons why Article 12 supports this conclusion. It argues that Article 12 protects the individual's legal capacity to make decisions and requires States Parties to provide supported decision-making to those who may not be able to exercise their rights. This Chapter argues that the specifics of Article 12 mark a shift away from substituted decision-making, an idea that has entered the human rights debate on persons with physical disabilities, but not been translated to the mental health sector.
Then, Chapter Five assesses Articles 14 and 17, which address the liberty and security of the person as well as the protection of the integrity of the person. These human rights are central to involuntary treatment and detention schemes in mental health laws, yet the CRPD has refrained from mentioning disability-specific limitations to these rights. This thesis argues that the move not to allow for differential treatment of persons with psychosocial disabilities has meaning to the human rights realisation of persons with psychosocial disabilities, in particular in light of Article 25 of the CRPD. Article 25 clarifies what (alternative) measures States Parties have to take in order to realise the right to health of persons with psychosocial disabilities. In conclusion, this Chapter argues that the CRPD provides for reasons to challenge the justifications for mental health legislation.

1.4.3 The Background to Domestic Mental Health Legislation and Human Rights Commitment

Chapters Six and Seven explore the domestic human rights situation of persons with psychosocial disabilities. Chapter Six first assesses the debate in Australia on human rights and mental health. The starting point of this evaluation is the 1993 National Inquiry into the Human Rights of Persons with Mental Illness, a core document on domestic mental health care and human rights. The Inquiry identified systematic human rights violations in mental health care and triggered a process of reform in law and policy-making. Based on an outline of the national policy developments since the Inquiry, Chapter Six reviews the achievements, obstacles and deficits of domestic mental health reform since the Inquiry. It argues that there are parallels in the shortcomings and challenges of the international human rights standards prior to the CRPD and the domestic experiences of mental health law and human rights realisation before Australia ratified the CRPD.

Chapter Seven outlines Australia’s commitment to the CRPD and the Optional Protocol to the CRPD. It assesses what obligations have arisen when Australia signed and ratified the CRPD and acceded to the Optional Protocol to


the CRPD. This Chapter points out that Australia has shown extraordinary commitment to an international human rights treaty, but then ratified the CRPD with a decaration that can be interpreted to uphold the current use and design of mental health legislation. However, when Chapter Seven analyses the impact of international human rights commitment within the Australian legal system, it shows that Australia does not have national human rights legislation. It points out that human rights legislation exist in two federal jurisdictions, but these Acts do not provide enforceable rights and focus on refraining from unjustified interventions into the human rights of individuals, rather than proactively ensuring that individuals can exercise their rights.

Chapter Seven further elaborates on how Australia gives effect to international human rights treaty obligations and argues that ensuring international human rights compliance within domestic law predominantly relies on Parliaments reviewing domestic legislation accordingly. It explores the consequences that arise when it is predominantly the responsibility of Australian Parliament to ensure international human rights compliance. It argues that the domestic human rights law has significant shortcomings to realising the human rights standards of the CRPD.

### 1.4.4 The Use and Design of Domestic Mental Health Legislation in Light of the CRPD

Chapters Eight and Nine assess the impact of the CRPD on domestic mental health legislation. Drawing upon the findings of the previous Chapters, Chapter Eight first assesses the justifications for mental health legislation. It applies the findings of Chapter Five to the domestic context and assesses the question whether or not domestic mental health legislation is discriminatory because it subjects persons with psychosocial disabilities to a separate legislative regime which allows for interventions into their human rights. Chapter Five also explores the purpose and objectives of domestic mental health legislation. It assesses whether or not it is justified to subject persons with psychosocial disabilities to a separate legislative regime because of their disability. It explores whether additional considerations, such as the need to protect others, may mean that there are objective, reasonable and proportionate grounds for allowing differential
treatment. Similarly, this Chapter assesses whether or not it complies with the CRPD to justify mental health legislation on the basis that it serves to protect the health or life of an individual with psychosocial disability. This Chapter then analyses the impact of Articles 1, 5, 14 and 17 of the CRPD on this debate.

Subsequently, Chapter Nine assesses whether the alternative of subjecting persons to involuntary treatment based on universally applicable grounds for interventions, such as a finding of incapacity to decision-making complies with the CRPD. Thus, this Chapter discusses the idea of fusing mental health and capacity legislation. It explores the advantages and disadvantages of the fusion proposal in light of the Australian mental health acts and in particular Article 12 of the CRPD. Article 12 deals with legal capacity and supported decision-making. Chapter Nine clarifies what changes are necessary in order to comply with the CRPD’s requirement to facilitate supported decision-making, instead of substituted decision-making. It argues that current mental health legislation conflict with the CRPD when they allow for overriding the decision of persons with psychosocial disabilities who are capable of decision-making. It also argues that the fusion proposal provides insight into alternative legislative responses to persons with psychosocial disabilities which incorporate important ideas of the CRPD.

1.4.5 The Impact of the CRPD on Australian Mental Health Legislation

Chapter Ten draws together the findings of the previous Chapters. It considers that Australia’s commitment to international human rights and its declaration to the CRPD present reasons for reconsidering whether or not mental health legislation should be abolished. It discusses the idea of upholding a separate legislative regime for the care and treatment of persons with mental disabilities as a means of bestowing rights on persons with psychosocial disabilities or progressively realising their equal opportunities to exercise their human rights. It explores the risks and benefits to upholding mental health legislation in light of the paradigm shift of the CRPD and Australia’s experiences on using human rights-based arguments to facilitate change in mental health care. Chapter Ten also explores the traditional focus on autonomy-based arguments within the interpretation and application of mental health legislation and its limitations to safeguarding the
human rights of persons with psychosocial disabilities. It evaluates in what ways the protection of equality and human dignity, as centrally incorporated in the CRPD, can be utilised to address these limitations. Chapter Ten evaluates this idea by considering that the CRPD now calls for States Parties to ensure that persons with psychosocial disabilities receive services and support.

However, it argues that in the Australian context, mental health law reform best serves to ensure the human rights of persons with disabilities as a first step towards the progressive realisation of the paradigm shift of the CRPD. It argues that the mental health acts of the Australian States and Territories need to substantiate the vision of the CRPD into a legislative framework that provides enforceable rights to persons with psychosocial disabilities. It also outlines what changes are necessary for Australian mental health law in order to comply with the new standards set by the CRPD.

Overall, this thesis argues that a detailed analysis of the CRPD indicates that mental health laws are discriminatory and should be abolished. However, given Australia’s interpretative declaration that the CRPD allows for involuntary detention and treatment, this thesis recognises that the abolition of mental health laws is unlikely to occur immediately and sets out options for reform to bring them more closely in line with the provisions of the CRPD.
CHAPTER 2

2 Pre-existing United Nations Treaty Law

This Chapter\(^1\) assesses the international human rights protection of persons with disabilities prior to the enactment of the CRPD. As mentioned in Chapter One, this assessment is important to the interpretation of the CRPD because the preparatory work of the CRPD and the circumstances of its conclusion are supplementary means of interpreting its provisions.\(^2\) Several commentators on the CRPD have claimed that the CRPD provides a “paradigm shift”\(^3\) in the understanding of disability and human rights realisation and that the formulation of the CRPD should be understood as a strong reaction to the deficits and controversies in the pre-existing human rights framework as well as a reaction to mainstream society’s lack of awareness of the situation of persons with disabilities when applying human rights.\(^4\) This Chapter assesses the international human rights treaties prior to the CRPD to evaluate the validity and the significance of this claim.

This Chapter predominantly addresses disabilities in general to explain the

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2. Vienna Convention on the Law of Treaties, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980), Article 32. The preparatory work of a treaty and the circumstances of its conclusion include, for example, the session reports on the drafting history of the CRPD.


movement behind the development of the CRPD and the evolving understanding of disability as a human rights issue. The following Chapter assesses in detail the special considerations given to the circumstances of persons with psychosocial disabilities and the differences in the international human rights debate on human rights and psychosocial disability. These differences and the response of the CRPD to these differences are important for the interpretation and application of the CRPD.

2.1 The International Bill of Human Rights

When considering international human rights and its potential impact on domestic legislation, it is important first to clarify that the focus of this thesis rests on the universal human rights instruments of the United Nations because they are the international human rights sources that are directly relevant to Australia.5

In order to understand the United Nations’ human rights scheme, it is important to bear in mind that the United Nations’ human rights scheme developed in response to the experience of two successive World Wars and the atrocities during World War II. The initial founding document of the United Nations, the Charter of the United Nations 1945 (UN Charter),6 enabled the various war-torn countries to get together under the aegis of the United Nations in order to develop international cooperation and a commitment to maintaining peace and security


6 Charter of the United Nations, opened for signature 26 June 1945, 1 UNTS XVI (entered into force 24 October 1945).

7 Building on, and replacing, the League of Nations.
amongst nations. The UN Charter largely focuses on issues beyond individual concern, such as the stability and solidarity amongst peoples and nations. But the United Nations also had to respond to extraordinarily grave human rights violations. The objectification of human beings through the totalitarian regimes, like the Nazi regime, resulted in state authorities and civilians subjecting fellow human beings to extermination, starvation, forced labour, medical experimentation and other forms of inhuman and degrading treatment. The United Nations recognised a paramount need to introduce international standards that direct state authorities to guarantee respect for the human dignity, equality and liberty of all human beings who are subject to their powers – as a matter of human flourishing as well as peace and stability amongst nations. The United Nations considered that it may obviate the need for humanitarian intervention when nations agree to protect all persons within their territory from human rights abuse. The UN Charter thus reaffirms faith in fundamental human rights and freedoms, in particular in the dignity, worth and equality of all human beings. By reaffirming basic human rights and fundamental freedoms, the UN Charter does not constitute an actual human rights scheme with enforceable rights; rather, its formulation is inspirational in character. It provided a starting point for the various nations to commence working out a universal human rights framework.

Subsequently, the United Nations established a complex international human rights scheme. The earliest, and still most central, document of the United Nations international human rights scheme is the Universal Declaration of Human Rights 1948 (UDHR). It is formulated in broad terms and in the form of a declaration. As a declaration, the UDHR was originally not designed to be a legally

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9 The United Nations increasingly clarified basic individual human rights as a matter of human flourishing with the understanding that human flourishing positively affects peace and stability amongst nations.
11 Charter of the United Nations, opened for signature 26 June 1945, 1 UNTS XVI (entered into force 24 October 1945), Preamble.
binding document. Rather, it aimed to set up a moral and political expression of “a common standard of achievement” amongst different nations. Some nations originally intended to set up a more comprehensive international bill of rights in a legally binding treaty, but agreement on a common standard could not be achieved easily within the global community. Many nations believed they lacked the resources to commit themselves to fulfilling human rights. Widespread discrepancies existed mainly in regards to civil and political rights which were perceived as ‘negative’ rights to certain freedoms from state interferences on the one hand and economic, social and cultural rights which were perceived as ‘positive’, resource-intensive entitlements from the state on the other hand.

Driven by the need to achieve ample and timely agreement amongst as many nations as possible, the various nations set up a guiding ideology without vigorous scrutiny of legal commitment. Thus, the diverse nations developed the UDHR as a foundational human rights declaration instead of a legally binding treaty. This approach incorporated both civil and political rights as well as economic, social and cultural rights in one document and they were declared to be interrelated and interdependent.

Once agreement on a basic human rights framework was settled, the

15 Statute of the International Court of Justice 1945, Article 38.
17 Also referred to as first generation rights. See also section 2.3.2 below.
18 Also referred to as second generation rights. See also section 2.3.2 below.
20 Since the UDHR has been declared in 1948, States Parties have developed a general practice of applying the UDHR with the belief that it expresses legal rights or obligations. They have done so through recognising the UDHR in domestic legislation and jurisprudence, in particular by incorporating the UDHR into domestic constitutions. Thus, it can be claimed that the UDHR has gained such a central position in the development of international human rights law that many of its provisions have become globally accepted and are now considered part of customary international law. As such they are considered as legally binding, even for nations that have not ratified the declaration, see Statute of the International Court of Justice 1945, Article 38. See also Thomas Buergenthal, ‘Centerpiece of the Human Rights Revolution’ in Barend van der Heijden and Bahia Tahzib-Lie (eds), Reflections on the Universal Declaration of Human Rights - A Fiftieth Anniversary Anthology (Martinus Nijhoff Publishers, The Hague/Boston/London, 1998) 91. Buergenthal et al argue that “few lawyers would deny today that the Universal Declaration is a normative instrument and that as such it is a source of legal obligation” (at 93).
United Nations commenced lengthy discussions on drafting enforceable and more precise human rights standards. Approximately 20 years after the adoption of the UDHR, the United Nations adopted two complementary treaties to the UDHR: the International Covenant on Civil and Political Rights 1966 (ICCPR) and the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR).

Such differentiation of human rights breaks with the premise of the UDHR that all human rights should be addressed comprehensively in one document. By differentiating human rights, the United Nations encouraged states to ratify at least one of the treaties, the ICCPR, if they were hesitant in committing to a more resource-intensive human rights standard. However, both treaties have been ratified by more than 80% of all countries. Today, the UDHR, the ICCPR with its two additional Optional Protocols and the ICESCR constitute the International Bill of Human Rights. Other thematic human rights treaties of the United Nations complement the United Nations International Bill of Rights. The CRPD is the

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24 As of 1 July 2011.


second latest treaty to complement the International Bill of Rights.  

The United Nations has evolved human rights as legal rights that are dependent upon the various levels of wealth and stability in different nations. There is limited power to enforce human rights as legal rights, but over the years, the United Nations has set up an increasingly specific international human rights framework for domestic enforcement. This framework consists of a range of documents with various legal effect, precision and specialisation. It distinguishes between legally binding and legally non-binding international human rights instruments. The legally binding instruments of the United Nations are the treaties and customary international law. Non-binding international human rights instruments are typically more specific human rights documents that further substantiate international human rights treaties in complementary ways: they serve to assist the consistent and contemporary interpretation and application of legally binding documents.

The following sections assess the central rights and freedoms of the International Bill of Rights and its complementary treaties in the context of disability and mental health. They address the human rights standards prior to December 2001, the time of the first preparatory discussions for the CRPD. Subsequently, the focus of this thesis will shift to non-binding instruments of the United Nations.

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28 As of 1 July 2011.
29 The United Nations has international jurisdiction for universal human rights violations under their aegis. In particular the United Nation’s Human Rights Council (replacing the United Nations Commission on Human Rights since 2005) governs rights. Resulting actions may include military enforcement, if the United Nations Security Council determines a human rights violation and authorises intervention, see Charter of the United Nations, opened for signature 26 June 1945, 1 UNTS XVI (entered into force 24 October 1945), Article 39. Yet, the United Nations has been criticised for not using force despite severe, large-scale human rights breaches, such as the Rwandan Genocide. Individual human rights enforcement predominantly relies on States Parties incorporating international human rights into their domestic legislation. The enforcement of individual rights outside of domestic jurisdiction is also limited and requires following a lengthy procedure.

30 International treaties are frequently referred to as conventions or covenants.
2.1.1  The Universal Declaration of Human Rights 1948 (UDHR)

The United Nations initiated its human rights scheme by finding common agreement amongst all nations. While it was initially difficult for the nations to find universal agreement on many human rights standards, there was agreement that human beings are born with equal dignity and worth, understood as a pre-existing inherent value of all human beings which calls for unconditioned respect\(^\text{34}\) and which is not confined to a pre-set religious, philosophical or cultural belief.\(^\text{35}\) The UDHR guarantees that this core value of human life must be ultimately protected from intrusions. David Kretzmer and Eckart Klein have argued that human dignity is the “foundation of human rights”.\(^\text{36}\) The UDHR establishes that every human being is recognised as a bearer of human rights\(^\text{37}\) and that no one should be treated as a pure object or means to an end.\(^\text{38}\) This idea is encompassed in Article 1 of the UDHR. Tore Lindholm has stated that this Article “provides the crucially important and cross-culturally unobjectionable normative premise”\(^\text{39}\) of universal human rights protection.

The UDHR guarantees the dignity, respect and equality of all human beings without discrimination in straightforward, but broad terms. In its over-arching provision, Article 2 of the UDHR guarantees all human beings the rights and freedoms as set forth in the UDHR. It specifically names certain criteria of differential treatment that constitute discrimination.\(^\text{40}\) Distinction based on race,


colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status constitutes discrimination and violates the respect for basic human rights. The UDHR does not explicitly include disability as a criterion for non-discrimination. However, the provision on non-discrimination leaves it open to the evolving understanding of human rights realisation to further clarify what “other status” can constitute discrimination. Further authoritative human rights interpretation has recognised that disability constitutes a similar criterion, in particular the Convention on the Rights of the Child 1989 (CRC) states that disability is a prohibited ground of discrimination.

The over-arching understanding of the non-discrimination provision is crucial for the application and interpretation of all subsequent rights and freedoms of the UDHR. All rights and freedoms of the UDHR need to be protected equally for persons with or without disabilities. Article 7 requires States Parties to ensure that all human beings are equal before the law and entitled without any discrimination to equal protection of the law. Thus, Article 7 extends the obligation to non-discrimination to all domestic law.

2.1.2 The International Covenant on Civil and Political Rights (ICCPR)

The ICCPR restates many of the rights set out in the UDHR. In particular, the ICCPR restates the right to life, the right to freedom from torture and other cruel, inhuman or degrading treatment or punishment and the right to liberty and

security of the person, including the right to freedom from arbitrary detention.\textsuperscript{47} The ICCPR also restates the right to liberty of movement, including the freedom to choose one's residence,\textsuperscript{48} the right to be recognised as a person before the law,\textsuperscript{49} and the right to be equal before the law.\textsuperscript{50} While most of the provisions of the ICCPR are much more detailed than the ones set out in the UDHR, none of them mention disability or psychosocial disability.

The comments of the Human Rights Committee are important for developing the interpretation and application of civil and political rights. The Human Rights Committee monitors the implementation of the ICCPR, considers regular reports of States Parties and reviews complaints of individuals against States Parties that have ratified the First Optional Protocol to the ICCPR. The Human Rights Committee releases General Comments that serve as an authoritative interpretation of the ICCPR. General Comments are not legally binding.\textsuperscript{51} Using the words of Kerstin Mechlem, the impact of a General Comment rather "depends on how convincingly and persuasively it is argued".\textsuperscript{52} General Comments typically focus on the interpretation and application of a specific provision of the ICCPR, rather than a selected area of human rights concern. The following sections outline General Comments that identify some links between the human rights and fundamental freedoms of the ICCPR and disability or psychosocial disability specifically. These observations will be discussed later in conjunction with the General Comments of the Committee on Economic, Social


\textsuperscript{51} As they directly clarify the interpretation and application of the treaty provisions, they are discussed within the scope of the legally binding treaties.

and Cultural Rights in order to provide a comprehensive discussion.

2.1.2.1 General Comment No 8

Article 9 of the ICCPR

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

2. Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him.

3. Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release. It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement.

4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.

In its General Comment No 8 (1982) concerning the right to liberty and security (Article 9), the Human Rights Committee stated that Article 9 applies broadly to all deprivations of liberty, including deprivations of liberty due to mental illness. This includes civil and preventive detention. The Human Rights Committee has clarified that Article 9 applies to deprivations of liberty in criminal cases only when the paragraphs of Article 9 explicitly refer to arrests for criminal charges (that is part of paragraph 2 and paragraph 3). According to Article 9(1), detention due to mental illness must not be arbitrary: its grounds and the relevant procedure must be established by law. By law, any person who is deprived of liberty must be immediately informed of the reasons for the detention (Article 9(2)). The law must also ensure that a detained person has the right to challenge the lawfulness of detention in court (Article 9(4)). In case the detention is judged unlawful, the person must be guaranteed release (Article 9(4)) and be given an enforceable right to compensation (Article 9(5)).

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53 Human Rights Committee, General Comment No 8: Right to Liberty and Security of Persons (Art. 9), 16th sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 179 (30 June 1982).
54 Ibid para 1.
2.1.2.2 General Comment No 18

Article 2 of the ICCPR

1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.

3. Each State Party to the present Covenant undertakes:

(a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;

(b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that the competent authorities shall enforce such remedies when granted.

Article 26 of the ICCPR

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

General Comment No 18 (1989) on non-discrimination clarified that Article 2(1) requires that States Parties must respect and ensure the non-discrimination of all individuals subject to their jurisdiction. The Human Rights Committee has clarified that the ICCPR does not define what constitutes discrimination. The term had been defined to some extent by the Convention on the Elimination of All Forms of Racial Discrimination 1969 (CERD) and the Convention on the Elimination of All

55 Human Rights Committee, General Comment No 18: Non-Discrimination, 37th sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 195 (10 November 1989).
**Forms of Discrimination against Women 1981 (CEDAW).** Similar in wording to these conventions, the Human Rights Committee has stated that discrimination is “any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms”. This definition covers direct (on purpose) and indirect (to the same effect) discrimination.

The Committee also has clarified that any reasonable and objective criteria for differentiation with the aim of achieving a legitimate purpose under the ICCPR does not constitute discrimination. However, the Human Rights Committee has not provided further details on its definition of non-discrimination and its application in practice.

The Committee has addressed the difference between Article 2 and Article 26. The Committee has clarified that Article 26 means that all persons are equal before the law and entitled without discrimination to the equal protection of the law. The Committee has stated that the difference between Article 2(1) and Article 26 of the ICCPR lies in their scope: Article 2(1) is limited to non-discrimination in regards to all rights and freedoms of the ICCPR, while Article 26 applies to any discrimination in domestic law and any other field of public life.

In this General Comment, the Human Rights Committee’s interpretation of the meaning of non-discrimination provides insight into some elements of non-discrimination, but the Committee did not comprehensively address the systematic understanding of the principle of non-discrimination and equality. However, the Human Rights Committee carefully stated that it “wish[ed] to draw the attention of

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States Parties\textsuperscript{62} to the fact that they sometimes have to become proactive in ensuring equality.\textsuperscript{63}

\subsection*{2.1.2.3 General Comment No 20}

\textbf{Article 7 of the ICCPR}

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Concerning the prohibition against torture and cruel, inhuman or degrading treatment or punishment (Article 7), the Human Rights Committee clarified in its General Comment No 20 (1992)\textsuperscript{64} that Article 7 allows for no limitation to this right, even in cases of public emergencies.\textsuperscript{65} Thus, the Human Rights Committee considers Article 7 to be an absolute provision that cannot be derogated from in light of other provisions. The Human Rights Committee has emphasised that Article 7 protects patients in medical institutions.\textsuperscript{66} It also has raised attention to the need to ensure that no one be subjected to medical or scientific experimentation without the free consent of the person concerned.\textsuperscript{67} The Human Rights Committee has stated that when persons who are not capable of giving valid consent are under any form of detention or imprisonment, Article 7 requires that those individuals should be subject to special protection and never be subjected to any treatment detrimental to their health.\textsuperscript{68} The Human Rights Committee has also clarified that domestic law must guarantee prompt and impartial remedies to complaints against maltreatment.\textsuperscript{69}

There are three important observations in these comments. First, the Human Rights Committee has implied that the decision-making on medical treatment must revolve around the question of personal ‘consent’. When the

\begin{footnotesize}
\begin{enumerate}
\item Ibid para 5.
\item Ibid para 5. Similar comments are contained in para 10.
\item Human Rights Committee, \textit{General Comment No 20: Replaces General Comment 7 concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)}, 44\textsuperscript{th} sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 200 (10 March 1992).
\item Ibid para 3
\item Ibid para 5.
\item Ibid para 7.
\item Ibid para 7.
\item Ibid para 14.
\end{enumerate}
\end{footnotesize}
Human Rights Committee stated that medical treatment requires ‘valid consent’, the Committee has implied that the expressed consent should be subject to scrutiny as to whether the individual has the capacity to give consent.

Second, in respect to medical or scientific experimentation, the Human Rights Committee has stated that ‘free consent’ is crucial. This means that experimental treatment requires that individuals must volunteer to participate in experimental treatment and consent to it free of force or undue influence. By emphasising that consent needs to be ‘free’, rather than ‘valid’, the Human Rights Committee has implied that the decision-making on experimental treatment is not subject to the scrutiny as to whether the person is capable, or willing, to consider and understand the relevant information about the suggested treatment. Rather, if it is not proven whether the treatment is beneficial to the health of the individual, stronger safeguards than ‘valid consent’ must apply because the experimental treatment is likely to bear more risks to the individual than non-experimental medical treatment. Thus, the person who opposes to participate in research must be presumed to have capacity to make that decision and treatment should only be administered when the person expresses the wish to participate in experimental treatment and when this decision has been made freely, that is, not under force or undue influence. In other words, it is not justified to subject a person to medical or scientific experimentation, if the individual objects to the experimentation, regardless of that individual’s capacity to decide for him- or herself.

Third, the Human Rights Committee has implied that the fact that a person is in detention or imprisoned must result in increased protection from treatment without consent. Thus, there must be increased protection to a person who receives medical treatment in detention or imprisonment which ensures that the person receives treatment only if he or she gives ‘valid consent’ to the treatment. A person who receives experimental treatment in such settings, must be subject to increased protection which ensures that he or she receives experimental treatment only if he or she gives ‘free consent’ to the treatment.

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70 See, ibid para 7. The question whether evidence-based treatment can result in detrimental outcomes is a separate one.
71 Or the individual does not protest to the experimentation.
72 It is not clear, if the Committee considered the case of an individual who volunteers but may not have the capacity to understand the treatment and its experimental nature.
2.1.2.4 General Comment No 21

Article 10 of the ICCPR

1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

2. (a) Accused persons shall, save in exceptional circumstances, be segregated from convicted persons and shall be subject to separate treatment appropriate to their status as unconvicted persons;

(b) Accused juvenile persons shall be separated from adults and brought as speedily as possible for adjudication.

3. The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation. Juvenile offenders shall be segregated from adults and be accorded treatment appropriate to their age and legal status.

General Comment No 21 (1992) concerning the humane treatment of persons deprived of liberty (Article 10) clarified that Article 10 applies to all institutions and establishments under the laws and authority of a States Party. The Human Rights Committee has emphasised that this right applies in particular to psychiatric hospitals. The Committee has stated that “[t]reating all persons deprived of their liberty with humanity and with respect to their dignity is a fundamental and universally applicable rule”. As such, treating persons with humanity and with respect to their dignity cannot be dependent on resource constraints. In this context, the Human Rights Committee has emphasised the need to instruct and train personnel. The Committee also has clarified that it oversees what measures States Parties have applied in order to comply with Article 7. This covers, for example, how detained persons are dealt with individually, how they are categorised and under what conditions they are ensured contact with the outside world.

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73 Human Rights Committee, General Comment No 21: Replaces General Comment 9 concerning Humane Treatment of Persons Deprived of Liberty (Art. 10), 44th sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 202 (10 April 1992).
74 Ibid para 2.
75 Ibid para 4.
76 Ibid para 4.
77 Ibid para 7.
78 Ibid para 12.
2.1.2.5 General Comment No 25

Article 25 of the *ICCPR*

Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions:

(a) To take part in the conduct of public affairs, directly or through freely chosen representatives;

(b) To vote and to be elected at genuine periodic elections which shall be by universal and equal suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electors;

(c) To have access, on general terms of equality, to public service in his country.

The Human Rights Committee addressed disability and mental incapacity in its General Comment No 25 (1996)\(^79\) on the right to participate in public affairs, voting rights and the right of equal access to public services. The Committee has stated that the right to vote may be subject only to reasonable restrictions. Restricting the right to vote on the ground of physical disability is explicitly named as an unreasonable limitation.\(^80\) But the Human Rights Committee has stated that the right to vote or to hold office may be denied for persons with established mental incapacity.\(^81\) In the same context, the Committee has clarified that the grounds for denying rights must be established by law and must be based on objective and reasonable grounds.\(^82\)

This Comment has indicated a narrow approach towards finding impairment to be a reason for limiting human rights and freedoms: Referring to ‘established’ mental incapacity indicates that incapacity should be recognised in the individual and that it should have a strong element of continuity or permanence. Thus, the Committee has implied that the understanding of established mental incapacity is different from psychosocial disability which may result in intermittent phases of


\(^80\) Ibid para 10.

\(^81\) Ibid para 4.

\(^82\) Ibid para 4.
impairment.83

2.1.2.6 General Comment No 27

Article 12 of the ICCPR

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.

2. Everyone shall be free to leave any country, including his own.

3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.

4. No one shall be arbitrarily deprived of the right to enter his own country.

General Comment No 27 (1999)84 addressed the right to freedom of movement (Article 12) which includes the freedom to choose one’s residency. This Comment has clarified that freedom of movement is an indispensable condition for the free development of a person.85 According to Article 12, all restrictions of movements must be exceptional.86 They must also be provided by law, consistent with other rights of the ICCPR and necessary to protect national security, public order, public health, morals or the rights and freedoms of others. This Comment has not referred to detention that is necessary to protect other rights of the individual concerned.

The Human Rights Committee has emphasised that it is not sufficient that these restrictions just serve permissible purposes. Rather, any restriction must also be ‘necessary’ to protect these permissible purposes and any restriction must conform to the principle of proportionality.87 In its elaboration on the principle of proportionality, the Human Rights Committee has clarified that proportional measures are those that have the following three features.88 First, proportional

83 See also World Health Organization, Resource Book on Mental Health, Human Rights and Legislation (World Health Organization, Geneva, 2005), 24 f. The WHO compared varying definitions of mental illness and found that references to ‘mental incapacity’ are “extremely narrow” in their application (at 24).
85 Ibid para 1.
86 Ibid para 11.
87 Ibid para 14.
88 Ibid para 14.
measures must be appropriate to achieving their protective function.\textsuperscript{89} Second, they must be the least intrusive instrument amongst those which might achieve the desired result and third, they must be proportionate to the protected interest.\textsuperscript{90} These safeguards must apply in the law and its formulation of any restrictions as well as to administrative and judicial authorities in applying the law.\textsuperscript{91} The Human Rights Committee also has clarified that all proceedings that restrict Article 12 must be expeditious and the reasons for restrictive measures must be given.\textsuperscript{92}

2.1.3 \textit{The International Covenant on Economic, Social and Cultural Rights (ICESCR)}

In regards to economic, social and cultural rights, the \textit{ICESCR} encompasses in particular the right of everyone to the opportunity to gain his or her living by work that is freely chosen or accepted (Article 6), the right to an adequate standard of living (Article 11), the right to the highest attainable standard of physical and mental health (Article 12) and the right to education (Article 13). Since realising many aspects of economic, social and cultural rights requires taking active steps, such rights are subject to resource constraints and progressive realisation (Article 2). The Special Rapporteur on the Right to Health\textsuperscript{93} has explained that realising rights subject to resource constraints means that the demands on a developed state are of a higher standard than the demands on a developing state.\textsuperscript{94} However, all states have to work continuously, expeditiously and effectively towards realising human rights.\textsuperscript{95} The Special Rapporteur on the Right to Health also has clarified that progressive realisation means that States Parties are obliged to use the maximum of their available resources and expected to be doing

\textsuperscript{89} Ibid para 14.
\textsuperscript{90} Ibid para 14
\textsuperscript{91} Ibid para 15.
\textsuperscript{92} Ibid para 15.
\textsuperscript{93} The following Chapters will further address some comments of the Special Rapporteur on the Right to Health that are relevant to this thesis. See sections 3.4.3, 3.7.4, 4.4.5, 5.2.1 and 5.5 below.
better in five years time than they are doing today.96

The following section briefly outlines the relevant General Comments of the Committee on Economic, Social and Cultural Rights,97 the monitoring body of the ICESCR. Subsequently, this Chapter discusses these Comments in conjunction with the General Comments of the Human Rights Committee.

2.1.3.1 General Comment No 5

The Committee on Economic, Social and Cultural Rights specifically addressed the human rights situation of persons with disabilities in its General Comment No 5 (1994).98 The Committee did not address the human rights of persons with disabilities in relation to a specific provision of the ICESCR, but rather addressed their human rights realisation in general. It has observed that States Parties “have devoted very little attention”99 to ensuring that persons with disabilities fully enjoy their economic, social and cultural human rights. The Committee has pointed out that there is a “lack of awareness”100 towards disability as a human rights issue and it has recognised that “[t]he effects of disability-based discrimination have been particularly severe in the fields of education, employment, housing, transport, cultural life, and access to public places and services”.101 The Committee has also stated that “[b]oth de jure and de facto discrimination against persons with disabilities have a long history and take various forms”.102 It has urged States Parties to “reduce structural disadvantages and give appropriate preferential treatment to persons with disabilities in order to achieve the objectives of full participation and equality within society”.103 It has also called for States Parties to implement anti-discrimination legislation as the legal situation of persons with

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97 The Committee on Economic, Social and Cultural Rights has a similar function in regards to the ICESCR, as the Human Rights Committee has in regards to the ICCPR. See section 2.1.2 above.
99 Ibid para 2.
100 Ibid para 6.
101 Ibid para 15.
102 Ibid para 5.
103 Ibid para 9.
disabilities “remains precarious”.\textsuperscript{104} In regards to psychosocial disability this General Comment only referred to the United Nations \textit{Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care} 1991 (\textit{MI Principles}).\textsuperscript{105} These principles and their current relevance will be addressed later.\textsuperscript{106}

2.1.3.2 General Comment No 14

\begin{center} \textbf{Article 12 of the ICESCR} \end{center}

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

One of the most significant developments concerning human rights and mental health is the development of the right to the highest attainable standard of physical and mental health (in short: the right to health). In General Comment No 14 (2000),\textsuperscript{107} the Committee on Economic, Social and Cultural Rights has re-emphasised the interrelatedness and interdependence of the right to health to other human rights.\textsuperscript{108} It has stated that the right to health includes access to “facilities, goods and services”\textsuperscript{109} and that health services need to be available, accessible, acceptable and of good quality.\textsuperscript{110} The Committee also has stressed

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{104} Ibid para 16.
\item \textsuperscript{106} See section 3.4 below.
\item \textsuperscript{107} Social and Cultural Rights Committee on Economic, \textit{General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 14)}, 22\textsuperscript{nd} sess, UN Doc E/C.12/2000/4 (11 August 2000).
\item \textsuperscript{108} Ibid para 3.
\item \textsuperscript{109} Ibid para 43.
\item \textsuperscript{110} Ibid para 12, with further clarification.
\end{itemize}
\end{footnotesize}
that the right to health contains both freedoms and entitlements. It has emphasised the importance of freedoms such as “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation”.

These freedoms have to be realised immediately, and thus some aspects of the right to health are not subject to progressive realisation and resource constraints. Concerning coercive medical treatment, the Committee on Economic, Social and Cultural Rights has stated that coercion should not be applied in medical treatment, but it can apply on an exceptional basis for the treatment of mental illness subject to the specific and restrictive conditions included in the MI Principles.

The Committee has addressed the general and specific legal obligations of States Parties to ‘respect,’ ‘protect’ and ‘fulfil’ the right to health. The Committee has stated that States Parties have to promote and support the establishment of institutions providing counselling and mental health services in order to comply with their obligations to ‘fulfil’ the right to health. General Comment No 14 also has identified violations of these obligations and what measures are necessary for domestic implementation.

2.1.3.3 Other Comments

Between December 2001 and December 2006, there were other significant developments in regards to the ICESCR. The Committee on Economic, Social and Cultural Rights released General Comment No 16 in mid 2005 which elaborated on the understanding of equality. In 2002, the former Commission of Human Rights appointed a Special Rapporteur on the Right to Health. The Special Rapporteur released two important reports in 2003 and 2005 respectively. These developments occurred in parallel to the drafting of the CRPD and will be

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111 Ibid para 8.
112 Ibid para 8.
113 Ibid para 34.
114 Ibid para 36.
116 In short for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
addressed in later sections of this thesis as this Chapter is concerned with the starting premise of the CRPD in 2001.

2.2 Other Complementary Thematic Treaties

The United Nations has developed other thematic human rights conventions that deal with a particular topic (such as racial discrimination or torture) or a particular group of persons that particularly tends to be subjected to discrimination (such as women, children or migrant workers). The CRPD is one of these thematic human rights conventions. All of these complementary thematic treaties incorporate fundamental non-discrimination provisions and equality principles.

The only international human rights treaty of the United Nations that addresses disability and predates the CRPD is the Convention of the Rights of the Child 1989 (CRC). The CRC explicitly includes disability as a prohibited ground of discrimination (Article 2). It considers the rights of the disabled child and calls for States Parties to provide for mechanisms which aim to ensure the social integration and individual development of children with disabilities (Article 23). Predating December 2001, there is only one General Comment of the Committee on the Rights of the Child which noted that “[d]iscrimination against children with disabilities is [...] pervasive in educational settings”.\textsuperscript{117} The General Comment has not clarified the interpretation and application of the CRC in regards to disabilities, let alone psychosocial disability. In light of the development of the CRPD, the Committee on the Rights of the Child released General Comment No 9 (2007) on the rights of children with disabilities.\textsuperscript{118} However, this Comment focused on children and adolescents with physical rather than psychosocial disabilities.

The Convention Against Torture 1984 (CAT) provides important safeguards to persons with disabilities who are in institutionalised settings and it is of “special importance in preventing disability as a result of torture”.\textsuperscript{119} The Committee Against Torture only issued two General Comments, neither of which addressed

\textsuperscript{117} Committee on the Rights of the Child, General Comment No 1: The Aims of Education, 26\textsuperscript{th} sess, UN Doc CRC/GC/2001/1 (17 April 2001) para 10.

\textsuperscript{118} Committee on the Rights of the Child, General Comment No 9: The Rights of Children with Disabilities, 43\textsuperscript{rd} sess, UN Doc CRC/C/GC/9 (27 February 2007).

disability or mental health care.\textsuperscript{120} Thus, while all other complementary thematic treaties apply to persons with disabilities, there has been miniscule guidance on the interpretation and application of treaty provisions in the context of disability or mental health care.

\section*{2.3 Observations}

When looking at the international human rights treaties and their authoritative interpretation, four important observations can be made.

\subsection*{2.3.1 The Central Importance of the Protection of Human Dignity and Equality}

First, since the foundation of the United Nations, the protection of human dignity and equality has been central to international human rights protection. The protection of human dignity and equality has been a consistent premise in the international human rights treaties since the \textit{UN Charter}. From the beginning of the international human rights scheme of the United Nations, the protection of human dignity has been linked to the idea that every human being must be recognised as a subject of rights.\textsuperscript{121} As a human right, the protection of equality, and the inherently related protection of non-discrimination, derives from the \textit{UDHR}. The protection of equality further evolved within the \textit{ICCPR}, the \textit{ICESCR} and other complementary human rights treaties. Physical disability has been accepted as a criterion for non-discrimination. This can be concluded in particular from General Comment No 25 of the Human Rights Committee, General Comment No 5 of the Committee on Economic, Social and Cultural Rights and Article 2 of the \textit{CRC}. The interpretation and application of the treaties has not explicitly stated the same about psychosocial disability.

However, authoritative human rights interpretation has shied away from accepting categorical differentiation solely based on psychosocial disability. General Comments 18, 20 and 27 of the Human Rights Committee have pointed

\begin{itemize}
\item \textsuperscript{121} See section 2.1.1 above.
\end{itemize}
out that limitations in exercising human rights must be reasonable, objective and proportional – in law and policy as well as in practice. This indicates that State measures should not be categorical, but must be able to take into account individual circumstances. It appears that the Human Rights Committee has considered an individual’s capacity to exercise rights to be the objective and reasonable criterion for differentiation. This may be concluded in particular when considering General Comment No 20. In General Comment No 20, the Human Rights Committee has stated that medical treatment decisions require the ‘valid consent’ of the individual concerned and that this must be safeguarded in particular to persons in medical institutions. This implies that persons with psychosocial disabilities, like other persons, should be assessed as to whether they are capable of giving ‘valid consent’. Medical treatment decisions in general health care settings are subject to informed consent and the Committee has indicated that the fact that persons are institutionalised or imprisoned does not change the requirement of consent to treatment. Rather, institutionalisation or imprisonment requires increased protection to ensuring that consent is valid.122

2.3.2 Positive and Negative Rights

Second, the Human Rights Committee and the Committee on Economic, Social and Cultural Rights have stressed that human rights realisation requires that States Parties refrain from certain interventions and proactively pursue the realisation of certain rights. Some of these State efforts require measures that are in contrast to the traditional understanding of the differentiation between civil and political rights and economic, social and cultural rights.

For example, the Human Rights Committee has pointed out that States Parties have to become proactive in order to ensure some civil and political human rights and freedoms, such as the right to humane treatment. In its General Comment No 21, the Committee stated that it requires resources to provide for adequate living conditions in institutional settings or adequate training of personnel in forensic institutions. In 1989, the Human Rights Committee approached this position carefully by ‘drawing attention’ to the States Parties that they ‘may have’

122 See section 2.1.2.3 above.
to become proactive in order to realise civil and political rights. In 1992 and 1996, the Human Rights Committee’s call for States Parties to become proactive was stronger and the Committee identified what measures are necessary to realise the respective rights. This indicates that the Human Rights Committee has increasingly considered the traditional differentiation between positive and negative rights as obsolete.

Similarly, the Committee on Economic, Social and Cultural Rights has recognised that the right to health includes immediately realisable freedoms, such as the freedom from non-consensual treatment. Thus, both monitoring bodies have acknowledged that there are important aspects in the interrelation between civil and political rights and economic, social and cultural rights.

General Comment No 5 of the Committee on Economic, Social and Cultural Rights was the most detailed General Comment on disability and human rights prior to the CRPD. It has identified the shortcomings in realising human rights when States Parties merely abstain from certain interventions without responding to the structural disadvantages that persons with disabilities have experienced. General Comment No 5 responded to the fact that the social integration of persons with disabilities has been lacking and the Committee has adjusted its human rights considerations to the different risks and shortcomings that persons with disabilities are more likely to experience.

Both monitoring bodies also have stressed that States Parties need to provide resources in order to establish and improve continuously the provision of health services. This seems to apply in particular to the lives of persons with disabilities.

2.3.3 Dangers of Segregation

Third, the Human Rights Committee has stated that persons with psychosocial disabilities are in a most vulnerable position and that they must be subject to

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123 See section 2.1.2.1 above.
human rights protection with strong and carefully considered safeguards.\textsuperscript{125} The Committee on Economic, Social and Cultural Rights has adopted a similar approach towards persons with disabilities in general. Both monitoring bodies also have great awareness of the risks of isolation and marginalisation contributing to severe human rights abuse, neglect and the risk of being systematically cut off exercising rights. They have acknowledged the dangers of institutionalisation or detention to human rights realisation and therefore call for increased safeguards to human rights protection.\textsuperscript{126}

2.3.4 Non-Consensual Treatment

Fourth, both Committees have stressed the importance of freedom from non-consensual treatment. The Human Rights Committee has taken the stance that medical treatment on an individual who is not capable of giving consent to treatment is permissible, if the treatment has been clinically tested to be beneficial to the health\textsuperscript{127} of the individual and if the administration of such treatment is strictly safeguarded. Thus, the Committee has indicated that decision-making capacity is the crucial consideration for legitimate differentiation, rather than the person’s need for treatment. In contrast to the Committee on Economic, Social and Cultural Rights, the Human Rights Committee has not made reference to the \textit{MI Principles} even though they were adopted shortly before General Comment No 21 addressed the humane treatment of persons in psychiatric institutions. Thus, the Human Rights Committee has not confirmed the \textit{MI Principles}.\textsuperscript{128}

The Human Rights Committee also approached the question of decision-making capacity as a matter of individual assessment to the task (or right) at hand. The Committee has emphasised that State measures must consider the individual circumstances, the principle of proportionality and that any restriction in human

\textsuperscript{125} See section 2.1.2.3 above.
\textsuperscript{126} See sections 2.1.2.3, 2.1.2.4, 2.1.3 and 2.1.3.2 above.
\textsuperscript{127} See the Human Rights Committee’s differentiation between medical and experimental treatment in Human Rights Committee, \textit{General Comment No 20: Replaces General Comment 7 concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)}, 44\textsuperscript{th} sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 200 (10 March 1992). See also section 2.1.2.3 above.
\textsuperscript{128} The question whether the \textit{MI Principles} conflict with the General Comments of the Human Rights Committee will be addressed in section 3.7.5.1 below.
rights and freedoms needs to be exceptional. By stating this, the Human Rights Committee has indicated that domestic mental health legislation can permit involuntary treatment only on an exceptional basis. Thus, the Committee seems to permit involuntary treatment when the individual concerned is not capable of deciding on the suggested course of treatment and when the following three criteria of proportionality are established: (1) involuntary treatment must be necessary to achieve the treatment’s objective of improving the individual’s health; (2) involuntary treatment must be the least intrusive means of improving the individual’s health; and (3) the intensity of involuntary treatment must be in balance with the purpose of improving the individual’s health.

2.4 Shortcomings in the Interpretation of Binding Human Rights Instruments

There are two significant shortcomings in the General Comments of the Human Rights Committee and the Committee on Economic, Social and Cultural Rights.

2.4.1 Miniscule Guidance on Psychosocial Disability

First, the General Comments have barely addressed disability as a human rights issue, let alone psychosocial disability. Some of the comments of the Human Rights Committee call for strong safeguards to guarantee the rights of persons with disabilities, in particular those living in institutionalised settings. However, the interpretation and application of human rights and fundamental freedoms remains in broad and ambiguous terms with a tendency to state a principle without indicating in what ways this could be translated into law or policy.

In regards to persons with psychosocial disabilities, the four observations above are basically the only specifications on human rights and mental health. The specifications on consent to treatment and the principle of proportionality provide

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129 See Human Rights Committee, General Comment No 20: Replaces General Comment 7 concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7), 44th sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 200 (10 March 1992) and Human Rights Committee, General Comment No 27: Freedom of Movement (Art. 12), 67th sess, UN Doc CCPR/C/21/Rev.1/Add.9 (2 November 1999). See also sections 2.1.2.3 and 2.1.2.6 above.

130 As derived from specifications in Human Rights Committee, General Comment No 27: Freedom of Movement (Art. 12), 67th sess, UN Doc CCPR/C/21/Rev.1/Add.9 (2 November 1999). See also section 2.1.2.6 above.
some framework for determining whether mental health specific interventions are justifiable, and if so, under what considerations. But these specifications tend to focus on safeguarding unambiguous cases. They have limited use for the scrutiny of mental health services beyond calling for basic procedural safeguards, in particular in cases when a person’s capacity to make decisions is called into question. For example, there are no specifications as to who should decide whether a person is capable of making decisions and who should act as substituted decision-maker in case a person is found to be incapable of making decisions.

The Committee on Economic, Social and Cultural Rights’ General Comments are significantly more detailed than those of the Human Rights Committee. The Committee on Economic, Social and Cultural Rights has identified measures that are necessary to comply with human rights obligations. However, it has not scrutinised the situation of persons with psychosocial disabilities. In its General Comment No 5 on persons with disabilities, the Committee has accepted differential treatment by reference to the MI Principles. Thus, guidance from both monitoring bodies barely assists the formulation of mental health law and policy, nor does it sufficiently help raise awareness of the human rights situation of persons with psychosocial disabilities.

In their comprehensive assessment of human rights and disability prior to the CRPD, Gerard Quinn and Theresia Degener have argued that insufficient guidance on how to translate human rights principles to the daily situation of persons with disabilities has caused a lack of responsiveness by governments and civil society to the differences that disability represents. If human rights standards are formulated in vague terms, there are shortcomings in respect to promoting changes and urging States Parties to implement substantial change that reaches beyond a token dedication to improving the human rights of persons with

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disabilities.133

2.4.2 Little Guidance on the Principle of Non-Discrimination

Second, the Human Rights Committee has taken some time in its development of the systematic understanding of non-discrimination. In 1989, the Committee addressed some details, but the Human Rights Committee has evolved the understanding of non-discrimination slowly and has provided little information of how to translate these basic ideas into the law, policy and practice of States Parties.

Only in 2009, after the adoption of the CRPD, did the Committee on Economic, Social and Cultural Rights elaborate on the dimension and understanding of non-discrimination in further detail.134 Chapter Four will outline how the Committee set out ways in which respecting the principle of non-discrimination can be better translated into law, policy and practice.135 Such interpretation of the principle of non-discrimination provides useful guidance to assisting domestic law, policy and practice while the pre-existing standard left much ambiguity in relation to one of the most central provisions on international human rights protection.

2.5 Concluding Thoughts

Thus, this Chapter has explored how pre-existing treaties did not adequately delineate the international human rights protection of persons with disabilities prior to the enactment of the CRPD. Thus, this Chapter confirms the claims136 that the international human rights law prior to the CRPD had many deficits in guiding States Parties on how to ensure that persons with disabilities have their human rights respected. It argues that these deficits are palpable in particular in respect to the human rights of persons with psychosocial disabilities which may have resulted in ongoing shortcomings to their human rights protection because States

133 See ibid, 1.
135 See sections 1 above and 4.4.6.1 below.
136 See section 2 above.
Parties did not have sufficient incentives to interpret and apply human rights to mental health law, policy and practice, nor sufficient guidance on how to do so. The following Chapter assesses whether and to what degree complementary United Nations human rights instruments have elaborated on the interpretation and application of human rights in respect to disability and psychosocial disabilities specifically.
CHAPTER 3

3 Other Pre-existing International Human Rights Instruments

In order to acknowledge the human rights of persons with disabilities, the United Nations has addressed disability and mental health in a number of complementary instruments that further clarify the scope of the legally binding treaties. Other international instruments, besides legally binding treaties, are international declarations, resolutions, principles, guidelines and rules.\(^1\) They are not legally binding, but express generally accepted ideas that represent a “moral and political commitment”\(^2\) of the States Parties. Their primary use is to set out guidance for States Parties which clarifies how to interpret legally binding provisions and how to ensure that national legislation and policies comply with international human rights standards. General policy documents, on the other hand, are documents that report outcomes of meetings such as world summits or conferences that result, for example, in World Programmes of Action. This Chapter\(^3\) provides an overview of the most relevant of these other documents that address disability in general or psychosocial disability specifically.

3.1 The Declaration on the Rights of Mentally Retarded Persons 1971

An early international human rights instrument on mental health is the United Nations Declaration on the Rights of Mentally Retarded Persons 1971.\(^4\) In its Preamble, the Declaration reaffirms a faith in the dignity and worth of the human

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\(^1\) Statute of the International Court of Justice 1945, Article 38.


\(^4\) Declaration on the Rights of Mentally Retarded Persons, GA Res 2856 (XXVI), UN GAOR, 26\(^{th}\) sess, 2027\(^{th}\) plen mtg, Supp No 29, UN Doc A/Res/2856/(XXVI) (20 December 1971).
person. In 1971, the Declaration was ground-breaking in that it specifically dealt with mental disability and encouraged the integration of 'mentally retarded persons’ into mainstream society and the development of their abilities.

The Declaration reiterates that 'mentally retarded persons' have the same fundamental human rights as other human beings. It sets out in particular the right to proper medical care, physical therapy, education, training and rehabilitation. It also stresses that the inability to exercise fully some rights should not be used to justify incapacity; rather, only when, and insofar, a person is unable to exercise rights, rights can be restricted or denied. This is an important confirmation that decision-making is not necessarily a set matter of competence or incompetence, but a matter of acknowledging a broad spectrum of capacities. The Declaration also provides that any restriction or denial of rights requires proper legal safeguards, an evaluation of the social capabilities of the person by qualified experts, periodic review and a right to appeal.

The Declaration has aimed to advance individual abilities and to maximise potential, rather than to restrict them. However, the Declaration contains many limitations when articulating rights, using phrases such as “to the maximum degree of feasibility”, “to the fullest possible extent of his capabilities” and “whenever possible”. The Declaration also focuses on the protection of “personal well-being and interests” and re-emphasises the necessity of assuring welfare and rehabilitation. As such, it promotes the welfare and best interests of 'mentally retarded persons', rather than their equality.

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5 Ibid para 1.
6 Ibid para 2.
7 Ibid para 7, with further clarification.
8 Ibid para 2.
9 Ibid para 1.
10 Ibid para 3.
11 Ibid para 4.
12 Ibid para 5.
13 Ibid Preamble.
3.2 The Declaration on the Rights of Disabled Persons 1975

In 1975, the United Nations Declaration on the Rights of Disabled Persons 1975\textsuperscript{14} was similarly ground-breaking in its recognition of the human rights of persons with disabilities. Some provisions and underlying ideologies of the Declaration are similar to the Declaration on the Rights of Mentally Retarded Persons, in particular in regards to the right to treatment, rehabilitation, education, training and services\textsuperscript{15} and the aim to improve the welfare and rehabilitation\textsuperscript{16} of persons with disabilities.

The Declaration on the Rights of Disabled Persons is, however, more elaborative than the Declaration on the Rights of Mentally Retarded Persons. It stresses the same rights and the non-discrimination of persons with disabilities as well as their inherent human dignity.\textsuperscript{17} The Declaration has aimed for persons with disabilities to achieve self-reliance\textsuperscript{18} and a higher standard of living.\textsuperscript{19} It refers to certain limitations, using phrases such as “as normal and full as possible”\textsuperscript{20} or “as close as possible”,\textsuperscript{21} but these limitations are not as evident as the ones in the Declaration on the Rights of Mentally Retarded Persons.

The Declaration on the Rights of Disabled Persons defines a ‘disabled person’ as “any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities”.\textsuperscript{22} Thus, it orients human rights achievement toward facilitating a ’normal’ life\textsuperscript{23} and incorporates a welfare-based idea that persons with disabilities need help to become ‘normal’ and need help in overcoming disability for their social integration. However, the Declaration stresses that existing abilities should be respected.

\textsuperscript{14} Declaration on the Rights of Disabled Persons, GA Res 3447 (XXX), UN GAOR, 30\textsuperscript{th} sess, 2433\textsuperscript{rd} plen mtg, Supp No 34, UN Doc A/Res/3447/(XXX) (9 December 1975).
\textsuperscript{15} Ibid para 6.
\textsuperscript{16} Ibid, Preamble.
\textsuperscript{17} Ibid paras 2, 3 and 4.
\textsuperscript{18} Ibid para 5.
\textsuperscript{19} Ibid, Preamble.
\textsuperscript{20} Ibid para 3.
\textsuperscript{21} Ibid para 9.
\textsuperscript{22} Ibid para 1.
\textsuperscript{23} Ibid paras 1, 3 and 9.
3.3 The **Tallinn Guidelines for Action on Human Resources Development in the Field of Disability 1989**

Following the International Year of Disabled Persons in 1981, the United Nations’ General Assembly adopted the *World Programme of Action Concerning Disabled Persons* (*World Programme of Action*) which has aimed to achieve the prevention, rehabilitation, ‘equalisation’ and full participation of disabled persons in social life and development. The Programme emphasises disabled persons’ self-reliance where possible and calls for social integration. It is notable in stressing full participation and equality more so than the earlier documents do. It has marked the beginning of a shift from perceiving persons with disabilities as holders of rights, rather than objects of welfare. The *World Programme of Action* also has marked the beginning of the Decade of Disabled Persons (1983-1992) which was devoted to improving human rights for those with disabilities. This decade has brought about a number of advancements such as the *Tallinn Guidelines for Action on Human Resources Development in the Field of Disability 1989* (*Tallinn Guidelines*).

The *Tallinn Guidelines* have marked a crucial step in the human rights development for disabled persons by considering them as “agents of their own destiny rather than objects of care” and by promoting the human resources development of persons with disabilities. These Guidelines stress the self-determination of persons with disabilities and the importance of involving them in decision-making processes as equal partners. They provide detailed strategies towards equalisation and participation. They set out specific strategies towards achieving integration, in particular in regards to policy-making, education, training programmes and employment and towards removing physical and communication

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26 The World Programme of Action uses the term ‘equalisation’ to emphasise that the aim of achieving the equality of persons with disabilities requires a process of changing State practices to ensure the equal opportunities of persons with disabilities.
27 The World Programme of Action concerning Disabled Persons was adopted on 3 December 1982 which now marks the International Day of Disabled Persons.
29 Ibid para 8.
30 Ibid paras 9 and 7.
barriers. They also address the promotion of community awareness to the situation of persons with disabilities.

Concerning psychosocial disabilities and community awareness, the Tallinn Guidelines point out that persons with intellectual and psychosocial disabilities “are among the most stigmatized groups of citizens”. The Guidelines state:

They have the right to make choices, take risks, control their own lives and live in the community. Their adult status, abilities and aspirations must be respected and reinforced by their inclusion in decision-making, although many may need individual advocacy to be clearly understood.

The Tallinn Guidelines acknowledge that persons with intellectual and psychosocial disabilities benefit from education, skills training and work opportunities which often require an individualised approach and the provision of support. This is an important clarification in regards to decision-making and the necessity for support of existing abilities. While the Declaration on the Rights of Mentally Retarded Persons articulates rights and readily points out their limitations, the Tallinn Guidelines specifically address what steps can be taken to support persons and they shy away from mentioning limitations.

3.4 The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991

The most specific international instrument on human rights and mental health prior to the CRPD are the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted in 1991 (MI Principles). The MI Principles have been the first comprehensive international guidelines of the United Nations on mental health. They consist of 25 principles that clarify the existing rights and freedoms of persons with psychosocial disabilities. The MI Principles apply to persons with a mental illness and those who

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31 Ibid para 42.
32 Ibid para 42.
33 Ibid para 42.
are being treated as such persons. Hence, they apply to persons with an actual or perceived mental illness and those who are detained in mental health facilities.

The *MI Principles* stress each individual’s dignity, autonomy and equality and call for resource allocation, training, improvement in services and the integration of persons with psychosocial disabilities into society. Some provisions have responded to grave human rights violations, in particular in institutional settings. Thus, the *MI Principles* prohibit the misuse or inappropriate use of physical restraint or involuntary seclusion, the administration of improper medication as a punishment, sterilisation, experimental treatment without consent and forced or unpaid labour. They provide important safeguards for personal representation, such as a right to paid representation, if a patient cannot afford to pay for a personal representative or the right to a personal representative free of conflicts of interests.

Michael Perlin points out that at the time when the *MI Principles* were adopted, many nations, including Western and European countries, lacked comprehensive mental health legislation. He stresses that mental health legislation not only grants individuals access to independent counsel and judicial review mechanisms, but mental health legislation also brings transparency into the living conditions of persons who are in most marginalised settings and regulates their humane treatment and living arrangements. He provides examples of

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41. Ibid, 343 ff.
neglect when states failed to regulate mental health services and did not provide for human living conditions in institutionalised settings. These examples include the lack of hygiene, clothing, food and food utensils, bedding and the lack of access to toilets and basic medical care.\textsuperscript{42} The \textit{MI Principles} call for States Parties to set up legal protection to persons with mental illness in order to prevent such abuse. Thus, the \textit{MI Principles} have provided States Parties with important guidance on how to establish, or improve, domestic mental health legislation to ensure the rights of persons with psychosocial disabilities.

However, the \textit{MI Principles} also set out a number of restrictions and they have been controversial and heavily criticised,\textsuperscript{43} even within the United Nations.\textsuperscript{44} Central to the criticism are the following concerns which will be relevant for arguments in subsequent Chapters.

### 3.4.1 Scope of Application

First, the \textit{MI Principles} provide for the protection of persons with an actual or perceived mental illness.\textsuperscript{45} In 2005, the World Health Organisation (WHO) introduced a Resource Book on Mental Health, Human Rights and Legislation in 2005 and stated that the use of the term ‘mental illness’ ensures a “very narrow”\textsuperscript{46} scope of application. When compared to the terminology of ‘mental disorder’ the use of the more narrow term of mental illness has the advantage that it is a relatively well-defined term and does not include “a range of conditions from the

\begin{footnotes}
\footnote{Ibid, 343 ff.}
\footnote{\textit{Progress of Efforts to Ensure the Full Recognition and Enjoyment of the Human Rights of Persons with Disabilities - Report of the Secretary-General}, 58\textsuperscript{th} sess, UN Doc A/58/181 (24 July 2003) para 12.}
\end{footnotes}
most benign to extremely serious".\textsuperscript{47} Thus, the \textit{MI Principles} take the stance that they allow for interventions only for a narrow group of persons.

When the \textit{MI Principles} address persons with a 'perceived' mental illness, they ensure that the legal protections and remedies that should be incorporated into mental health legislation apply to any individual who is treated for a mental illness prior to, or without, a diagnosis. This formulation also ensures that these legal protections and remedies apply to persons who live in psychiatric settings for other reasons than 'actual' mental illness, such as political reasons or their sexual orientation.

However, when the \textit{MI Principles} apply to persons with actual and perceived mental illness, they have the potential to open the scope of interventions on the ground of mental illness also to those who do not have an actual mental illness. They do not set out legal safeguards and remedies only, but allow for responding to people with forces that are subject to close scrutiny outside of mental health settings. Eric Rosenthal and Clarence Sundram have stated that the \textit{MI Principles} “apply to all persons admitted to a mental health facility, whether or not they are diagnosed as mentally ill”.\textsuperscript{48} The \textit{MI Principles} allow for their involuntary treatment and detention, but Rosenthal and Sundram argue that they contain “a number of weak protections against involuntary treatment”.\textsuperscript{49} The \textit{MI Principles} allow for involuntary treatment and detention if it is necessary to protect the “patient's own safety or the safety of others”.\textsuperscript{50} Thus, they aim to protect individuals from interventions by setting out that interventions are permissible only when strictly necessary and subject to strict legal safeguards. However, they also allow for interventions in order to \textit{protect} the rights of any individual with an actual or perceived mental illness. Rosenthal and Sundram have argued that the \textit{MI Principles} thus apply to a larger group of persons than the narrow definition of 'mental illness' may purport to cover. This may have the effect that, in practice, the

\begin{itemize}
\item\textsuperscript{47} Ibid, 24 f.
\item\textsuperscript{49} Ibid, 475 with further references.
\item\textsuperscript{50} Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, GA Res 46/119, UN GAOR, 46\textsuperscript{th} sess, 75\textsuperscript{th} plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), Principle 11(6)(b).
\end{itemize}
powers of limiting individuals’ rights set out in the *MI Principles* may be applied broadly and they may be susceptible to abuse.

### 3.4.2 Informed Consent and Capacity to Consent

**Principle 11 of the *MI Principles*: Consent to Treatment**

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

   (a) The diagnostic assessment;
   
   (b) The purpose, method, likely duration and expected benefit of the proposed treatment;
   
   (c) Alternative modes of treatment, including those less intrusive; and
   
   (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

   (a) The patient is, at the relevant time, held as an involuntary patient;
   
   (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and
   
   (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons.
Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

Second, the MI Principles allow for differential treatment in regards to the requirement of informed consent to treatment on grounds that may not be objective, reasonable and appropriate grounds for differentiation. In general health settings medical treatment requires the informed consent of the individual
Principle 11(6)(b) of the *MI Principles* authorises medical treatment without the personal consent of the individual with mental illness, if he or she is incapable of making decisions. According to Principle 11(6)(b), a person with mental illness who has capacity to make decisions can also be treated without his or her consent. Principle 11 states that a person may be treated:

- if he or she is held as an involuntary patient, unreasonably withholds consent and the treatment is in the best interest of the patient’s health needs;
- if an appointed representative, who is empowered by law to consent to treatment, consents for the patient;
- if a qualified mental health practitioner determines that treatment is urgently necessary in order to prevent immediate or imminent harm to the patient or others;
- if it is considered, after independent review, that it would best serve the health needs of the patient to carry out a major medical or surgical procedure; and
- if a competent, independent (mental health) review body approves the patient’s admission to a clinical trial or the provision of experimental treatment.

Principle 11(6) has been subject to criticism as it overrides the requirement of informed consent of a person who is capable of making decisions on the ground of unreasonable refusal to treatment.

Since the early stages of the United Nations international human rights law, freedom from non-consensual medical treatment has had central importance. By
inference, Principle 11(6)(b) directly equates incapacity to consent to unreasonably withholding consent as they are used as direct alternatives. By equating incapacity to consent to unreasonably withholding consent, Principle 11(6)(b) is ambiguous in relation to the understanding of informed consent.57

The provision might be viewed as encompassing the administration of treatment prior to a capacity assessment or the consistent administration of psychiatric medication to persons who may experience intermittent stages of capacity due to a fluctuating nature of their psychosocial disability. Psychiatric medication often should not be taken or stopped abruptly and the daily administration of drugs could be compromised, if the assessment of legal capacity is continuously required. However, if Principle 11(6) is incorporated into domestic law as a legal provision,58 it explicitly allows for overruling the requirements of informed consent instead of addressing the difficulties of securing a crisis response or consistency in a course of treatment to which the patient could have consented at a time when he or she was capable of doing so. By implying that capacity can be overruled at any stage, the provision can be criticised because it does not value the decision-making capacity of a person with actual or perceived mental illness. Principle 11(6) infers that persons with psychosocial disabilities who are capable of making decisions can be lawfully questioned as to the reasonableness of their decision.59

This limitation is in stark contrast to respecting the decision-making capacity of a person without psychosocial disability.60 Other persons who are capable of making decisions can refuse even life-saving treatment on morally accepted, but


58 Unlike many other documents of the United Nations, the MI Principles are formulated like legal provisions, ready to be adopted directly into domestic law.


not rational grounds, such as religious beliefs. In general health practice, there are many difficulties in ensuring appropriate communication and understanding of relevant information that is necessary for genuine, informed consent. There are also reasons for debating to what extent informed consent should be respected as a result of autonomy being favoured over other interests. However, the principle of informed consent to medical treatment has become central to medical law. The law of trespass and negligence protects adults who have decision-making capacity from treatment without consent. In principle, medical law and ethics is based on the respect for autonomy and has accepted, as Denys Court puts it, that "[c]apacity depends upon understanding rather than wisdom; the essential feature is understanding, not how wisely it has been applied". According to the MI Principles, persons with psychosocial disabilities who are capable of making treatment decisions are in a significantly different position. Principle 11(6) can allow for preventing persons with psychosocial disabilities taking risks in their treatment or in negotiating alternatives to the recommended treatment. Caroline Gendreau has criticised the MI Principles and states that there is an "obligation to be reasonable: being capable is not enough".

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61 See Genevra Richardson, 'Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions' (2002) 65 Modern Law Review 702, 704. This comparison does not imply that religious views are intrinsically irrational. This comparison serves to point out that religious views do not have to be based on rational grounds to be protected within the international human rights scheme.


64 Including assault, battery and/or unlawful detention. Janine McIlwraith and Bill Madden, Health Care & the Law (Thomas Reuters (Professional) Australia, 5th ed, Pyrmont, 2010), 57.


3.4.3 Bias towards Refusal of Treatment Being Unreasonable

Third, the *MI Principles* have been criticised in that they tend to regard treatment refusal as something that is inherently negative and unsafe.\(^69\) This can foster the interpretation of refusal being unreasonable and it can distract from the obligation to assess the individual’s ability to make treatment decisions. The bias can be concluded from Principle 11(4). According to Principle 11(4), the consequences of refusing or stopping treatment must be explained to the patient. It is important that the patient understands the consequences of non-treatment, but an explanation of the effects of treatment, and non-treatment, is usually part of obtaining informed consent and information must not be limited to pointing out negative effects only. Caroline Gendreau comments in this regard:

> This provision shows an obvious tendency to presume that the refusal of treatment always and exclusively has negative effects and that the acceptance of treatment always and exclusively has positive effects. It implies that everything must be done to make those who refuse treatment change their mind, whether or not they are competent, by stressing the consequences of the negative choice they made. In such circumstances, one may well doubt that a free decision was made by the patient and that an informed consent was validly obtained.\(^70\)

Thus, the consequences of respecting ‘consent’ seem to change once a patient disagrees with the suggested course of treatment to the effect that the crucial differentiation may be whether the patient volunteers for treatment, rather than the patient making an informed choice.

The *MI Principles* emphasise the scrutiny for a refusal of treatment. However, they do not call for similar scrutiny of the decisions by an individual who may not be capable of making decisions, but simply complies with treatment.\(^71\) This conceptualisation of the *MI Principles* raises the suspicion that a patient who

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\(^69\) Ibid, 270.  
\(^70\) Ibid, 270.  
\(^71\) See, for example Kate Diesfeld, 'Neither Consenting nor Protesting: An Ethical Analysis of a Man with Autism' (2000) 26 *Journal of Medical Ethics* 277; Damien Bruckard and Bernadette McSherry, 'Mental Health Laws for those "Compliant" with Treatment' (2009) 17(1) *Journal of Law and Medicine* 16.
does not refuse treatment is confused with, or deliberately equated to, a consenting patient who was properly informed and makes a deliberate choice.

In contrast to the Declaration on the Rights of Retarded Persons, the MI Principles do not emphasise that a person’s capacity to make treatment decisions is a matter of acknowledging a broad spectrum of capacities. Rather, they seem to emphasise the need for intervention. The following section will elaborate on this thought.

3.4.4 Best Interests Considerations

Fourth, some commentators on the MI Principles have criticised their “continued focus on treatment and protection” and the promotion of a “paternalistic medical model perspective, rather than a rights-based approach”. This is in stark contrast to the parallel achievements in the general disability sector where the medical focus on understanding disability was, at that time, debated and increasingly rejected. The Tallinn Guidelines focus on equality and self-determination. They stress respect for the decision-making of persons with disabilities, their right to make choices and to take risks. Thus, it seems that the Tallinn Guidelines focus on supporting persons with disabilities towards achieving what they consider is best for them. If there are situations when the individual with disability cannot participate in making a decision, the decision-making process is guided by what the person would have wanted.

In contrast, the MI Principles stress that medical treatment should be “in the best interest of the patient’s health needs” and consider the “patient’s safety or

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72 See section 3.1 above.
the safety of others. Thus, the MI Principles also focus on ensuring what is best for a person with mental illness, but the MI Principles seem to imply that the interpretation of what is best for the person is not driven by the individual’s preferences. Rather, medical and public interest considerations drive the interpretation of what is best for the person with mental illness.

The MI Principles indicate that the question of what is reasonable is based on considerations of the patient’s health, welfare or the safety of others. Thus, Principle 11 can lead to the effect that the recommended ‘best course’ of treatment can readily trump the patient’s choice because acting against the opinion of a medical expert can be readily judged to be unreasonable. The review process of treatment decisions is also guided by medical expert advice. This can be concluded from Principle 16 of the MI Principles as the decision to admit a patient involuntarily is safeguarded by the second opinion of a mental health practitioner. However, the parallel human rights development in respect to disability in general, displayed a shift away from decisions on treatment and admission that are purely guided by medical considerations.

3.4.5 Minimum Standard of Protection

Fifth, in contrast to many other international human rights instruments, the MI Principles are not inspirational in terms of what nations should achieve. Rather, they focus on defining in what circumstances established human rights can be limited. Thus, the MI Principles run the risk of being applied without sufficient awareness that restrictions should be exceptional.

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Several commentators argue that the *MI Principles* define a minimum standard of protection.\(^{79}\) However, United Nations’ international human rights instruments usually aim to guide States Parties on how to achieve human rights compliance. Providing inspirational guidance is important to the international human rights realisation in that States Parties are subject to ongoing scrutiny as to what they can achieve. Similar to the requirement of progressive realisation, an inspirational standard encourages States Parties to keep on trying their best to achieve the full realisation of human rights and freedoms.

### 3.4.6 Conclusions

This thesis argues that the ways in which Principle 11 subjects persons with mental illness to different standards in respect to their informed consent to medical treatment is concerning because persons with mental illness who are capable of making decisions about their treatment can refuse treatment only, if their refusal is reasonable. This concern increases when the *MI Principles* emphasise the best interests of the patient’s *health needs* and *safety* as well as the *safety of others* because they imply that the interpretation of what is best for the persons should be guided by medical and public interest considerations.

Some commentators consider that the *MI Principles* have done “more harm than good”.\(^{80}\) Eric Rosenthal and Leonard Rubenstein have commented that the *MI Principles* “are the product of the inevitable conflict between the desire to treat


and the libertarian imperative to leave someone alone", 81 but they “remain a compromise not only on substantive issues but on the values that support them”. 82 In the end, the MI Principles contain substantive compromises, limitations and ambiguities to such a degree that their use in clarifying appropriate human rights standards has been limited to identifying some severe human rights breaches. Tim Harding has commented that:

At the best, the UN Principles can be seen as a recognition of the mentally ill as a vulnerable group and the need to provide them with adequate protection. At worst, they constitute a set of cosmetic, superficial, ineffective and unenforceable recommendations which give a wholly false impression of dealing with the rights of mentally ill persons. Indeed, there is a risk that the Principles interfere with or impede protection of mentally ill persons under general provisions of human rights law. 83

3.5 The Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1993


The focus of the Standard Rules has been on the preconditions and target areas for equal participation, measures for implementation and monitoring mechanisms. They have identified that social factors, including ignorance, neglect, superstition and fear, have isolated persons with disabilities and delayed their

82 Ibid, 267.
development.\textsuperscript{85} The \textit{Standard Rules} clarify that States Parties have a responsibility to take appropriate actions to remove obstacles that hinder the human rights realisation and full participation in society of persons with disabilities.\textsuperscript{86}

The \textit{Standard Rules} stress that it is important to raise awareness of the capabilities of persons with disabilities and their rights, needs, potential and contributions.\textsuperscript{87} In the development of human rights and disability, the \textit{Standard Rules} have played an important role in that they elaborate in detail on measures aimed at ensuring participation and assisting the development of policy-making. Also, the \textit{Standard Rules} are based on active and close cooperation with persons with disabilities, their parents, guardians, advocates and organisations.\textsuperscript{88} These \textit{Standard Rules} led in 1994 to the appointment of the Special Rapporteur on Disability who promotes and monitors the implementation of the \textit{Standard Rules}, reports to the Commission for Social Development and consults with experts on disability.

3.6 Consistent Themes

There are some important observations that can be drawn from the human rights developments concerning disability and mental health as portrayed in the non-binding instruments of the United Nations prior to the \textit{CRPD}. In particular, the following consistent themes in the understanding of human rights and disabilities can be observed.

3.6.1 The Shift in Understanding Disability in its Social Context

First, the central observation of the human rights development under the non-binding instruments of the United Nations is that the \textit{World Programme of Action}, and the instruments on general disability resulting from it, marked a steady shift from understanding disability as a matter of physical or mental characteristics to understanding disability in its social context.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{85} Ibid, Introduction, para 3.
\item \textsuperscript{86} Ibid, Introduction, para 15.
\item \textsuperscript{87} Ibid, Rule 1.
\item \textsuperscript{88} Ibid, Preamble.
\end{itemize}
\end{footnotesize}
3.6.1.1 The Medical Model of Disability

The early Declaration on the Rights of Mentally Retarded Persons and the Declaration on the Rights of Disabled Persons reflected the times in which the medical model of disability was still predominant. According to the medical model of disability, an individual with disabilities is defined by his or her physical or mental characteristics. These characteristics are measured in regards to society at large. The medical model of disability rests on the idea that if persons with disabilities do not fit into society as it exists, they need medical assistance or modification to overcome their disability and to be included into society. Failing that, persons with disabilities are viewed as being in need of constant welfare and have enjoyed limited social participation only to the effect that those who looked after individuals with disabilities decided what is best for them.

Because of the experience of abuse and neglect, strong safeguards for the human rights protection of persons with disabilities have been put in place. However, the medical model of disability relies heavily on the good will and good deeds of others. It has run the risk of leaving persons with disabilities in marginalised positions with their abilities undervalued, underused and undermined where they experienced significant barriers to claiming change.

The Declaration on the Rights of Mentally Retarded Persons and the Declaration on the Rights of Disabled Persons are based on the medical model of disability. Irrespective of the use of terminology that is now considered derogatory, the Declaration on the Rights of Mentally Retarded Persons reflects the medical

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89 See also, Michael L Perlin, International Human Rights and Mental Disability Law - When the Silenced Are Heard (Oxford University Press, New York, 2011). Michael Perlin states that "the characterization of ‘disability rights’ (especially the rights of persons with mental disabilities) as a social issue was not discussed in a global public, political, or legal debate until the early 1990s" (at 3).


91 Ibid, 13 ff.


model of disability, even more so than the Declaration on the Rights of Disabled Persons. Both Declarations have aimed to achieve welfare and rehabilitation. Yet, the Declaration on the Rights of Disabled Persons has emphasised protection from discriminatory treatment more than the Declaration on the Rights of Mentally Retarded Persons and it has less readily addressed the inherent limitations of its substantive rights. This thesis argues that today, both instruments are mainly of historic value. They help to identify the ideological differences in addressing disability as human rights issue, but they no longer express appropriate human rights standards because the human rights framework now reflects the social model of disability.

3.6.1.2 The Social Model of Disability

With the World Programme of Action, the focus of international human rights protection has shifted to seeing disabled persons as holders of rights, rather than objects of welfare. The Tallinn Guidelines and the Standard Rules stress that persons with disabilities are subjects of rights. They provide for law and policy to facilitate the social integration of persons with disabilities. Seeing persons as holders of rights contains the idea that it is society that needs to guarantee that all human beings can equally enjoy their rights and freedoms. Thus, society needs to ensure that persons with disabilities can exercise their rights and freedoms on an equal basis to others. This requires that society must ensure disabled individuals’ inclusion and participation in society.

The World Programme of Action and subsequent instruments have

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95 Both documents also contain statements to respecting equal rights of ‘retarded’ or disabled persons, but in light of their specifications it seems to be rather a rhetoric formulation.
emphasised that persons with disabilities can exercise many human rights only when they are integrated into society and when their environment is inclusive and responsive to persons with disabilities. Rights such as the right to work, the right to education, the right to participate in political affairs and the right to a fair and public hearing are quintessentially linked to integration into society and access to devices, services and facilities. Many disability rights advocates have claimed that “it is society which disabled the person”. This perception is at the heart of the social model of disability. It understands disability in its social context and embraces disabilities as part of human diversity which needs to be valued when respecting the human dignity of a person with disabilities. This perception demands that society remove the barriers that hinder the realisation of the human rights and freedoms of persons with disabilities. The social model of disability also responds to attitudinal barriers which disable persons with impairments when society undervalues the worth and skills of individuals with disabilities.

3.6.2 The Central Importance of the Protection of Human Dignity and Equality

Second, the non-binding human rights instruments that addressed disability have been consistent in their focus on the protection of human dignity of all human beings. The instruments that developed under the influence of the medical model of disability had significant shortcomings in fostering equality, but in principle they have aimed at respecting the equal value of persons with disabilities. It took time to change the idea that true equality cannot be achieved when individuals have

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101 Phillip French and Rosemary Kayess, ‘Deadly Currents Beneath Calm Waters: Persons with Disability and the Right to Life in Australia’ in Luke Clements and Janet Read (eds), Disabled People and the Right to Life (Routledge, Oxon & New York, 2008) 57, 62. For example, the fact that a person who is physically unable to walk is treated differently must be understood in the social context of that individual in order to judge whether differential treatment is discriminatory. The social model of disability emphasises that the fact that the individual cannot walk becomes an irrelevant consideration for differentiation when the individual lives in a wheelchair accessible environment.
physical and mental differences. The change in perceiving persons with disabilities as different, but equal\textsuperscript{102} human beings may echo medical, technological and ideological advances within societies. However, the early Declaration on the Rights of Mentally Retarded Persons and the Declaration on the Rights of Disabled Persons have strongly emphasised the protection of human dignity. Subsequent human rights instruments increasingly acknowledged the equality of persons with disabilities and focused on the means to ensuring their equal standing in society.

3.6.3 The Central Importance of Resource Allocation

Third, non-binding instruments of the United Nations have been consistent with the United Nations treaty law which has confirmed that resource allocation is central to furthering the human rights protection of persons with disabilities, including persons with psychosocial disabilities. The controversial MI Principles also stress this important element of human rights realisation. Thus, there has been a consistent recognition that States Parties have to become proactive in order to realise the human rights and freedoms of persons with disabilities, regardless of whether the right or freedom is considered a civil and political right or an economic, social or cultural right.

Also, the United Nations has increasingly recognised that it is important to provide substantial guidance to States Parties on how to allocate resources and what changes in law and policy are necessary in order to realise the equal standing of persons with disabilities within society. The non-binding documents of the United Nations on disability provided an increasingly tangible framework for measuring achievements in domestic efforts towards human rights realisation.

3.6.4 Equal Opportunities to Exercise Human Rights

Fourth, the developments under the World Programme of Action have illustrated that the human rights realisation for persons with disabilities requires furthering

cooperation with disability interest groups and continuous State efforts to attain the equal standing of persons with disabilities in society. The Tallinn Guidelines and the Standard Rules have demanded the equalisation of opportunities and the full participation of persons with disabilities. They have identified what steps are required to pursue these goals and in what ways States Parties have to adjust State practices towards the inclusion of persons with disabilities. They have stressed that States Parties have to become proactive to ensure that persons with disabilities enjoy equal opportunities to exercise their rights and in particular the Standard Rules have recognised that law and policy need to be improved in consultation and cooperation with persons with disabilities.

3.7 Shortcomings and Challenges

There have also been the following shortcomings and challenges to the human rights realisation of persons with psychosocial disabilities prior to the CRPD.

3.7.1 Numerous Documents on Human Rights and Disability

First, detailed interpretative guidance on the human rights realisation of persons with disabilities has existed in a number of different instruments. Thus, one of the main shortcomings of the human rights documents on disability prior to the CRPD was that guidance could be found in a demanding and diffuse patchwork of general comments, guidelines, principles, standards and other documents. The Committee on Economic, Social and Cultural Rights and the World Programme of Action pointed out that persons with disabilities have had their human rights severely neglected. A wealth of different documents has not sufficiently provided a clear sign to States Parties that immediate action for improvement is necessary and if they aimed to realise the human rights of persons with disabilities they had to assess how these different sources of information relate to one another and if they are consistent in their detailed specifications.

3.7.2 Details in Non-Binding Documents

Second, the international human rights framework prior to the CRPD had shortcomings to the human rights realisation of persons with psychosocial disabilities because the documents or comments that addressed disability in detail were non-binding. They have provided guidance for the interpretation and application of human rights only. In particular, the shift in the understanding of disability in its social context has been articulated to States Parties only in interpretative guidelines and rules. Under the aegis of the United Nations, it is already difficult to enforce binding international human rights standards on States Parties,\(^{105}\) and it is even harder to call for change using non-binding documents.\(^{106}\)

3.7.3 Non-Comprehensive Details

Third, prior to the CRPD, the international human rights instruments had shortcomings to the human rights realisation of persons with psychosocial disabilities because the instruments that expressed a shift to the social model of disability have not reassessed all existing human rights and freedoms comprehensively. The Tallinn Guidelines and the Standard Rules have stressed the equality of persons with disabilities and called for States Parties to understand the social barriers to the realisation of all human rights and freedoms for persons with disabilities. However, they have focused on some target areas and addressed only a selection of rights, such as the right to education and employment. They have neglected other rights, such as the right to participate in political affairs. Thus, at the time when the discussion arose whether the United Nations should set up a new thematic convention that specifically addressed disability, many commentators agreed that it was necessary to address disability as a human rights issue in a comprehensive and legally binding core treaty\(^{107}\) because a thematic convention would send a clear sign to the human rights community what

\(^{105}\) See, for example, Michael Kirby, 'United Nations - Up Close' (2005) 24 The University of Queensland Law Journal 279, 284.

\(^{106}\) See section 2.1 above which also pointed out that non-binding international human rights documents can have binding effect, if they become part of customary law.

disability means in the context of human rights realisation.\textsuperscript{108}

\section*{3.7.4 \textit{Slow Advances in Respect to Psychosocial Disability}}

Fourth, when specifically looking at the human rights realisation of persons with psychosocial disabilities, it seems that the human rights development has been running a step behind advances in social change. The \textit{Declaration on the Rights of Retarded Persons} has been less advanced in promoting the equality of persons with psychosocial disabilities than the \textit{Declaration on the Rights of Disabled Persons}. In the general disability sector, major human rights advances have evolved with the understanding that persons with disabilities have to be respected as full and equal members of society. The \textit{Declaration on the Rights of Disabled Persons} has stressed that persons with disabilities should receive welfare and rehabilitation to be integrated into society. Subsequent human rights documents have increasingly stressed that society has to accommodate their social inclusion and create accessible environments. Many facilities and services are now accessible to persons with disabilities, while this was not the case at the time when these early declarations were formulated. However, it seems that the idea of ‘accommodation’\textsuperscript{109} has not been followed up in regards to psychosocial disability.

The United Nations has recognised that persons with physical disabilities had their decision-making capacities denied due to misconceptions. Yet, at the same time, the United Nations barely safeguarded persons with psychosocial disabilities from similar misconceptions. The \textit{Declaration on the Rights of Retarded Person} has stressed that decision-making is a matter of a broad spectrum of capacities.\textsuperscript{110} The \textit{MI Principles} are not sufficiently based on that idea. They seem to accept  – rather than substantially scrutinise if  – persons with psychosocial disabilities are inherently unreasonable when they refuse treatment. Also, the \textit{MI Principles} delegate decision-making concerning treatment to others who are expected to protect not only the welfare interests of the person with psychosocial


\textsuperscript{109} The meaning of the idea that society has to accommodate the social inclusion of persons with disabilities will be further addressed in section 4.4.6.3 below.

\textsuperscript{110} See section 3.1 above.
disability, but also the interests of others.

In contrast to the development under the *Tallinn Guidelines* and the *Standard Rules*, the binding and non-binding international human rights instruments have kept addressing psychosocial disability with a traditional focus on negative obligations on States Parties. Negative obligations aim to safeguard freedoms from unjustified interventions. The *MI Principles* have stressed the idea that resource allocation is necessary to realise the human rights of persons with mental illness, but in comparison to the *Tallinn Guidelines* and the *Standard Rules* they do not sufficiently elaborate what measures of implementation or monitoring may be necessary to overcome structural disadvantages, to ensure equal opportunities and to support existing abilities. Rather, the detailed provisions of the *MI Principles* focus on clarifying under what circumstances interventions are justified and how to ensure that persons with mental illness have access to justice when they want to challenge their involuntary treatment and detention.

The *MI Principles* incorporate important legal safeguards and measures of control. But they also incorporate formulations that are convoluted and more useful to address matters of liability, rather than achievements towards human rights realisation. Also, the *MI Principles*’ approach to psychosocial disabilities rests on the medical model of disability in that they aim to respond to shortcomings in the human rights realisation of persons with psychosocial disabilities with involuntary treatment, emphasise the best (medical) interests of the person and rely on clinical experts deciding on treatment. This contrasts with the movement in general disabilities which has addressed more straightforwardly what States Parties need to do in order to facilitate for the social integration of persons with disabilities.

With the *Declaration on the Rights of Retarded Persons* being an outdated document, the controversial *MI Principles* have remained the primary guidelines on human rights and psychosocial disabilities prior to the *CRPD*. Like many other commentators on the *MI Principles*, the United Nations Secretary-General\(^{111}\) and

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the Special Rapporteur on the Right to Health\textsuperscript{112} criticised the \textit{MI Principles} and questioned their validity as the Principles allow for substantial unequal treatment in regards to respecting the decision-making capabilities of persons who are capable of giving informed consent.\textsuperscript{113} In that regard, the \textit{Declaration on the Rights of Retarded Persons} incorporated stronger protection than the \textit{MI Principles}.

\textbf{3.7.5 Inconsistencies with Binding Treaty Interpretation?}

Fifth, the international human rights protection of persons with psychosocial disabilities had shortcomings because the most detailed provisions on psychosocial disability as set out in the \textit{MI Principles} conflict with the General Comments of the Human Rights Committee. They also indicate some conflict with the General Comments of the Committee on Economic, Social and Cultural Rights. This has left ambiguity as to what the correct human rights standard is, to the effect that persons with psychosocial disabilities have experienced difficulties in claiming their rights. Also, States Parties may have adopted the \textit{MI Principles} as the most detailed human rights standard on the assumption that they are consistent with the treaty law.

\textbf{3.7.5.1 Considerations of the Human Rights Committee}

The \textit{MI Principles} allow for the involuntary treatment of persons with mental illness who are capable of consenting, if they unreasonably refuse treatment. Prior to the adoption of the \textit{MI Principles}, the Human Rights Committee stated that interventions may be justified on reasonable and objective grounds.\textsuperscript{114} After the adoption of the \textit{MI Principles}, the Human Rights Committee has addressed the detention of persons with psychosocial disabilities in General Comments 20 and 21. The Committee has accepted that incapacity to make decisions is a reasonable and objective ground not to require informed consent to treatment.


\textsuperscript{113} See section 3.7.5.3 below.

\textsuperscript{114} See Human Rights Committee, \textit{General Comment No 18: Non-Discrimination}, 37\textsuperscript{th} sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 195 (10 November 1989), see section 2.1.2.2 above. This position is later confirmed in Human Rights Committee, \textit{General Comment No 25: The Right to Participate in Public Affairs, Voting Rights and the Right of Equal Access to Public Services (Art. 25), 57\textsuperscript{th} sess, UN Doc CCPR/C/21/Rev.1/Add.7 (12 July 1996), see section 2.1.2.5 above.
However, the Committee has not equated incapacity to make treatment decisions to unreasonable refusal of treatment. Rather, it seems that the Committee has acknowledged that there are circumstances in which the free will of a person needs to be respected, regardless as to whether or not that person is capable of making an informed choice.\textsuperscript{115} The Committee has established that a person’s free will needs to be respected, if medical treatment is experimental and thus not based on sufficient evidence that it is beneficial.\textsuperscript{116} The Committee has implied that in such circumstances a person’s refusal to be treated should be the decisive consideration, in particular when the person also lives in an institutionalised setting.\textsuperscript{117} In contrast, the \textit{MI Principles} allow for medical treatment without consent if the individual unreasonably refused consent and they allow for experimental treatment on persons with psychosocial disabilities against their will subject to the approval of a competent, independent review body.\textsuperscript{118}

The \textit{MI Principles} scrutinise the suggested treatment as to whether or not the treatment serves the best interests of the person with mental illness. Restrictively interpreted, it can be argued that a person’s refusal to be treated is reasonable, if the suggested course of treatment is not proven to be beneficial. However, if there are no alternative options available, it may also be argued that it is reasonable to trial treatment, even if it is not yet certain whether the treatment has the expected outcome because non-treatment may be the worse of two alternatives. In this context, the reasonability criterion is too vague to provide substantive scrutiny. In an environment of limited resources and services, this criterion provides much room for arguing why shortcomings in mental health services can restrict the rights of the individual with psychosocial disability. The Human Rights Committee seems to follow a different approach in taking the stance that, when doubt exists as to whether or not treatment will be beneficial, interventions are not justified, if they conflict with the free will of the person.

\begin{flushright}
\textsuperscript{115} See Human Rights Committee, \textit{General Comment No 20: Replaces General Comment 7 concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)}, 44\textsuperscript{th} sess, UN Doc HRI/GEN/1/Rev.9 (Vol. I) at 200 (10 March 1992). See also section 2.1.2.3 above.
\textsuperscript{116} See ibid and section 2.1.2.3 above.
\textsuperscript{117} See ibid and section 2.1.2.3 above.
\textsuperscript{118} \textit{Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care}, GA Res 46/119, UN GAOR, 46\textsuperscript{th} sess, 75\textsuperscript{th} plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), Principle 15.
\end{flushright}
The Committee did not refer to the *MI Principles* in its General Comment No 20, even though the *MI Principles* have been released just prior to the comment.\(^\text{119}\) The Human Rights Committee also did not refer to the *MI Principles* in subsequent General Comments, indicating that the Committee has not changed its earlier position and that there may be conflict in respect to the interpretation and application of the *ICCPR*.

Also, the Human Rights Committee seems to follow the idea that persons can be treated without their consent in exceptional circumstances only. As addressed above, the *MI Principles* leave much scope for interpreting the requirements of involuntary treatment too broadly to consider them to be used in exceptional circumstances.\(^\text{120}\) Nor do they set out the consideration of the principle of proportionality in individual circumstances. Rather, they are susceptible to the interpretation that persons with psychosocial disability are categorically unequal in exercising their freedom from non-consensual treatment.

### 3.7.5.2 Considerations of the Committee on Economic, Social and Cultural Rights

In contrast to the Human Rights Committee, the Committee on Economic, Social and Cultural Rights referred to the *MI Principles*. However, the Committee did not comment on the content of the *MI Principles*. The controversy about the *MI Principles* has focused on the provision on informed consent, while the *MI Principles* also contain important safeguards to the human rights of persons with psychosocial disabilities who are subject to mental health specific limitations of their rights and freedoms. The *MI Principles* are detailed principles and the fact that the Committee has referred to them may not provide support in respect to all the details of the *MI Principles*. The General Comments of the Committee have shown a tendency not to accept categorical differentiation solely based on psychosocial disability and stress the exceptional nature of interventions.\(^\text{121}\) In that respect, the General Comments of the Committee conflict with some of the details

\(^{119}\) See section 2.1.2.3 above.


\(^{121}\) See section 2.3.1 above. See also General Comment No 16 as addressed in section 4.4.6.1 below.
of the MI Principles.

3.7.5.3 Other Considerations of the United Nations Secretary-General and the Special Rapporteur on the Right to Health

The United Nations Secretary-General confirms the view that there have been inconsistencies in the international human rights protection of persons with psychosocial disabilities. The Secretary-General has stated that the MI Principles “offer in some cases a lesser degree of protection than that offered by existing human rights treaties”.\(^\text{122}\) Hence, it has been uncertain along which lines to protect the decision-making capacities of persons with psychosocial disabilities. Paul Hunt, the Special Rapporteur on the Right to Health, also criticised the MI Principles and has commented that Principle 11 of the MI Principles have rendered “the right to informed consent almost meaningless”.\(^\text{123}\)

3.7.6 Concluding Thoughts

The international human rights instruments had shortcomings to the human rights realisation of persons with psychosocial disabilities because the nature of psychosocial disabilities has posed significant challenges to the human rights protection of persons with psychosocial disabilities. If the decision-making processes of persons with psychosocial disabilities are permanently impaired or go through fluctuating stages of impairment, it is difficult, maybe impossible, to provide consistent psychiatric treatment that can foster general improvements in life. Academic human rights discussions in the mental health sector have long addressed the conflicting interests in intervention and the respect for a person to decide his or her own destiny – with the possible consequence that persons might be “rotting with their rights on”,\(^\text{124}\) if they are strongly protected from involuntary


treatment. How to balance the protection of personal liberty and autonomy with the right to health, or the right to life, remains a matter of controversy.\textsuperscript{125}

However, the human rights debates regarding persons with psychosocial disabilities have been marked by a presumption that persons with psychosocial disabilities are not capable of realising their rights and freedoms because of the nature of their disability. That is, due to their disability, it has been presumed that individuals with psychosocial disabilities run the risk of inhibiting their human rights realisation, rather than ensuring it with the consequence that others have to safeguard their rights and freedoms. Michael Perlin has addressed these issues in reference to ‘sanism’ and ‘pretextuality’.\textsuperscript{126} He describes sanism as decision-making which “is inspired by (and reflects) the same kind of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic and religiously – and ethically – bigoted decision-making”.\textsuperscript{127} He concludes that sanist attitudes have resulted in pretextual decisions “(in which dishonest testimony is either explicitly or implicitly accepted) in mental disability law jurisprudence”.\textsuperscript{128} The later Chapters will elaborate on sanism and pretextuality.\textsuperscript{129}

The human rights framework prior to the CRPD left many questions unanswered. It is, however, odd that the United Nations has recognised that marginalisation and stigmatisation increase the risk of human rights violations and


\textsuperscript{127} Michael L Perlin and Deborah A Dorfman, ‘Sanism, Social Science, and the Development of Mental Disability Jurisprudence’ (1993) 11(1) Behavioral Sciences and the Law 47, 47.

\textsuperscript{128} Ibid, 47.

\textsuperscript{129} See sections 9.1.3.3 and 9.1.6.4 below.
that persons with psychosocial disabilities are most vulnerable to marginalisation and stigmatisation – and then, its most specific instrument on the human rights protection of persons with psychosocial disabilities includes a principle that broadly overrides the requirement of informed consent to medical treatment. It seems that the difficult question of finding the fine line between intervention and non-intervention was delegated to the medical profession, while human rights treaties address States Parties to respond to human rights concern and ensure their laws and practices incorporate realisable human rights principles.

Now, the *CRPD* provides some innovative new elements in the international human rights framework. The following Chapter addresses these elements in preparation for the discussion whether or not they might change the human rights debate and guide domestic mental health reform in a new direction.
CHAPTER 4

4 The CRPD and its New Understanding of Human Rights Realisation

This Chapter\(^1\) provides an overview of the CRPD and addresses the changes to the international human rights framework that came with the CRPD. It builds upon the findings of Chapters Two and Three and assesses in what ways the CRPD has responded to the pre-existing international human rights framework. It provides a brief overview of the development and content of the CRPD. Then, it highlights what new features the CRPD has introduced to the international human rights protection of persons with disabilities. It argues that the CRPD completes the ‘paradigm shift\(^2\) to understanding disability in its social context and informs the States Parties on what measures they have to take in order to ensure the equality and non-discrimination of persons with disabilities.

This Chapter addresses some of the human rights interpretations of the Committee on Economic, Social and Cultural Rights and the Special Rapporteur on the Right to Health made during the time in which the CRPD was drafted and after its enforcement. It identifies the general principles of the CRPD which guide the interpretation of its specific provisions. These findings inform Chapter Five which explores the CRPD’s specific provisions that are most relevant to persons with psychosocial disabilities as well as Chapters Eight to Ten which assess the impact of the CRPD on Australian mental health legislation.

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4.1 Adoption of the CRPD

The United Nations adopted the CRPD on 13 December 2006, five years after it was initiated. One month after its 20th ratification, the CRPD entered into force on 3 May 2008. In the history of the United Nations, the CRPD was the most rapidly negotiated international human rights treaty with the highest number of opening signatures and an impressive number of swift subsequent ratifications. Philip French and Rosemary Kayess have commented that:

The rapidity with which it was developed, and the enthusiasm with which the international community has embraced it, appears to be unique in the history of international human rights law.

The CRPD is a comprehensive treaty that clarifies disability as a human rights issue. At its heart, it respects the inherent human dignity of persons with disabilities as worthy of equal protection in the same way as other human beings. A sense that persons with disabilities had been denied the equal realisation of their human rights and freedoms for too long, prevailed over initial fears that a disability specific treaty could further single out persons with disabilities and reinforce stereotypes of persons with disabilities as being especially vulnerable.

The CRPD is an unusually lengthy document in comparison to other international human rights treaties. It was introduced with the understanding that it just restates already established human rights and fundamental freedoms of the International

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Bill of Rights. But the CRPD clarifies these rights and freedoms in unprecedented detail and identifies measures that States Parties have to take in order to ensure the integration, respect and non-discrimination of persons with disabilities. When looking at its details, this Chapter argues that the CRPD creates new rights. Further, the CRPD now provides a common standard of assessment across different cultures and levels of economic development and serves as an authoritative and global reference point for the human rights realisation of persons with disabilities.

4.2 Scope of Application

During the drafting process of the CRPD, the States Parties discussed whether or not disability should be defined. The necessity for a definition to be included was emphasised by pointing out that the CRPD would operate ineffectively if disability was not clarified. Nevertheless, there was a strong movement not to include a definition as it could be interpreted narrowly and be “subject to minute legalistic analysis”. A definition ran the risk of unintentionally excluding some persons, as disability is a divergent and changing concept, at least in keeping with the social model of disability. The risk of excluding persons was taken seriously and it was decided that disability should not be defined.

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9 See sections 4.4.2 and 4.4.5 below.


12 Ibid, 595.


Instead, the CRPD contains a very broad description of its understanding of disability. According to that description, the CRPD applies to all persons “who have long-term physical, mental, intellectual or sensory impairments”\(^{15}\) which includes “psychiatric and multiple disabilities”.\(^{16}\) The CRPD acknowledges that disability can be “permanent, temporary, episodic and perceived”.\(^{17}\) Hence, the CRPD does not consider disability and illness as clearly distinguishable conditions.\(^{18}\) Rather, the CRPD considers disability as an evolving concept ... that ... results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.\(^{19}\)

Thus, the CRPD emphasises that disability is not defined by deviations from the norm of physical and mental abilities. It may originate from medical or biological conditions, but the CRPD acknowledges that the actual disability may be a social construct whereby impairments may arise from social interactions, attitudes and the environment responding inappropriately to an individual’s diversity in body or mind.

The CRPD does not understand disability as a condition that determines or hinders a person’s skills and potential to exercise their rights. Rather, the CRPD understands disability as a feature that has resulted in inequality. This understanding of disability does not undermine the importance of medicine, care, protection or rehabilitation services in the context of disability. However, it shifts away from valuing persons with disabilities through ideas of medicine, care, protection or rehabilitation. According to the CRPD, the core of understanding


\(^{18}\) See also section 5.1.1 below.

disability is the respect for human dignity.\textsuperscript{20}

As the \textit{CRPD} incorporates such an open understanding of disability that considers social aspects of integration, the scope of application of the \textit{CRPD} is broad and relational. Disability is not understood as a status, but ‘defined’ by societal barriers and obstacles that react unfavourably to individual impairments.

4.3 Overview of the \textit{CRPD}

In its Preamble, the \textit{CRPD} recognises and considers many important issues related to its general interpretation and application. The Preamble starts with recalling the importance of protecting the human dignity and equality of all human beings. This is the premise of the \textit{CRPD}. The Preamble recalls existing human rights treaties and reaffirms the universality, indivisibility, interdependence and interrelation of all human rights and fundamental freedoms. The Preamble also recognises the \textit{World Programme of Action} and the \textit{Standard Rules}. It is significant that the Preamble already adopts the social model of disability into the Preamble by stating that disability results from the interaction between persons with impairments and attitudinal and environmental barriers.\textsuperscript{21}

The \textit{CRPD} then continues with interpretative guidance in its Articles 1 and 2 where it states the purpose of the \textit{CRPD} and defines certain terminology. The purpose of the \textit{CRPD} is to promote, protect and ensure equality and the respect for inherent human dignity.

Articles 3 to 9 provide the framework of the \textit{CRPD}. Article 3 identifies the general principles which guide the \textit{CRPD} like a “moral compass”,\textsuperscript{22} while Article 4 clarifies general obligations of the \textit{CRPD}. The general obligations focus on the measures that need to be taken in general in order to realise all human rights and freedoms set out in the \textit{CRPD} without discrimination. They address, for example, resource constraints and progressive realisation in regards to economic, social


and cultural rights and the consultation with, and active involvement of, persons with disabilities into the development of law and policy-making.

Articles 5 to 7 recognise the equality and non-discrimination of persons with disabilities and address multiple discrimination specifically of women and children with disabilities. The subsequent Articles 8 and 9 present new fundamental elements of the CRPD: awareness-raising and accessibility. States Parties have an obligation to change public awareness of, and attitudes towards, disability. They also have to facilitate independent living and participation through ensuring access to facilities, services and communication relevant to all aspects of life. The significance of some of these elements will be further addressed in subsequent sections of this thesis.23

Articles 10 to 30 set up specific rights and freedoms. Articles 10 to 20 are based on traditional civil and political rights and Articles 24 to 28 and Article 30 are based on traditional economic, social and cultural rights. Some of these Articles restate already established human rights and fundamental freedoms, such as the freedom from torture or cruel, inhuman and degrading treatment or punishment (Article 15). But in its extensive details, the CRPD incorporates new dimensions to these established rights – to such a degree that this thesis will argue that the CRPD breaks with the traditional categories of rights and constitutes new rights that have not been articulated in pre-existing international human rights treaties.24

The subsequent Articles 31 to 40 set out provisions for the implementation and monitoring of the CRPD. They establish the Committee on the Rights of Persons with Disabilities as a monitoring body and clarify reporting procedures. The last section of the CRPD, comprising of Articles 41 to 50, contains operational provisions. The CRPD was also set up with an Optional Protocol that allows for complaints procedures for individuals or groups of individuals to claim a violation in their rights or freedoms of the CRPD.

23 See section 4.4.2 below.
24 See sections 4.4.5 and 4.4.6.3 below.
4.4 Remarkable Features of the CRPD

4.4.1 Completion of the Underlying Paradigm Shift to the Socio-Legal Model of Disability

As assessed in the previous Chapter, one of the shortcomings in the pre-existing human rights framework concerning persons with disabilities was that numerous documents guided the interpretation and application of human rights, but not all of these documents reflected the social model of disability.\(^2^5\) The documents that reflected the social model of disability, did not address established human rights and fundamental freedoms comprehensively.\(^2^6\)

Now, the CRPD has completed the significant 'paradigm shift'\(^2^7\) in the understanding of disability from a welfare-centric, medical model of disability to a rights-based social model of disability. It recognises that “disability resides in society, not in the person”\(^2^8\) and acknowledges that persons experience being disabled through exclusion from society. The CRPD specifically addresses commonly existing barriers and obstacles to the human rights realisation of persons with disabilities and clarifies that they may lie in attitudes and the environment.\(^2^9\) The CRPD sets up in detailed terms how equal treatment can be facilitated despite differences in abilities. Thus, the CRPD illustrates in what ways diversity in abilities does not make a difference to equal treatment.

The CRPD embeds this new understanding of disability in a comprehensive legal framework. By adopting the social model of disability into clearly articulated human rights, the CRPD follows a socio-legal model of disability which comprises

\(^{25}\) See section 3.7.1 above.
\(^{26}\) See section 3.7.3 above.
\(^{27}\) See Gerard Quinn and Oddný Mjöll Arnardóttir, 'Introduction' in Oddný Mjöll Arnardóttir and Gerard Quinn (eds), The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives (Martinus Nijhoff Publishers, Boston, 2009) xv, xvii. Also, the United Nations website on the CRPD states that the CRPD marks a “paradigm shift” at <www.un.org/disabilities/default.asp?navid=13&pid=150> at 1 July 2011.
the social model of disability with empowerment in a legal framework.\textsuperscript{30} In contrast to international human rights instruments prior to the CRPD, the CRPD has incorporated the social model of disability straightforwardly into one of the central human rights treaties of the United Nations that complements the International Bill of Rights. The CRPD addresses both civil and political rights as well as economic, social and cultural rights and clarifies their application in detail. By doing so, the CRPD gives “disability rights a firm and fixed place within the constellation of international human rights”\textsuperscript{31} with the understanding that persons with disabilities can claim their human rights and fundamental freedoms to be respected and realised.

4.4.2 Awareness-Raising and Accessibility

The CRPD strongly responded to the central shortcoming in the international human rights protection of persons with disabilities, that is, invisibility.\textsuperscript{32} Persons with disabilities have shared a history of living lives of marginalisation, institutionalisation and exclusion.\textsuperscript{33} Mainstream society did not see what it means to live a life with disability and neglected to protect the human rights of persons with disabilities. That is, the more persons with disabilities had been out of sight, the easier it was for the able-bodied or able-minded society not to understand the situation in which disabled persons lived, to differentiate themselves from disabled


The \textit{CRPD} now systematically addresses the invisibility of persons with disabilities. It aims at ensuring the full and effective participation of persons with disabilities on an equal basis with others and it identifies barriers and obstacles to the realisation of their human rights and fundamental freedoms. In order to make disabled persons visible in mainstream society, the \textit{CRPD} promotes the general awareness of the capabilities and contributions of persons with disabilities and highlights abuses as human rights breaches. Melinda Jones states that:

In order to bring about change, persons with disabilities need to have a presence in the community, to be seen as participants in social discourse and as part of the fabric of societies in which they live.\footnote{Melinda Jones, ‘Can International Law Improve Mental Health? Some Thoughts on the Proposed Convention on the Rights of People with Disabilities’ (2005) 28 \textit{International Journal of Law and Psychiatry} 183, 194.}

Aaron Dhir has commented that this applies in particular to psychosocial disability as its stigma is “arguably more entrenched than other forms of disability-related stigma”.\footnote{Aaron A Dhir, ‘Human Rights Treaty Drafting through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities’ (2005) 41 \textit{Stanford Journal of International Law} 181, 191; Nisha Mehta and Graham Thornicroft, ‘Stigmatisation of People with Mental Illness and of Psychiatric Institutions’ in Hanfried Helmchen and Norman Sartorius (eds), \textit{Ethics in Psychiatry: European Contributions} (Springer, New York, 2010).}

Although the United Nations has traditionally aimed at changing attitudes as a means of preventing human rights violations, it is innovative that the \textit{CRPD} now sets up a separate provision on awareness-raising in Article 8. Article 8 identifies measures that States Parties can take to approach a change in public attitudes. For example, States Parties have to combat stereotypes, prejudices and harmful practices. One measure to this end is encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the \textit{CRPD}. The \textit{CRPD} also urges States Parties to combat attitudes in the private
sector. This is not a policy document calling upon States Parties to change attitudes as a matter of goodwill – it is a human rights obligation subject to immediate, effective and appropriate realisation.\(^{37}\) This does not overcome the shortcomings in enforcing human rights. However, the CRPD put these issues on the agenda of States Parties. Now, persons with disabilities can claim that States Parties must address these issues in consultation with persons with disabilities. The nature and scope of Article 8 is fundamentally new in that it reaches beyond traditional civil and political rights or economic, social and cultural rights to rights to social development.\(^{38}\)

The same can be stated about Article 9 which relates to accessibility. Improving accessibility is another vital step towards the social inclusion of persons with disabilities.\(^{39}\) Article 9 calls upon States Parties to enable independent living and full participation for persons with disabilities. It clarifies that this requires ensuring the accessibility of the physical environment, transportation, information, communication, facilities and services. Providing for the training of stakeholders on accessibility issues is, for example, an appropriate measure to ensure access to services.

Awareness-raising and accessibility are central to ensuring the social integration and human rights protection of persons with disabilities. These provisions are far-reaching and in an overarching position within the structure of the CRPD. They are relevant to the application and interpretation of all subsequent specific human rights and fundamental freedoms of the CRPD. Articles 8 and 9 also include a framework for assessing States Parties’ achievements. Phillip French and Rosemary Kayess argue that the provisions on awareness-raising and accessibility pose “undoubtedly two of the greatest challenges to the international

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\(^{38}\) Prior to the adoption of the CRPD, the CRC has recognised that children have the right to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development, see *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), Article 27(1). When compared to the CRC, the CRPD does not incorporate the idea of a right to social development as one right amongst other human rights and fundamental freedoms. Rather, the CRPD clarifies the idea of social development within Article 8 which guides the interpretation and application of all substantive rights of the CRPD.

community”. Given that obligations to raise awareness and ensure accessibility are outside of the classical categorisation of rights, they will pose questions in regards to their application and effect. Articles 8 and 9 demand that States Parties improve attitudes towards persons with disabilities and their social inclusion. Article 8 requires States Parties to take “immediate, effective and appropriate measures”. Unlike Article 8, Article 9 refers to “appropriate measures” only. However, Article 9 addresses accessibility to equality and non-discrimination, a traditional civil and political right. Hence, the realisation of Article 9 has elements of immediate effect to it. Thus, Articles 8 and 9 require States Parties to become proactive, but they are not traditional economic, social and cultural rights subject to resource constraints and progressive realisation. When both provisions refer to the obligation to undertake ‘appropriate measures’, this may lead to a similar effect, but it requires further clarification.

Both Articles also call for measures of improvement throughout society, including via private entities and families. The articulation of awareness-raising and accessibility as human rights obligations is a significant amendment to the human rights protection of persons with disabilities. Thus, this thesis argues that Articles 8 and 9 form a new category of rights.

4.4.3 Authoritative and Inclusive Human Rights Clarification

In December 2001, the Mexican government successfully took the initiative to put forward a resolution calling for the consideration of an international convention on disability. The subsequently formed Ad-Hoc Committee invited regional commissions and inter-governmental organisations to make suggestions on the convention. Remarkably, the Committee extended this invitation to Non-


That is the classification of human rights in civil and political rights on the one hand and economic, social and cultural rights on the other hand.

Kerstin Mechlem provides a critical response as to whether international human rights treaties may be applied and interpreted in respect to private entities in Kerstin Mechlem, 'Treaty Bodies and the Interpretation of Human Rights' (2009) 42 Vanderbilt Journal of Transnational Law 905.

Governmental Organisations (NGOs)\textsuperscript{44} and persons with disabilities\textsuperscript{45} whose participation was facilitated. This has resulted in an “unprecedented involvement of civil society”\textsuperscript{46} in the negotiation process to a degree that the CRPD could be considered “having been largely written by disabled persons”.\textsuperscript{47} Tara Melish has described the negotiation process as a “dynamic process of dialogue, cooperation and mutual trust”\textsuperscript{48} with an “unparalleled degree of transparency, enthusiasm, lack of politicalisation and cooperation”.\textsuperscript{49} Aaron Dhir has commented that the participation of NGOs and persons with disabilities was “a crucial step in the empowerment of disabled persons itself whereby disabled persons are no longer considered just being the objects of policy, but rather its agents.”\textsuperscript{50}

By including NGOs and persons with disabilities, the CRPD is not only about persons with disabilities, but it is also made with the participation of those whose rights are concerned,\textsuperscript{51} commonly referred to under the slogan “Nothing About Us, Without Us!”\textsuperscript{52} This gives the CRPD an unparalleled authoritative and inclusive value as it directly draws upon the experiences and suggestions of the very persons the Convention is about. The CRPD clarifies how to achieve, in some regards at least progressively, the integration and human rights protection of persons with disabilities in countries of different economic, social, cultural, political

\textsuperscript{44} Accreditation and Participation of Non-Governmental Organizations in the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 56\textsuperscript{th} sess, UN Doc A/56/510 (26 July 2002).

\textsuperscript{45} Participation of Persons with Disabilities in the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 56\textsuperscript{th} sess, UN Doc A/DEC/56/474 (23 July 2002).


\textsuperscript{47} Ibid, 618 f.


\textsuperscript{49} Ibid, 43.


\textsuperscript{52} James I Charlton, Nothing About Us Without Us: Disability Oppression and Empowerment (University of California Press, Berkeley & Los Angeles, 1998).
and legal background. It systematically addresses many aspects of daily life and the connection between disability, exclusion, poverty, lack of education, unemployment and health. The CRPD signals a "shift away from a state-centric model of treaty negotiation".\(^{53}\) In the future, when States Parties develop and implement national laws and policies to give effect to the obligations under the CRPD, they are obliged to consult with persons with disabilities or their representatives.\(^{54}\) This is an important and innovative step in ensuring that the CRPD is inclusive of the actual experiences and expectations of persons with disabilities. Responding to ongoing human rights violations with a treaty aimed at making disabled persons visible.\(^{55}\)

The CRPD has unambiguously signalled that systematic change within society is urgently necessary. The CRPD now also serves as an important tool for persons with disabilities to voice their claims. By clarifying the human rights and fundamental freedoms in great detail, the purpose, general principles, historical development and specific content of the CRPD has given supporters of the human rights of persons with disabilities a new academic and political foundation for arguing their point and challenging established standards.\(^{56}\)

### 4.4.4 International Cooperation, Monitoring and Accountability

The CRPD recognises the importance of international cooperation in enhancing national efforts to realise the rights and freedoms of the CRPD and to target imbalances amongst States Parties at different levels of development. As all States Parties have to take measures to realise the rights of persons with

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disabilities, they have to develop strategies and programmes which aim to achieve the purpose and objectives of the CRPD in practice.

States Parties have to report to the United Nations on a regular basis and address their achievements concerning the circumstances of persons with disabilities within their country. These reports will be a valuable resource for improving the human rights situation of persons with disabilities. They will be submitted to the Committee on the Rights of Persons with Disabilities which can compare the different national approaches and identify what programmes and measures work in practice. The Committee on the Rights of Persons with Disabilities can use these observations of different States' practices to release suggestions, recommendations or general comments and provide authoritative guidance. Paul Hunt argues that this is a matter of accountability in international law which is sometimes narrowly understood to mean blame and punishment, whereas it is more accurately regarded as a process to determine what is working (so it can be repeated) and what is not (so it can be adjusted).

Substantial findings may encourage other existing monitoring bodies to pay close attention to the activities of the Committee on the Rights of Persons with Disabilities. These findings may influence a consistent approach amongst the monitoring bodies, in particular since the CRPD elaborates on central rights and freedoms that are included in other treaties as well. The Committee on the Rights of Persons with Disabilities also considers individual complaints on violations of the rights set out in the CRPD from persons with disabilities of States Parties that have ratified the Optional Protocol. Observations from these complaints can also be used to re-evaluate existing State practice.

The CRPD makes another new important move towards ensuring domestic human rights realisation. It requires States Parties to ensure domestic implementation and monitoring mechanisms. According to Article 33, States

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57 Sections 8.4.3.1 and 9.1.6.2 below will address some comments of the Committee on the Rights of Persons with Disabilities.
Parties must designate one or more focal points within government to ensure coherent policy-making on the implementation of the CRPD and they must coordinate action in different sectors and at different levels.\textsuperscript{59}

States Parties must also maintain, strengthen, designate or establish a domestic framework with one or more independent mechanisms to promote, protect and monitor the implementation of the CRPD. These mechanisms must involve the participation of civil society, in particular persons with disabilities and their representative organisations.\textsuperscript{60} This provides criteria for assessing domestic implementation and monitoring. So far, a similar provision has been incorporated only in the Optional Protocol to the United Nations Convention Against Torture.\textsuperscript{61}

\textbf{4.4.5 A Hybrid Convention Breaking with the Traditional Categories of Rights}

The Committee on Economic, Social and Cultural Rights and the Special Rapporteur on the Right to Health have approached disability and human rights from the viewpoint that the traditional differentiation between categories of rights is obsolete, if not detrimental, to the human rights realisation of persons with disabilities. As outlined in Chapter Two, the Committee on Economic, Social and Cultural Rights has pointed out in its General Comment No 14 that the right to health contains both freedoms and entitlements.\textsuperscript{62} The right to health includes in particular the freedom to control one’s health and body and the freedom from interference and non-consensual treatment.\textsuperscript{63} The protection of these freedoms must apply with immediate effect.\textsuperscript{64}

Paul Hunt, the Special Rapporteur on the Right to Health, has made similar


\textsuperscript{60} Ibid, 30.

\textsuperscript{61} \textit{Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment}, opened for signature 18 December 2002, A/RES/57/199 (entered into force 22 June 2006).

\textsuperscript{62} See section 2.1.3.2 above.


\textsuperscript{64} Ibid, at 30.
comments. He argues that the traditional categorisation of rights is impractical. He points out that while the right to health is traditionally an economic, social and cultural human right, many aspects of the right to health are not subject to progressive realisation and resource constraints, but immediately realisable, such as the freedom from forced sterilisations or discriminatory practices.\(^{65}\) Paul Hunt emphasises the interdependence of the right to health with other human rights and fundamental freedoms, including the right to work, education, life, non-discrimination, equality, prohibition of torture, privacy, participation in society, access to information, freedom to association and assembly.\(^{66}\)

Also, some scholars such as Amita Dhanda have criticised the “falseness of the dichotomy”\(^{67}\) between civil and political rights and social, cultural and economic rights.\(^{68}\) As pointed out in Chapter Two, the distinction between civil and political rights on the one hand and economic, social and cultural rights on the other hand, goes back to the United Nations’ decision to set up the ICCPR and the ICESCR as two separate treaties.\(^{69}\) This decision had a strong strategic component to it as it aimed at increasing the number of ratifications, at least in respect to the ICCPR.\(^{70}\) The separation of rights has been controversial and criticised from the beginning\(^{71}\) as the UDHR is based on the premise that all its human rights are inseparable.\(^{72}\)

The CRPD builds upon established human rights and freedoms and makes reference to economic, social and cultural rights being subject to resource

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\(^{66}\) Ibid para 31.


\(^{69}\) See section 2.1 above.

\(^{70}\) See section 2.1 above.


\(^{72}\) See section 2.1 above. Other treaties, including the CRPD confirm that international human rights are universal, indivisible, interdependent and interrelated which is in line with the clarification in the Vienna Declaration: World Conference on Human Rights, *Vienna Declaration and Programme of Action*, UN Doc A/Conf.15/23 (12 July 1993) para 5.
constraints and progressive realisation. Despite this reference, this thesis argues that the CRPD actually merges civil and political rights with economic, social and cultural rights not just under one treaty, constituting a hybrid convention, but also in content.

For example, the freedom from torture or cruel, inhuman and degrading treatment or punishment as expressed in Article 15 extends to the freedom from all forms of exploitation, violence and abuse as clarified in Article 16. Article 15 rephrases an established human right. It addresses the freedom from interferences and confines itself to clarifying that States Parties must refrain from certain practices and ensure their prevention. Article 16 clarifies what specific measures States Parties have to take in order to ensure the freedom from exploitation, violence and abuse. This is a significant elaboration of Article 15. Jointly, Article 15 and 16 clarify important negative and positive state obligations towards the realisation of humane treatment.

Articles 19 and 20 provide other examples of ‘new’ rights. These two articles expand on the liberty of movement and nationality as expressed in Article 18. Article 19 recognises independent living and the inclusion into the community and Article 20 requires States Parties to ensure personal mobility. While the protection of liberty of movement, including the freedom to choose one’s residency, has been long established in international human rights, Articles 19 and 20 specifically address the situation of persons with disabilities. Thus, it seems that the CRPD first reconfirms established civil and political rights and then further clarifies their application to the situation of persons with disabilities under

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77 See also ibid, 6. French and Kayess argue that Articles 19, 20 as well as Article 17, the protection of the integrity of a person, expand on Article 14, the right to liberty and security of the person. The author believes that Article 17 is more closely related to Articles 15 and 16 and rather elaborates on the well-established Article 15, while Articles 19 and 20 expand on Article 18.
subsequent headings through stressing what efforts States Parties have to take in order to realise the full scope of human rights, such as the liberty of movement. However, Article 21, which sets out the right to freedom of expression and opinion, and access to information, expresses positive and negative duties in one provision that derives from a traditional civil and political right.

In regards to traditional economic, social and cultural rights, the provisions of the CRPD tend to be very detailed under the heading of well-established rights, such as the rights to health (Article 25) and work and employment (Article 27). These rights introduce new dimensions into the international human rights protection of persons with disabilities through their detailed clarification. Some of them are also followed by significant extensions under separate headings. For example, Article 26, on the right to habilitation and rehabilitation elaborates on the right to health as expressed in Article 25.

By following this structure, the CRPD is remarkably explicit in clarifying what human rights and fundamental freedoms mean in the context of disability. The CRPD provisions identify what measures States Parties have to take in order to ensure these rights and freedoms. Lance Gable states in this context that the CRPD exemplifies the combination of “structural augmentation and normative development”\(^78\) in an international treaty. That is, it substantiates the content of human rights in their context and combines components of control on how rights and freedoms are applied and enforced.\(^79\) By doing so, the CRPD finally breaks with the perception that civil and political rights (traditionally perceived as negative rights to freedom from interferences) and economic, social and cultural rights (traditionally perceived as positive rights to entitlements) are clearly distinguishable.

The CRPD responded to the shortcomings of the pre-existing human rights protection which did not sufficiently realise that traditional rights and freedoms need to be re-evaluated when there are disability-specific barriers to exercising traditional freedoms from state interference or interventions into rights that are traditionally considered as entitlements. Ida Koch used the following words to


\(^{79}\) Ibid, 535.
describe why the CRPD needed to break with the old differentiation that did not sufficiently translate into reality:

Human rights are there for the sake of persons; they must reflect and respect the factual conditions of human life and the complexity of human activity. The various elements of our lives are inextricably intertwined, and human experience rarely confines itself into neat categories. ... The CRPD is one of the finest examples of the fact that human rights necessarily have to be indivisible, interrelated and interdependent, if one aims to address the factual situation of persons with disabilities instead of insisting on a categorisation of rights which have no foundation in fact.  

The CRPD now requires States Parties to assess their positive and negative obligations that arise when they have committed themselves to ensure that persons with disabilities have equal opportunities to exercise their rights and freedoms.

4.4.6 Equality, Non-Discrimination and Reasonable Accommodation

Another significant response to pre-existing shortcomings in the international human rights framework is that the CRPD incorporates strong safeguards to the protection of equality and non-discrimination of persons with disabilities. The CRPD stresses the equality of persons with disabilities throughout the text of the CRPD. It provides for measures to ensure the substantive equality of persons with disabilities, addresses indirect discrimination and incorporates the denial of reasonable accommodation into the definition of discrimination.  

The Tallinn Guidelines and the Standard Rules have aimed at achieving the substantial equalisation of opportunities for persons with disabilities. They have provided significant interpretative guidance in regards to a number of central

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human rights. However, in 1996, the Special Rapporteur on Disability, who monitors the implementation of the *Standard Rules* and reports annually to the Commission for Social Development, stated that “countries place the highest importance on rehabilitation and prevention (that is, a welfare approach), while less emphasis is given to accessibility measures and anti-discrimination law”. In 2006, the Special Rapporteur stated that after 13 years have passed on the adoption of the Standard Rules for the Equalization of Opportunities for Persons with Disabilities there is as yet no complete and comprehensive implementation of the Rules in any country.

He stated that the latest survey revealed that “equalization of opportunities has not occurred”. Two influential reports in 1993 and 2002 also identified that calls to facilitate the equality of persons with disabilities were not sufficiently translated into the practice of many States Parties. Thus, persons with disabilities still face discrimination in law, policy and practice.

The **CRPD** and parallel developments during the drafting of the **CRPD** have significantly developed the understanding of equality and non-discrimination which can be viewed as “simply the positive and negative statements of the same principle”.

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84 Ibid.


discrimination can be well-illustrated when looking at the following General Comments of the Committee on Economic, Social and Cultural Rights.

4.4.6.1 Formal (De Jure) and Substantive (De Facto) Equality

As outlined in Chapter Two, the Human Rights Committee’s General Comment No 18 on Non-discrimination (1989) made reference to the “enjoyment of rights and freedoms on an equal footing”. This indicates a dedication towards substantial equality, but the General Comment remained vague as to what this means in practice. It carefully addressed its “wish to draw the attention of States Parties to the fact that the Covenant sometimes expressly requires them to take measures to guarantee the equality of rights of the persons concerned”. However, this careful approach did not sufficiently establish that discrimination can derive systematically from structures in society which can be changed in order to facilitate equality. Thus, it is not surprising that States Parties did not have sufficient awareness as to what is necessary to treat persons with disabilities with respect to substantial equality.

During and after the drafting process of the CRPD, the Committee on Economic, Social and Cultural Rights significantly amended its understanding of equality. In its General Comment No 16 (2005) and General Comment No 20 (2009), the Committee on Economic, Social and Cultural Rights detailed the conceptual framework of equality and non-discrimination. The Committee’s assessments in General Comment No 16 focused on the equality of men and women, but the underlying analysis clarifies the general understanding of equality and non-discrimination.

In 2005, the Committee on Economic, Social and Cultural Rights

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89 Ibid para 5. See also para 10.
92 Many of the aspects that are addressed in General Comment No 16 are confirmed in General Comment 20 (2009) of the Committee on Economic, Social and Cultural Rights.
emphasised that equality is a concept that carries substantive meaning. It reaches beyond formal expressions of equality in law and policy to practice. Thus, guarantees of non-discrimination and equality mandate States Parties to ensure ‘de jure’ and ‘de facto’ equality. The Committee equates de jure equality to formal equality. It has stated that “[f]ormal equality assumes that equality is achieved if a law or policy treats [equal groups] in a neutral manner”. De facto equality equates to substantial equality. Substantial equality is concerned “with the effects of laws, policies and practices and with ensuring that they do not maintain, but rather alleviate, the inherent disadvantages that particular groups experience.”

The Committee’s analysis of de facto and de jure equality helps explain why the human rights protection of persons with disabilities traditionally fell short. Disability advocates have identified that in particular de facto discrimination happened systematically throughout the world, including in wealthy countries with long-established human rights schemes and anti-discrimination legislation.

A dedication towards formal equality in State practices led to systematic shortcomings in the human rights protection of persons with disabilities. Formal equality which aims at achieving equality in law and policies, stems from a rationale that equals should be treated equally. Facing the dilemma that persons with disabilities have not shared equal standing in society, a dedication to ensuring formal equality has had significant and systematic shortcomings as it “fails to correct structural inequalities”. Thus, human rights and disability experts have

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94 Ibid para 6.
95 Ibid para 7.
96 Ibid para 7.
called for substantive or material equality\textsuperscript{99} understood as equality of opportunities and results.\textsuperscript{100}

Gerard Quinn and Theresia Degener argue that equal opportunities in the context of disabilities entails tackling structural exclusion, instances of discrimination in everyday life as well as deep-seated social attitudes to disability.\textsuperscript{101} They point out that substantial equality entails training persons with disabilities to the very best of their abilities,\textsuperscript{102} while equality of results refers to every person’s entitlement to certain minimum rights regardless of their contribution or capacity to contribute.\textsuperscript{103} The division between de facto and de jure equality set out by the Committee on Economic, Social and Cultural Rights raises awareness of the systematic understanding of non-discrimination and clarifies that ensuring non-discrimination requires more than guaranteeing formal equality – a claim that persons with disabilities long tried to get across.\textsuperscript{104}

\subsection*{4.4.6.2 Direct and Indirect Discrimination}

The Committee on Economic, Social and Cultural Rights also elaborated on the differences between direct and indirect discrimination.\textsuperscript{105} The Committee has stated that “[d]irect discrimination occurs when a difference in treatment relies directly and explicitly on distinctions based exclusively on [non-discrimination

\begin{footnotesize}
\begin{enumerate}
\item Ibid, 17.
\item Ibid, 17.
\item Ibid, 18.
\item The systematic understanding of non-discrimination is not fundamentally new to international human rights law: The European human rights scheme has provided guidance to the understanding of non-discrimination that is similar to the differentiations assessed in this section. However, the United Nations human rights scheme did not pursue to provide clarification with a similar structured approach. While the European human rights scheme can inspire the United Nations human rights scheme, it does not directly influence the United Nations human rights standards. For further information see, for example, Wouter Vandenhole, \textit{Non-Discrimination and Equality in the View of the UN Human Rights Treaty Bodies} (Intersentia, Antwerpen, Oxford, 2005), 33 ff.
\item See also ibid, 58 ff and 68 ff; Social and Cultural Rights Committee on Economic, \textit{General Comment No 14: The Right to the Highest Attainable Standard of Health} (Art. 14), 22\textsuperscript{nd} sess, UN Doc E/C.12/2000/4 (11 August 2000) para 19.
\end{enumerate}
\end{footnotesize}
criteria] and characteristics [of persons or groups who feature such non-discrimination criteria], which cannot be justified objectively". In other words, direct discrimination occurs when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground, such as a person’s disability. For example, a rule or practice that excludes persons with psychosocial disabilities from voting is directly discriminatory in regards to the freedom to vote, including the freedom to choose freely who to vote for – a classical civil and political right. This kind of distinction is readily recognisable as it identifies a psychosocial disability as the criterion that is decisive for differentiation.

Indirect discrimination does not readily identify that differential treatment is based on discriminatory criteria, but it has a discriminatory effect when implemented. At first sight, an indirectly discriminatory rule or practice looks like a neutral one, but it has a disproportionate effect on some persons and the relevant differentiation is based on discriminatory criteria. Designing voting procedures in such a way that they are inaccessible to wheelchair users or require a person to see are examples of indirectly discriminatory practice. This kind of distinction can be less readily identifiable when wheelchair users or persons with vision impairments are not openly excluded from the voting procedure. However, persons who then need to rely on the assistance or presence of others in order to

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fill in the ballot are at risk of undue influence or abuse, if not provided with voting assistance that incorporates thorough safeguards.

Both, direct and indirect discrimination are still widely present in regards to persons with disabilities, although there is a tendency towards indirect discrimination in relation to persons with physical disabilities as persons with disabilities have not had equal access to services and facilities. Given that indirect discrimination is generally hard to identify, the susceptibility to discrimination of persons with disabilities is exacerbated by their invisibility and marginalisation.

Equal protection of human rights and freedoms not only applies to civil and political rights, but also economic, social and cultural rights. Yet, the reasons for differential treatment in respect of economic, social and cultural rights in practice are less readily identifiable than they are in regards to civil and political rights. Many aspects to realising economic, social and cultural rights of persons with disabilities are matters of multiple considerations. In particular resource constraints play an important role. For example, in realising the right to just and favourable conditions of work for a person with disability, practical rationalisations as to why realising the right cannot be facilitated can easily coincide with discriminatory attitudes. Costs to individual workplace adjustments may be indeed too high in individual cases, but the employability of a person with disability can be denied too readily if an employer is not willing to consider providing for any adjustments at all.

What can or cannot be facilitated is subject to the consideration of what is reasonable in the individual circumstances and what structural changes can be achieved to improve accessibility in general. Thus, for example, in the public service, an employer’s standard policy cannot readily presume that an employee’s disability results in excessively high costs to workplace adjustments without consideration of the individual circumstances. The employer cannot negate all responsibilities to invest in workplace improvements. This comes close to the idea behind the CRPD’s obligation on States Parties to eliminate discrimination through reasonable accommodation.

111 For example, accessibility can be achieved by improving the design of new work environments or giving tax relief for employers’ additional costs on partaking workplace adjustments.
4.4.6.3 The Concept of Reasonable Accommodation

The *CRPD* incorporates the denial of reasonable accommodation into the definition of discrimination.\(^{112}\) According to Article 5(3), States Parties must take appropriate steps to ensure reasonable accommodation in order to promote the equality of persons with disabilities and eliminate discrimination. A failure to provide reasonable accommodation will constitute discrimination.

The requirement for reasonable accommodation is set out in one of the over-arching provisions that apply to all specific rights and freedoms in Articles 10 – 30 of the *CRPD*. It is the first time that an international human rights treaty has defined the denial of reasonable accommodation as discrimination. Thus, States Parties now have to be proactive towards realising that persons with disabilities enjoy their human rights and fundamental freedoms equally. They have to provide devices, services or facilities that allow persons with disabilities to participate in society on an equal basis to others. By requiring States Parties to be proactive, the *CRPD* aims at achieving the substantive equality of persons with disabilities in regards to all human rights and fundamental freedoms.\(^{113}\) This signals that the principle of equality is not to be understood as guaranteeing formal equality only.

The concept of reasonable accommodation is defined 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".\(^{114}\) States Parties have to identify existing barriers and obstacles\(^{115}\) and make ongoing efforts to improving the realisation of all human rights and fundamental freedoms, as for example, accessibility to work place environments. They have to take positive steps to include persons with


disabilities into society and realise their human rights, in general and under consideration of individual circumstances. Reasonable accommodation encompasses that States Parties have

to ensure that rights of all kind – whether they are classified as economic, social or cultural rights or as civil and political ones – become available, in a meaningful sense, to disabled persons. It thus directly challenges the traditional clear-cut division between civil and political rights, on the one hand, and economic, social and cultural ones, on the other – making it clear that all human rights will impose positive as well as negative obligations on States.116

The concept of reasonable accommodation is articulated in Article 5, the CRPD's provision on equality and non-discrimination, which is subject to immediate realisation.117 The CRPD combats direct discrimination by referring to "any distinction, exclusion or restriction on the basis of discrimination"118 and indirect discrimination by referring to a similar effect.119 It aims to facilitate substantial equality by including the obligation to provide reasonable accommodation in regards to all human rights and fundamental freedoms of the CRPD.

Prior to the CRPD, General Comment No 5 of the Committee on Economic, Social and Cultural Rights has called for "reasonable accommodation" to ensure the rights of persons with disabilities.120 Eric Rosenthal and Clarence Sundram have outlined how some countries adopted the requirement of reasonable accommodation into domestic laws aimed at preventing discrimination against persons with disabilities. They argue that "growing jurisprudence … [on the


concept of reasonable accommodation] ... can be used to develop effective protections”. They focused on the jurisprudence of the United States of America, but indicated that other countries have had similar experiences. This indicates that the concept of reasonable accommodation may indeed serve as a legal standard that can result in measurable outcomes.

4.4.6.4 Temporary Preferential Treatment and Measures to Ensure Equality and Non-Discrimination

In 2005, the Committee on Economic, Social and Cultural Rights emphasised in its General Comment No 16 (2005) that sometimes States Parties have to take temporary special measures in favour of certain groups in order to bring disadvantaged or marginalised groups or persons to the same substantive level as others. In its General Comment No 20 (2009), the Committee confirmed this approach and stated that “such measures are legitimate to the extent that they represent reasonable, objective and proportional means to redress de facto discrimination and are discontinued when substantive equality has been sustainably achieved”. The Committee has also stated that States Parties have to respect, protect and fulfil equality and non-discrimination. The obligation to ‘respect’ requires States Parties to refrain from discriminatory actions that directly or indirectly result in the denial of an equal right. The obligation to ‘protect’ “requires States Parties to take steps aimed directly at the elimination of prejudices, customary and all other practices that perpetuate the notion of

122 Ibid, 508.
125 Ibid para 9.
inferiority or superiority of either [groups] and stereotyped roles”. The obligation to ‘fulfil’ “requires State Parties to take steps to ensure that in practice [all human beings] enjoy their economic, social and cultural rights on a basis of equality”.

4.4.7 Concluding Thoughts

The CRPD strongly responded to shortcomings in the pre-existing human rights framework and it incorporates innovative features into the international human rights scheme. Most significantly, it adopts the social model of disability and incorporates it into a comprehensive and authoritative legal framework to the effect that persons with disabilities can now require States Parties and civil society to work towards their equalisation and full participation into society.

The CRPD states that a deviation from the norm in individual physical or mental abilities cannot be used to justify unequal treatment in regards to States Parties’ obligations to promote, respect and fulfil the realisation of all human rights and fundamental freedoms. In other words, a person’s disability cannot justify the restriction of human rights and fundamental freedoms. This is a strong and far-reaching message. In order to assure the realisation of all human rights and fundamental freedoms, States Parties have to provide reasonable accommodation without differentiation between traditional categories of human rights. They also have to work towards improving consultation with persons with disabilities and they have to generally improve attitudes towards persons with disability and the accessibility of the environment in public and private sectors.

General Comments 16 and 20 of the Committee on Economic, Social and Cultural Rights complement the CRPD and its understanding of equality and non-discrimination. They guide States Parties to adjust their law, policy and practice in order to facilitate the equal enjoyment of all human rights and fundamental freedoms. The CRPD also explicitly refers to equality of opportunities, de facto

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127 Ibid para 19.
129 See section 2.1.2.2 above.
equality\textsuperscript{131} and specific measures (positive discrimination or temporary preferential treatment).\textsuperscript{132} It requires States Parties to do more than refraining from formal discrimination in law and policy.\textsuperscript{133} Now the

“[e]mphasis on equality and non-discrimination is to be found in almost every article. Accordingly, the major task will be to interpret the concept of ‘equal enjoyment of rights’ best suited to the needs of persons with disabilities”\textsuperscript{134}

The next Chapter assesses these observations when they are applied to the specific provisions of the \textit{CRPD} that are most relevant to the situation of persons with psychosocial disabilities.


CHAPTER 5

5 The Specific Provisions of the CRPD and Psychosocial Disability

This Chapter\(^1\) explores the specific provisions of the CRPD that are most relevant to persons with psychosocial disabilities. It follows up on the analysis of Chapter Four which identified the new features of the CRPD that inform the interpretation and application of its specific provisions. Chapter Five outlines how the CRPD substantiates its underlying principles into the formulation of its specific provisions. It argues that this approach serves to measure compliance with the CRPD and to ensure the substantial equality of persons with psychosocial disabilities.

This Chapter first addresses Articles 1 and 5 which elaborate on the CRPD’s meaning of equality and non-discrimination. It highlights the ways in which the CRPD has extended its international human rights commitment to persons with psychosocial disabilities without naming any grounds for differentiation in exceptional circumstances, such as when the need arises to protect them from causing harm to themselves or others. It argues that this approach aims to challenge the pre-existing rationale for the differential treatment of persons with psychosocial disabilities.

Then, this Chapter addresses the CRPD’s understanding of the equal recognition before the law as expressed in Article 12 which deals with the concept of legal capacity and substituted decision-making. It posits that the CRPD calls for supported decision-making which is responsive to a broad spectrum of an individual’s abilities to decision-making. This Chapter argues that the CRPD set up a nuanced model of decision-making which responds to individuals who experience a variety of impairments or difficulties in decision-making. It argues that

this model may serve to alleviate the conflict between the polarised options of intervention and non-intervention which both aim to realise the rights of persons with psychosocial disabilities.

Subsequently, Chapter Five assesses Article 14 on the liberty and security of the person. It discusses the meaning of the sentence “the existence of a disability shall in no case justify a deprivation of liberty” which was inserted into Article 14. It argues that the insertion of this sentence reinforces the view that the CRPD has extended its full protection to persons with psychosocial disabilities and departs from the connotation that persons with psychosocial disabilities may be subject to differential treatment because of their disability.

In stark contrast to other provisions of the CRPD, Article 17 on the protection of the integrity of the person lacks further details. This Chapter outlines how Article 17 refrained from allowing involuntary treatment on the ground of disability, even though the inclusion of a sentence to that effect has been put into the draft of the CRPD. It argues that this result is ‘negotiated silence’ which has the potential to change the human rights realisation of persons with psychosocial disabilities.

Then, this Chapter discusses Article 25 on the right to health which calls for States Parties to provide appropriate mental health services. It follows up on the discussion in Chapter Four which elaborated on the CRPD’s new understanding of human rights realisation and argues that the CRPD has merged positive and negative aspects of human rights realisation. This Chapter addresses the significance of the right to health in respect to realising the human rights of persons with psychosocial disabilities, in particular if the right to health is used to substantiate the concept of reasonable accommodation. It argues that the right to health complements an individual’s right to freedom from intervention.

This Chapter concludes with an analysis on the achievements and the remaining challenges to the human rights realisation of persons with psychosocial disabilities. This analysis will focus on addressing the key issues that arise with the interpretation and application of the CRPD in respect to the use and design of mental health legislation. The impact of the provisions, and the feasibility of changing mental health legislation, will be discussed later when Chapters Eight to
Ten analyse the current provisions of the Australian mental health acts.

5.1 Articles 1 and Article 5: the Purpose of Respecting Equality, Human Diversity and Human Dignity and the Equality and Non-Discrimination

Article 1 of the CRPD: Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. ²

Article 5 of the CRPD: Equality and Non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. 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.

One of the most important features of the CRPD in relation to the human rights of persons with psychosocial disabilities is its unambiguous dedication to ensuring respect for the equality and human dignity of persons with any kind of disability.

The CRPD stresses the equality of persons with disabilities in the Preamble, in the CRPD’s purpose,³ in the general principles⁴ and general obligations⁵ and in almost all other specific provisions.⁶ The CRPD protects the

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² Second sentence omitted. Sections 1.2 and 4.2 above address the discussion of the second sentence which describes the term ‘disability’.
⁶ The only specific rights and freedoms that do not explicitly stress the equal enjoyment of the respective rights are Articles 16, 20 and 26. However, implicitly, these provisions guide States Parties on what measures of protection they have to incorporate in order to realise equal opportunities.
equality and non-discrimination of persons with psychosocial disabilities in the following ways that amount to an unprecedented strong protection of their human rights and fundamental freedoms.

5.1.1 The Full Inclusion of Persons with Psychosocial Disabilities and the Departure from the MI Principles

First, the CRPD extends its full protection to persons with psychosocial disabilities. The CRPD explicitly adds disability to well-established criteria of non-discrimination. It states that persons with disabilities include those with mental impairment and that any unfavourable distinction, exclusion or restriction on the basis of disability constitutes discrimination.

It may be argued that the CRPD does not provide a significantly new human rights standard for persons with psychosocial disabilities as the CRPD may not comprehensively reflect the special considerations of psychosocial disability. While the CRPD applies to persons with “physical, mental, intellectual or sensory” impairments, Anna Lawson has pointed out that it can be argued that the CRPD focuses on impairments such as intellectual, cognitive and neurological impairment, autism or dementia, rather than psychiatric illnesses or diseases that can be treated. Hence, one interpretation is that the CRPD applies to some individuals with psychosocial disabilities, but in general the specifics of psychosocial disability and human rights realisation should still be guided by the MI Principles as they remain the most specific international human rights document on mental illness.

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9 Understood as “impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms” (Convention on the Rights of Persons with Disabilities, opened for signature 30 March 2007, Doc.A/61/611 (entered into force 3 May 2008), Article 2).
However, in response to this interpretation of the *CRPD*, it is necessary to consider Articles 31 and 32 of the *Vienna Convention on the Law of Treaties* 1969 (*Vienna Convention*). According to Article 31(1) of the *Vienna Convention*, a treaty must be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in light of its objective and purpose.

The objective and purpose of the *CRPD* is to promote and ensure the equality and non-discrimination of persons with disabilities, explicitly including those with mental disabilities. As discussed earlier, the *CRPD* left the understanding of disability deliberately open to apply broadly and inclusively to the diverse nature of disabilities. Chapter One explained that the *CRPD* does not require permanent impairments. Rather, the *CRPD* refers to ‘long-term’ impairment. The ordinary meaning of the term ‘long-term’ impairment includes some conditions that have been traditionally considered as illnesses. Persons with psychosocial disabilities may experience long-term effects of their conditions, for example, when they are subject to long-term treatment, when they choose to live with their illness instead of having treatment or when they experience differential treatment because their psychosocial disability is mentioned on health records. This favours the claim that the *CRPD* applies to persons with psychosocial disabilities.

Chapter Four argued that the *CRPD* did not adopt a definition of disability because a definition could result in “legalistic analysis”. In particular, the *CRPD* does not focus on diagnostic criteria and medical differences between illnesses and disabilities. Rather, the *CRPD* revolves around the impact of individual impairments which are linked to the individual’s condition of body and mind. The *CRPD* has extended the understanding of disability to persons who face attitudinal and environmental barriers to their human rights realisation in response to them.

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15 See sections 1.2 and 4.2 above.

16 See section 1.2 above.

17 See section 4.2 above.

18 See section 4.2 above.
having certain conditions in body and mind.\textsuperscript{19} This also favours the claim that the \textit{CRPD} applies to persons with psychosocial disabilities.

In its Preamble, the \textit{CRPD} recalls pre-existing treaty law. The \textit{CRPD} explicitly recognises the \textit{World Programme of Action}\textsuperscript{20} and the \textit{Standard Rules}.\textsuperscript{21} The \textit{MI Principles} evolved alongside the \textit{Standard Rules} as the most specific guidance on the human rights protection of persons with psychosocial disabilities. The \textit{CRPD} does not mention the \textit{MI Principles} which allow for differential treatment of persons with psychosocial disabilities. This may indicate that the \textit{CRPD} does not provide specific guidance to persons with psychosocial disabilities. However, an alternative interpretation is that the \textit{CRPD} departs from the \textit{MI Principles}.

The practice of the application of the \textit{CRPD} favours the latter interpretation. According to Article 31 of the \textit{Vienna Convention}, the practice of the application of an international treaty is a legitimate means to its interpretation.\textsuperscript{22} Official publications of the United Nations that provide further information on the \textit{CRPD}, such as the official Handbook for Parliamentarians\textsuperscript{23} and the official manual on the Monitoring of the \textit{CRPD},\textsuperscript{24} include specifics on the human rights situation of persons with psychosocial disabilities and address their equal protection under the \textit{CRPD}. Thus, the practice of applying the \textit{CRPD} already has confirmed that persons with psychosocial disabilities are covered by the \textit{CRPD}.

According to Article 32 of the \textit{Vienna Convention}, the preparatory work of the treaty and the circumstances of its conclusion provide supplementary means of interpretation, if a treaty still leaves ambiguity as to its meaning. Persons with psychosocial disabilities and their representative groups were actively involved in

\textsuperscript{19} See section 4.2 above.
\textsuperscript{21} \textit{Standard Rules on the Equalization of Opportunities for Persons with Disabilities}, UN GAOR, 85\textsuperscript{th} plen mtg, UN Doc A/RES/48/96 (20 December 1993). See section 3.5 above.
the drafting of the **CRPD**. The differential treatment of persons with psychosocial disabilities was discussed during the drafting of the Preamble of the **CRPD**.

As just mentioned, the **CRPD** makes no reference to the **MI Principles**. During the drafting process of the **CRPD**, it was proposed to include a reference to the **MI Principles** in the Preamble of the **CRPD**. However, there was concern that the **MI Principles** were “no longer considered fair or correct.” The final wording of the **CRPD** does not include a reference to the **MI Principles**, confirming the view that the **CRPD** deliberately departs from the former human rights standard of the **MI Principles** -- to the effect that any provision of the **MI Principles** that is in conflict with the **CRPD** is invalid because the international treaty law overrides predating and non-binding international instruments. The **MI Principles** responded to the non-therapeutic use of medical powers and aimed at ensuring fair legal procedures to those who are subject to detention or involuntary treatment. As Michael Perlin has pointed out, they still provide important guidance to those nations which have not signed or ratified the **CRPD** and they still incorporate important guidance on providing those who experience interventions on the ground of their psychosocial disability with legal safeguards.

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29 The same can be stated in respect to the Declaration on the Rights of Mentally Retarded Persons, GA Res 2856 (XXVI), UN GAOR, 26th sess, 2027th plen mtg, Supp No 29, UN Doc A/Res/2856/(XXVI) (20 December 1971) and the Declaration Declaration on the Rights of Disabled Persons, GA Res 3447 (XXX), UN GAOR, 30th sess, 2433rd plen mtg, Supp No 34, UN Doc A/Res/3447/(XXX) (9 December 1975).

30 Statute of the International Court of Justice 1945, Article 38.

As will be discussed later, the drafting sessions of the CRPD also discussed the differential treatment of persons with psychosocial disabilities in respect to Article 14 and Article 17. By doing so, the CRPD has considered the situation of persons with psychosocial disabilities under direct application of the CRPD. The CRPD refrained from including any references in the text of the CRPD that could serve to justify the differential treatment of persons with psychosocial disabilities. Thus, this thesis argues that the CRPD extends its full protection to persons with psychosocial disabilities.

5.1.2 No Assumptions of a Debilitating Effect of Psychosocial Disability

Second, the CRPD strongly protects the equality and non-discrimination of persons with psychosocial disabilities by identifying the barriers and obstacles to equal human rights realisation outside of individual impairment and by combating presumptions against disability.32 The CRPD clarifies that disability has hindered equal participation in society in interaction with various attitudinal and environmental barriers.33 Thus, the CRPD is driven by the idea that it is not individual physical or mental disability that hinders human rights realisation.34 In other words, the CRPD breaks with the immediate connotation that disability is debilitating and that interventions may be justified on the assumption that interventions may result in better outcomes for persons with disabilities. Rather, the CRPD understands individual impairment as part of human diversity and combats any immediate connotations of inherent deficiencies.35 It focuses on identifying the ways in which society’s attitudes and the environment may pose barriers and obstacles to the human rights realisation of persons with disabilities.

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34 United Nations Office of the High Commissioner for Human Rights, Monitoring the Convention on the Rights of Persons with Disabilities: Guidance for Human Rights Monitors (New York & Geneva, 2010), 48. Disability may impair an individual's ability to exercise certain rights, but the CRPD takes the view that reasonable accommodation can assist the individual, while disability specific interventions have resulted in systematic shortcomings to the human rights realisation of persons with disabilities. This can be concluded from the CRPD’s move away from the medical model of disability, see section 3.6.1 above.
Some of these attitudinal and environmental barriers or obstacles have been recognised. Many advances in medical care and technology have supported persons with physical disabilities in living independent and inclusive lives. Once presumed to be incapable of independent travelling, wheelchair users have gained access to public transport - not by overcoming their disability but through buses with lowering doors, trains with platform access, lowered ticket machines and similar adjustments. Language recognition software assists persons with dyslexia to improve academic performances, persons with vision impairments can access the Internet through reading software and persons with hearing impairments can follow movies in mainstream cinemas with subtitles. Many products, environments, programmes and services can be designed in such a way that they are useable by all persons (universal design). Additional assistive devices can further facilitate equal participation in life. Persons with severe disabilities can be provided with increased support and reasonable accommodation towards inclusion.

In this respect, the CRPD is inspirational. The CRPD guides States Parties to provide support and reasonable accommodation, but in contrast to pre-existing human rights guidance on disability, the CRPD does not address the legitimacy of intervention in case measures of support are lacking. In respect to persons with psychosocial disabilities, this is a remarkably new approach. The human rights realisation of persons with psychosocial disabilities has been closely linked to the assessment of dangerousness, the prevention of risks and the necessity of intervention, at least as a measure of last resort. The idea that some kinds of psychosocial disability may have at least a contributing factor to some kinds of harmful behaviour seems difficult to deny. Some persons with psychosocial disabilities have attempted suicide, engaged in self-harming or violent behaviour, dissipated their finances or strained family bonds. There are reasons to believe that if untreated, some individuals with psychosocial disabilities run (at least) an

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37 If support and reasonable accommodation does not suffice to assist the individual with disabilities to exercise his or her right, the CRPD requires that the individual must be assisted to live a life with respect to his or her human dignity.
increased risk of compromising their own health, committing suicide, straining existing interpersonal relationships or experiencing unemployment, drug addiction, poverty and homelessness, thus severely compromising the conditions of their human rights realisation.  

There are also a number of persons who have been subjected to involuntary measures and approved of such intervention in retrospect.  

Psychiatric knowledge seems to be advancing rapidly and the CRPD does not question its contributions and scientific foundation. However, the CRPD raises issues with the law imposing interventions against the will of persons with psychosocial disabilities on the ground of medical assessments. The use of force for therapeutic purposes is deeply embedded into mental health law, but its application may be influenced by non-clinical factors, such as ethical and legal issues, social expectations, attitudes and beliefs. It is difficult to judge the necessity of the role of using force for therapeutic purposes when the therapeutic means of responding to persons with psychosocial disabilities have changed. Mental health laws may have not yet responded accordingly. From a global perspective, it is difficult to compare what measures work best in psychiatric practice within different jurisdictions and health systems when the conditions to accessing psychiatric care, and the funding of it, vary significantly, even within countries of comparable wealth and similar legal background. It is also difficult to generalise such observations in order to draw a distinct line between the justification of the need for intervention and the need to respect the individual’s freedom from such intervention.  

The CRPD seems to take the stance that detrimental behaviour can also be  

39 Chapters Eight and Nine will address further details. Graham Thornicroft elaborates on the links between psychosocial disability and poverty, unemployment and discrimination in Graham Thornicroft, Shunned - Discrimination against People with Mental Illness (Oxford University Press, Oxford & New York, 2006).  


41 See, for example, Thomas W Kallert, Juan E Mezzich and John Monahan, Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects (John Wiley & Sons Ltd, West Sussex, 2011), in particular Tilmann Steinert and Peter Lepping, ‘Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects’ in Thomas W Kallert, Juan E Mezzich and John Monahan (eds), Is it Possible to Define a Best Practice Standard for Coercive Treatment in Psychiatry? (John Wiley & Sons Ltd, West Sussex, 2011) 49.  

42 Chapters Eight and Nine will address further details in the Australian context.
experienced by those who do not have psychosocial disability and links between psychosocial disability and some associations to it, such as dangerousness, homelessness, poverty and drug addiction, are not clear cut.\textsuperscript{43} There are grounds for believing that there needs to be more research into the reasons for harmful behaviour, its interrelation with the diversity of clinical diagnoses or social, economic and behavioural factors and the role of the law in preventing harmful behaviour.\textsuperscript{44} In particular, Michael Perlin and Deborah Dorfman call for empirical data which confirms both, the existence and the causal role for differentiation by law.\textsuperscript{45}

Before and during the development of the CRPD, persons with physical disabilities identified how much they were disabled via inaccessible environments and general assumptions into their abilities, their best interests and their need for help and protection.\textsuperscript{46} During the drafting process of the CRPD, the States Parties recognised pre-existing misconceptions as drivers for differentiation.\textsuperscript{47} They immediately agreed\textsuperscript{48} that despite various instruments and undertakings, persons with disabilities have continued to face severe and systematic barriers in their participation as equal members of society and violations of their human rights.\textsuperscript{49} By inviting persons with psychosocial disabilities into the drafting session of the CRPD, considering their views and then extending its full protection to persons


\textsuperscript{45} Ibid, 48.


\textsuperscript{47} See, for example, United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 58\textsuperscript{th} sess, UN Doc A/58/118 & Corr1 (3 July 2003) in reference to Panel Discussion I and II.

\textsuperscript{48} See United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 56\textsuperscript{th} sess, 88\textsuperscript{th} plen mtg, UN Doc A/Res/56/168 (19 December 2001).


The CRPD does not downplay individual impairment when it adopts such an approach towards the understanding of disability.\footnote{See also Aart Hendriks, 'UN Convention on the Rights of Persons with Disabilities' (2007) 14 European Journal of Health Law 273, 280.} However, it addresses disabling factors outside the individual with disability and responds to the diversity of impairments and their effects onto the lives of persons with disabilities. By doing so, the CRPD can be viewed as consistent in its protection. It is a strongly reactive human rights instrument that takes a precautionary stance against prejudices and misconceptions of disabilities and incorporates strong safeguards to prevent interventions based on presumptions.

If the CRPD conceptualised individual impairment as potentially inhibitive towards human rights realisation, the CRPD could resort to the medical model of disability. The medical model of disability could allow for the treatment of persons with disabilities because of their disability. However, the CRPD considers that persons with disabilities need to be protected from such interventions because persons with disabilities have the right to be respected as human beings the way they are or the way they choose to live their lives. They are subject to only those restrictions in exercising their rights and freedoms that apply to all other human beings. The United Nations Office of the High Commissioner for Human Rights stressed in its Manual on the Monitoring of the Rights of Persons with Disabilities that the CRPD “does not seek to prevent disability – which is a medical approach – but rather to prevent discrimination on the basis of disability”.\footnote{United Nations Office of the High Commissioner for Human Rights, Monitoring the Convention on the Rights of Persons with Disabilities: Guidance for Human Rights Monitors (New York & Geneva, 2010), 23.}

This is a strong political message. However, the CRPD does not neglect those who may have such severe impairments that they do not understand or
cannot communicate their preferences. The CRPD safeguards their rights when it stresses their rights to health (Article 25), to humane treatment (Articles 16 and 17) to habilitation and rehabilitation (Article 26). The CRPD also clarifies that services must be in place to realise the rights of all persons with disabilities which may require substantial efforts in providing support to the individual. The formulation of the CRPD focuses on opportunities to realise individual rights while respecting the varying diversity of each individual’s abilities. It focuses on opening pathways and options to realising the human rights to the fullest degree possible.

Thus, the CRPD responds to impairments with support towards facilitating equal opportunities and calls for access to services. But in the end, the CRPD refrains from justifying interventions into the rights of persons with psychosocial disabilities on the ground that an intervention may realise other rights or prevent behaviour that may have harmful consequences. Rather, the CRPD combats the assumption that persons with psychosocial disabilities need interventions in order to have their human rights protected.

5.1.3 The Understanding of Direct and Indirect Discrimination

Third, the CRPD protects the equality and non-discrimination of persons with psychosocial disabilities by prohibiting direct and indirect discrimination based on psychosocial disability. In other words, the CRPD prohibits not only discrimination that explicitly or ‘solely’ differentiate persons on the basis of psychosocial disability, but also any other differentiation that indirectly affects only persons with psychosocial disability. Thus, the CRPD takes the stance that restrictive practices, laws and policies on the basis of psychosocial disability are directly discriminatory. Similarly, measures that have the same effect indirectly constitute discrimination as well.

The analysis of the background of the CRPD has indicated that States Parties have increasingly recognised and removed direct discrimination towards persons with physical disabilities. For example, in respect to the right to vote,

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53 The significance of the word ‘solely’ will be discussed in section 5.3 below.
54 See sections 4.4.6.2 above and 5.3 below.
55 See the discussion on the World Programme of Action on human rights and disability and the human rights documents resulting from it, section 3.6 above.
persons with physical disabilities still face many barriers and obstacles, but in many Western democracies, voting procedures do not explicitly exclude persons with physical disabilities. However, in mental health care, direct discrimination still exists quite openly. The existence of a psychosocial disability serves as providing an exception to many general rules in law or ethics.\textsuperscript{56} In respect to persons with psychosocial disabilities and the right to vote, Paul Appelbaum has stated that “[o]ne of the last groups still subject to systematic restrictions on access to the ballot is persons with mental disabilities, both mental illnesses and mental retardation”.\textsuperscript{57}

The full inclusion of psychosocial disability into the CRPD provides for significant grounds to challenge the justifications for mental health legislation. Mental health legislation varies in its provisions, but it typically allows for the involuntary treatment and detention of persons with psychosocial disabilities. The involuntary treatment and detention of persons with psychosocial disabilities allows for state interventions into central human rights and fundamental freedoms, such as the rights to bodily integrity and freedom of movement. Mental health legislation applies these interventions explicitly on the ground of psychosocial disability (direct effect). Even if these restrictions apply only under consideration of additional criteria to psychosocial disability, mental health legislation subjects persons with psychosocial disabilities to standards that do not apply to persons without psychosocial disabilities (indirect effect).\textsuperscript{58}

The UDHR,\textsuperscript{59} the Human Rights Committee and in particular the Siracusa Principles on the Limitation and Derogation Provisions in the International


Covenant of Civil and Political Rights 1984 (Siracusa Principles)\(^{60}\) clarify that restrictions on human rights and freedoms are legitimate, if they abide by strict principles. The Human Rights Committee has accepted that the right to freedom of movement may be limited in exceptional cases, if the limitation is necessary to protect permissible purposes, is consistent with other rights and is proportionate.\(^{61}\) Similarly, the Siracusa Principles allow for limitations on personal liberty, if they are not arbitrary or unreasonable,\(^{62}\) but objective.\(^{63}\) The Siracusa Principles explicitly allow for limitations that serve to protect public health and public interests, including the health of others.\(^{64}\) The subsequent Chapters Eight and Nine assess whether the justifications of the Australian mental health acts provide objective, reasonable and proportional grounds for differential treatment.

## 5.1.4 Silence on Exceptional Differentiation

Fourth, the CRPD protects the equality and non-discrimination of persons with psychosocial disabilities to an unprecedented degree because the CRPD has refrained from incorporating clauses on exceptional differentiation. Previously, considerations of welfare and the belief that rights cannot apply equally led to systemic failures in relation to persons with disabilities. That means that in contrast to pre-existing human rights instruments, the CRPD strongly shies away from mentioning limitations in the human rights realisation of persons with psychosocial disabilities or derivations from pursuing a general principle or obligation. The CRPD repeatedly refers to considerations of appropriateness, but it does not provide for measures of last resort or exceptional treatment. For example, formulations such as ‘to the maximum degree of feasibility’, ‘to the fullest possible extent’ or ‘whenever possible’ are not included. Chapter Three pointed out that such formulations which addressed exceptional circumstances have marked the human rights standard of persons with psychosocial disabilities prior to the


\(^{61}\) Human Rights Committee, General Comment No 27: Freedom of Movement (Art. 12), 67\(^{th}\) sess, UN Doc CCPR/C/21/Rev.1/Add.9 (2 November 1999).


\(^{63}\) Ibid, I.A.10.

\(^{64}\) Ibid, I.B. iv, vii and viii.
Now, they are not included in the CRPD. Neither does the CRPD refer to a need to exercise rights on behalf of individuals with disabilities or a need to protect the health or safety of individuals with disabilities or others.\textsuperscript{66}

This is an important feature of the CRPD as it subjects the differential treatment of persons with psychosocial disabilities to scrutiny on two different levels. First, the CRPD implies that the human rights realisation of persons with psychosocial disabilities is not inherently limited while pre-existing limitation clauses may have had such an effect.\textsuperscript{57} Second, the CRPD does not provide any terminology that can be used to justify why certain limitations in the realisation of human rights may be permissible. In other words, the CRPD refrains from incorporating vague terminology, such as what is ‘possible’ or what is ‘necessary’.\textsuperscript{68} It seems that human rights guidance which has mentioned disability-specific limitations, such as the Declaration on the Rights of Mentally Retarded Persons and the MI Principles, run the risk of leaving the connotation that there is, and must be, a disability-specific exception which requires less scrutiny than other limitations.\textsuperscript{69}

States Parties now have to explain what measures they take to realise the human rights of persons with disabilities, instead of considering why it is not ‘possible’ or not ‘feasible’.\textsuperscript{70} The difference may be subtle, but it may increase scrutiny on the reasoning processes of States Parties and it may provide more insight into what different kinds of measures States Parties have considered or adopted in combating shortcomings in the human rights realisation of persons with disabilities.

In respect to the human rights realisation of persons with psychosocial

\textsuperscript{65}See sections 3.4.5 and 3.7.4 above.
\textsuperscript{67}Thus, confirming the conclusion in section 5.1.2 above.
\textsuperscript{68}See the discussion on the limitation clauses in pre-existing United Nations documents as addresses in Chapter Three above.
\textsuperscript{70}See the discussion on the limitation clauses in pre-existing United Nations documents as addresses in Chapter Three above.
disabilities, this is fundamentally new. Mental health legislation in itself poses an exception to the norm. One of the features of mental health legislation is that it allows for certain interventions, while human rights law prohibits such interventions in relation to persons without psychosocial disabilities.

5.1.5 Persons with Psychosocial Disabilities as Subjects of Rights

Fifth, the CRPD protects the equality and non-discrimination of persons with psychosocial disabilities in the following way. The CRPD sends the political message that it embraces persons with disabilities as equal bearers of rights. In acknowledging the experiences of persons with disabilities, the CRPD has taken a remarkably precautionary approach to pre-existing dangers of exclusion, potential for abuse and presumptions about disability, in particular when they apply to a group as diverse as persons with psychosocial disabilities.71 The CRPD’s approach takes into account the powers and potential for human rights violations that arise when the individual becomes an ‘object’, rather than a ‘subject’ of rights. As mentioned above, the CRPD does not deny that psychosocial disability may result in behaviour detrimental to the overall human rights realisation of the individual, but it does not define it as a barrier or obstacle to human rights realisation which must be prevented. Defining barriers and obstacles outside of individual impairment safeguards the acceptance of disability as a part of human diversity. The CRPD takes the stance that this position is important in recognising that each individual remains a subject of rights.72

Persons with psychosocial disabilities have claimed that for too long their psychosocial disability was understood as a ground for medical interference despite drug treatment not always being effective.73 States Parties have been criticised as being insufficiently aware of the damage of intervention in relation to the human rights status of persons with psychosocial disabilities. For example, Peter Bartlett and Ralph Sandland have stated that "[f]orced intervention, either

73 See section 4.4.3 above.
through confinement in hospital, enforced medication or control of the individual in the community, seems both intrusive and not obviously effective except perhaps in the short term”.74

Even if there are strong legal safeguards relating to the application of restrictive laws, persons with psychosocial disabilities run the risk of being subjected to such significant limitations of their rights that they essentially lose being considered the agent of their rights. It may leave persons with psychosocial disabilities in a position in which their status as holders of rights is fragile or systematically out of reach.75 There is the risk that an individual will be presumed to have legal incapacity based on the existence of psychosocial disability and that if he or she does not agree with clinical decision-making, he or she will be presumed to be acting unreasonably.76 Tina Minkowitz, in commenting on the experience of persons with psychosocial disabilities, argues that “[t]he notion of legal incapacity permeates much law and policy-making about persons with disabilities, such as coercive mental health laws, creating a limbo in which virtually anything can be justified”.77 In other words, the existence of psychosocial disability could be used as an almost unquestioned limitation to well-recognised and strongly protected rights.

Given that persons with psychosocial disability have been recognised as being subject to wide-ranging discrimination and that some of the strongest

75 See also John Dawson, ‘Compulsory Outpatient Treatment and the Calculus of Human Rights’ in Bernadette McSherry and Penelope Weller (eds), Rethinking Rights-Based Mental Health Laws (Hart Publishing, Oxford & Portland, 2010) 327, 353 who points out the wealth of rights that are affected for persons who are placed under detention or a Community Treatment Order.
76 This idea is reinforced in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, GA Res 46/119, UN GAOR, 46th sess, 75th plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), see section 3.4.3 above.
criticism towards using mental illness as a criterion for differentiation by law\(^\text{78}\) has come from clinical experts,\(^\text{79}\) there is a concern that, if psychosocial disability is an objective criterion for differentiation, human rights realisation will become out of reach to persons with psychosocial disability. The CRPD responds to this by placing the individual with disability at the centre of decision-making. The CRPD implies that persons with psychosocial disabilities need to be the driver of decision-making because their experience of being systematically cut out of exercising rights has been taken seriously. This position does not deny that individual choice may result in negative outcomes, but it aims at supporting improvements in a system that currently does not prevent negative outcomes for persons with or without psychosocial disabilities alike, while deliberately allowing for specific limitations to the human rights of persons with psychosocial disabilities.

### 5.1.6 Equality through Support and Reasonable Accommodation

Another reason why the CRPD incorporated an unprecedentedly strong protection of the equality and non-discrimination of persons with psychosocial disabilities stems from Article 3 of the CRPD. In contrast to the pre-existing debate on human rights and mental health, the CRPD does not consider that there is a choice between the two extremes of intervention and leaving people alone to "rot with their rights on".\(^\text{80}\) Since the objective and purpose of the CRPD is to ensure human rights and respect for human dignity, the CRPD does not support such an outcome. Article 3 of the CRPD demands support and reasonable accommodation to ensure persons with psychosocial disabilities have equal opportunities to realise their rights.

\(^{78}\) Peter Bartlett and Ralph Sandland have commented on the understanding of the term mental illness and its use in mental health legislation that "mental health law is never far from a collection of other complex interests". Peter Bartlett and Ralph Sandland, Mental Health Law: Policy and Practice (Oxford University Press, 3rd ed, Oxford & New York, 2007), 49.


\(^{80}\) See section 3.7.6 above in reference to Paul Appelbaum and Thomas Gutheil used this phrase which marked the subsequent debate in the 1980s on treatment refusal of persons with psychosocial disabilities, see Paul S Appelbaum and Thomas G Gutheil, 'Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients' (1979) 7 Bulletin of the American Academy of Psychiatry and Law 308, 308.
their rights and freedoms. The concept of reasonable accommodation aims at achieving substantial equality and responds to pre-existing shortcomings arising from a commitment to formal equality only. Most importantly, persons with psychosocial disabilities must have access to services – services must be available (in particular prior to acute mental health crises), accessible (and in particular affordable), appropriate and of good quality.

The effect of Article 3 is that if persons with psychosocial disabilities experience severe mental impairment and object to the treatment offered, they must receive ongoing support through improved services. This requires significant changes to, and funding of, mental health services, but it also highlights claims that current service provision is inappropriate in respect to human rights considerations.

One way of improving mental health services is to account for the relational nature of rights realisation. The CRC first introduced into the human rights framework the idea that human rights realisation can be relational. This approach recognises that children exercise human rights as situated within their relationship to their family. They are moral agents, even if they may have not fully realised their potential as such. Some decisions involve considering the “knowledge of those who take care of and care for the child attentive to the child’s needs, coping abilities and happiness”. Ruth Zafran states that the concept of children’s rights as relational rights places the child at the center of any legal determination and mandates consideration, as part of the child’s array of rights, of her relationships with the central figures in her life — parents, members of extended family, and friends from various social circles in which she takes part.

The CRPD has incorporated relational aspects into its human rights scheme. In its

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terminology, the CRPD refrains from ‘best interests’ assessments that are relevant to the CRC,\(^{85}\) but both treaties accept that an individual exercises rights within a framework of support from interpersonal relationships. This understanding of rights realisation embraces the individual as a bearer of rights whereby his or her liberty, autonomy and equality must remain ensured,\(^{86}\) but it also “recognises that not all individuals are self-sufficient, inherently autonomous agents”.\(^{87}\)

This approach to rights realisation acknowledges the context of central relationships to an individual’s human rights realisation. Persons with psychosocial disabilities, like other persons, can “claim the essential support that will enable them to live a dignified life and to maximise their autonomy as a matter of positive right”.\(^{88}\) This alleviates the polarised options of using force or leaving persons with psychosocial disability dying or ‘rotting with their rights on’. The CRPD encourages States Parties to establish mental health services that work with the individual with psychosocial disability in the context of his or her family support or other social circles.\(^{89}\) It also aims at facilitating a relationship of mutual trust between the individual with psychosocial disability and the mental health professional by removing elements of pressure and power differences. Thus, States Parties must establish support services in consultation with persons with psychosocial disabilities and their families, friends or support networks.

5.1.7 Conclusions on Article 1 and 5

The CRPD protects the equality and non-discrimination of persons with disabilities to an unprecedented extent by identifying the links between equality and other human rights throughout its text. The CRPD takes the stance that despite some

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\(^{88}\) Ibid, 166.

\(^{89}\) As determined by the individual with psychosocial disability.
good intentions and efforts, the equalisation of opportunities and inclusion have failed because persons with disabilities have not been systematically accepted as full bearers of rights. Their disabilities were widely misunderstood, their existing capabilities undervalued and pre-existing human rights realisation focused on target areas only. In conjunction with the marginalisation of persons with disabilities and pre-existing connotations that human rights could be guaranteed only as far as possible, human rights realisations remained significantly limited. The idea that States Parties can accommodate products, environments, programmes and services to the requirements of persons with physical disabilities has increasingly changed the human rights situation of persons with physical disabilities; some achievements in target areas are visible and some attitudes have changed.

This thesis argues that the CRPD extends its full protection of equality and non-discrimination to persons with psychosocial disabilities. The CRPD guarantees that persons with psychosocial disabilities should not be treated unequally on the basis of their disability or because it is presumed that their disability is detrimental to their human rights realisation. In contrast to pre-existing human rights interpretation, the CRPD refrains from allowing human rights interference because of the individual’s disability. Rather, its general premise is to realise human rights to the fullest extent possible. It addresses the potential of intervention with great caution and instead focuses on realising human rights through support and reasonable accommodation. This supports a strong position against disability-specific restrictions as incorporated in special mental health legislation, in particular if the mental health legislation overrides personal choices on the basis that the individual has a psychosocial disability. Considering how committed governments are “to specific mental health legislation authorising detention on grounds of mental disorder plus the presence of risk to own health or safety or the safety of others”90 and how politically unpopular it is to change mental health legislation, it is surprising that so many countries embraced the ratification of the CRPD, when its central position is that there should not be differentiation on

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the basis of disability, including psychosocial disability.

5.2 Article 12: the Equal Recognition before the Law

Article 12 of the CRPD: Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

In addition to the strong protection of the equality and non-discrimination of persons with psychosocial disabilities, the CRPD includes Article 12, the equal recognition of persons with disabilities before the law. Article 12 addresses the legal capacity of persons with disabilities and decision-making. Hence, Article 12 is important to the human rights situation of persons with psychosocial disabilities and the principle of informed consent to treatment.

Chapter Two set out how since the beginning of the international human rights framework of the United Nations, the freedom from non-consensual treatment has been subject to strong protection in respect to individual autonomy and the right to self-determination. This has been brought about by the memory of the injustices and degradations experienced by persons who were forcibly subjected to medical research and treatment.\(^91\)

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\(^91\) In particular as revealed during, and after, World War II.
In general health care, it has not just been accepted, but it has been required, that an individual who has capacity to consent to medical treatment determines the course of medical treatment after proper consultation with the medical expert. The importance of informed consent is now strongly embedded in medical law, professional ethics and bioethics.\textsuperscript{92} Difficulties that arise when persons make choices that may be detrimental to their health are approached carefully with the tendency to increase communication and to keep on engaging with the patient.\textsuperscript{93} The consideration as to whether or not the decision is objectively reasonable does not override the decision.\textsuperscript{94}

In mental health care, it is not necessarily required that a person with psychosocial disabilities provides informed consent to medical treatment.\textsuperscript{95} As outlined in Chapter Three, the most detailed guidance on mental health and human rights, the \textit{MI Principles}, affirmed that the informed consent of an individual with psychosocial disabilities can be overridden, notwithstanding that individual's capacity to consent.\textsuperscript{96}

The \textit{CRPD} now addresses legal capacity in Article 12. Article 12 marks an

\textsuperscript{92} See, for example, Robert Young, 'Informed Consent and Patient Autonomy' in Helga Kuhse and Peter Singer (eds), \textit{A Companion to Bioethics} (Wiley-Blackwell Publishing Ltd, 2\textsuperscript{nd} ed, Oxford, 2009) 530; Russell Pargiter and John Coverdale, 'The Ethical Dimension' in Sidney Bloch and Bruce S. Singh (eds), \textit{Foundations of Clinical Psychiatry} (Melbourne University Press, Melbourne, 2001) 32; Sara Fovargue and José Miola, 'One Step Forward, Two Steps Back? The GMC, the Common Law and ‘Informed’ Consent' (2010) 36(8) \textit{Journal of Medical Ethics} 494.


\textsuperscript{94} See Mary Donnelly, \textit{Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism} (Cambridge University Press, Cambridge, 2010), 145. Mary Donnelly further assesses the separate issues of assessing whether a person has the ability to make rational or reasonable decisions and whether or not a person reaches a reasonable decision.

\textsuperscript{95} The exact requirements depend on the formulation of mental health legislation, but many statutes are based on the premise that they override the requirement of informed consent. Also, in bioethical discussion, the requirement of informed consent is frequently not applied to persons with psychosocial disabilities on the premise that they are unable of making proper treatment decisions. See, for example, Carl Elliott, 'Patient Doubtfully Capable or Incapable of Consent' in Helga Kuhse and Peter Singer (eds), \textit{A Companion to Bioethics} (Wiley-Blackwell Publishing Ltd, 2\textsuperscript{nd} ed, Oxford, 2009) 541, 542.

\textsuperscript{96} See section 3.4.2 above.
important shift in the understanding of legal capacity by recognising that legal capacity is central to a person’s equal recognition before the law. It establishes that all persons with disabilities not only possess but also exercise legal capacity on an equal basis with others in all aspects of life. By guaranteeing the possession of legal capacity, the CRPD establishes that persons with disabilities have to be recognised as full bearers of rights regardless of their disabilities. By guaranteeing the exercise of legal capacity, the CRPD ensures that persons with disabilities can enjoy and realise their rights to the fullest degree of their capabilities.

Article 12 further sets out that States Parties have to take appropriate measures to provide access to support, if persons with disabilities require support to exercise their legal capacity. In other words, if deficits in decision-making exist, they do not exclude persons with psychosocial disabilities from having their rights respected and realised. Rather, the individual remains an integral driver of decision-making and must be assisted towards realising it. Article 12 also ensures appropriate and effective safeguards to prevent abuse, such as respecting the individual’s rights, will and preferences as well as ensuring the decision-making is free of conflicts of interest and undue influence. Any measure towards restriction must also be proportional, tailored to individual circumstances, apply for the shortest time possible and be subject to regular review by a competent, independent and impartial authority or judicial body. There are two important core messages in Article 12.

5.2.1 The Presumption of Legal Capacity

First, Article 12 ensures that the legal capacity of the person with disability must be presumed. Article 12 recognises persons with disabilities as equal bearers of human rights and fundamental freedoms. Stemming from this premise, Article 12

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guarantees that persons with disabilities must be presumed to be legally capable of making their own decisions and having their self-determination respected on an equal basis to others. This is an unambiguous move away from legal presumptions of incapacity based on psychosocial disabilities.

It follows from that position that decision-making is not a matter prejudiced by the existence of a disability, but a matter of individual capacities and their assessment for the kind of decision at hand. This premise is important for ensuring that persons with psychosocial disabilities are properly and equally informed about treatment options. Paul Hunt, the former Special Rapporteur on the Right to Health, has pointed out that persons with psychosocial disabilities were too readily denied access to information “because they are wrongly judged to lack the capacity to make or participate in any decisions about their own treatment and care”.\(^{100}\)

Article 12 supports the view that the CRPD aims at facilitating a move away from clinician-based decision-making – a move that has taken place in general health care settings, but has not been translated to the disability sector, let alone to mental health care.

### 5.2.2 A Nuanced Model of Decision-Making

Second, Article 12 calls for a nuanced\(^{101}\) model of decision-making that is marked by self-direction, support and a set of important safeguards. The following paragraphs address the conceptualisation of this model in further detail.

#### 5.2.2.1 Self-Direction as a Guiding Principle

Article 12 guarantees that the free will and preferences of a person must be safeguarded. The underlying reason why Article 12 is not just looking at decision-making capacities is that the CRPD responds to experiences of abuse and power imbalances of persons with disabilities. Violations of basic rights have occurred

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despite the inherent good intentions of many lawmakers. One element that has made these violations invisible for so long was that persons with disabilities were marginalised and systematically placed under guardianship. Guardianship laws have not always included sufficient safeguards to prevent persons with disabilities having their will and preferences ignored, trivialised or readily trumped by ideas of protection. The CRPD responds to that experience.\textsuperscript{102} It claims that persons with disabilities are not defined by their abilities or Inabilities, but by their inherent self-worth.\textsuperscript{103}

The CRPD takes the stance that respecting the will and preferences of the person ensures that he or she is acknowledged as a human being who has a say in matters that directly affect him or her. This premise regards persons with disabilities expressing their will and preferences as an indicator as to what is in their best interests and as a safeguard to ongoing engagement with the person. It considers that individuals may make better decisions when they are thoroughly engaged with and supported to do so. It also considers that overriding the will and preferences of any person may have counter-productive effects.\textsuperscript{104}

Considering the will and preferences of a person with psychosocial disabilities may also ensure a better ground for establishing a relationship of trust with mental health professionals. Thus, an expression of how persons with disabilities wish to define their life must be an integral part of decision-making as a driver for, and as a safeguard of, decision-making. Placing value on a person’s will and preferences and respecting other forms of safeguards to decision-making are central to respecting a person as the subject of rights. By respecting a person’s will and preferences, the CRPD also ensures that previous decisions or psychiatric advance directives must be taken into account as an indicator as to what the person would have wanted, in case he or she cannot express a preference at the time of decision-making.


\textsuperscript{103} See section 5.1 above.

\textsuperscript{104} See also, for example, Tina Minkowitz, ‘Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities’ in Bernadette McSherry and Penelope Weller (eds), Rethinking Rights-Based Mental Health Laws (Hart Publishing, Oxford & Portland, 2010) 151, 171 ff; David Webb, Thinking about Suicide: Contemplating and Comprehending the Urge to Die (PCCS Books, Herefordshire, 2010).
5.2.2.2 Self-Direction through Supported Decision-Making

The CRPD endorses the position that if a person has impairments which may influence that person's decision-making capacity, supported decision-making should take place.\textsuperscript{105} It refrains from subjecting persons with impairments in decision-making to substituted decision-making. Rather, the CRPD aims at enhancing equality by considering impairments only where necessary and only to the degree to which they make a difference.

If impairments in decision-making exist, the CRPD recognises the diversity and the social context of disabilities. It understands that legal capacity cannot be approached on an “all or nothing”\textsuperscript{106} basis where persons have either full or no capacity to decide on treatment. Rather, what is relevant is the decision at hand, the correlating abilities of the individual and the measures of support. Psychosocial disabilities may impede decision-making on different levels, as decision-making is a process of understanding the facts involved, appreciating their nature and significance, reasoning and processing information as well as deliberating and choosing one option.\textsuperscript{107}

Assessing whether an individual with psychosocial disabilities has the capacity to make a decision is complicated and may be a matter of degree, momentum and intensity. However, the decision-making capacities of persons with disabilities have been readily denied in the past and Article 12 now demands that the capabilities of persons with psychosocial disabilities must be respected. Penelope Weller has expressed this by stating that “mental health laws must seek  


\textsuperscript{107} Based on considerations of the MacArthur Competence Assessment Tool for Treatment considerations, as developed by Thomas Grisso, Paul S Appelbaum and Carolyn Hill-Fotouhi, 'The MacCAT-T: A Clinical Tool to Assess Patient's Capacities to Make Treatment Decisions' (1997) 48 Psychiatric Services 1415.
to conceptualise capacity and competence along a continuum of capability. Recognition of the decision-making capacity of persons with mental illness will be a first step in challenging the deeply discriminatory legacy of the law.\textsuperscript{108}

The \textit{CRPD} now calls for States Parties to develop models of supported decision-making that respect, protect and fulfil a person’s legal capacity most effectively and accommodate deficits in decision-making capacities. There are methods of achieving supported decision-making. For example, support services, community engagement, networks as well as personal assistance can be established or improved, if they already exist.\textsuperscript{109} This approach may assist in ensuring that persons with psychosocial disabilities are properly assessed as to their capabilities to the decisions at hand. It also ensures that existing abilities are continuously respected and supported.

The range of persons who can act as a support person can vary quite significantly and can be adjusted to the realities of countries with limited resources. It is possible to incorporate a system of nominated or appointed persons to assist in decision-making, ranging from lay persons, independent advocates to experts in the field. Support persons who a person with disabilities can choose range from family members, friends, partners, carers, independent advocates to any other selected person. Independent advocates may be social workers, lawyers or persons with other relevant qualifications and experience who are able to provide formal advice and legal assistance to the person.

If the person is unable to nominate a support person, an appropriate authority can be granted power to appoint a support person. The details as to how such a system might meet the demands of practice have to be trialled and be subjected to regular review. What is important is that the \textit{CRPD} emphasises that treatment decisions for persons with psychosocial disabilities should be guided by clinical criteria, like in general health settings, rather than decided by a clinician alone. Article 12 aims to prevent persons with psychosocial disabilities being


systematically cut off from decision-making purely based on their status.

5.2.2.3 Safeguards to Decision-Making

Article 12 includes important safeguards to decision-making. Apart from ensuring that any measure relating to the exercise of legal capacity must respect the rights, will and preferences of the person, Article 12 requires that any interference must be free from any conflict of interest and undue influence, be proportional and tailored to the person’s circumstances, apply for the shortest time possible and be subject to regular review by a competent, independent and impartial authority or judicial body.

These specifications ensure that capacity must be assessed as a matter of degree, momentum and intensity. Also, any limitations in exercising legal capacity must be subject to proper review procedures. These specifications aim to ensure an environment that recognises and respects the rights of persons with disabilities. When Article 12 mentions legal safeguards to exercising legal capacity, it adopts precise and careful language. This indicates that the CRPD responds to the potential for abuse when legal provisions adopt terminology that is open to broad, or value-driven, interpretation.110

5.2.2.4 The Silence on Substitute Decision-Making

In its extensive elaboration on legal capacity, Article 12 does not mention substituted decision-making as a legitimate limitation at all. Substituted decision-making was extensively debated during the drafting process of the CRPD and deliberately left unmentioned.111 This change of wording is relevant to the

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110 See, for example, Ian Freckelton, ‘Distractors and Distressors in Involuntary Status Decision-Making’ (2005) 12(1) Psychiatry, Psychology and Law 88. Ian Freckelton discusses the use of descriptors in the context of civil commitment decisions.

interpretation and application of Article 12.\textsuperscript{112}

Rosemary Kayess and Ben Fogarty have pointed out that the reality of practice in mental health services means that support is not always sufficient in all cases, thus substituted decision-making must exist as a measure of last resort, at least on a case-by-case basis.\textsuperscript{113} There are persons with psychosocial disabilities who are of the view that involuntary treatment worked for them and improved, or even saved, their lives.\textsuperscript{114} Thus, the CRPD may still allow for substituted decision-making when support cannot assist persons with disabilities to make a choice, in particular when the person’s life is at stake.

However, it may be argued that these individuals could have responded well to support, if support mechanisms were properly established in a manner that the CRPD envisages. Tina Minkowitz argues that even in extreme cases, such as unconsciousness, decision-making must ensure substantive support, rather than substitution.\textsuperscript{115} That is, if a third person truly considers what the person would have wanted, he or she provides support towards expressing the wishes or the values of that individual. Tina Minkowitz argues that this understanding of support is necessary in order to prevent a person becoming an object of decision-making.\textsuperscript{116} She argues that the natural will of a person must be protected absolutely in order to ensure that the individual is respected as a subject of rights.\textsuperscript{117} Difficulties arise when persons with psychosocial disabilities refuse treatment without sufficiently understanding the need for treatment and its effects. However, clinical experts who deal with severe forms of disability, or mental illness, have argued that continued engagement and accommodation in a safe

\begin{itemize}
\item \textsuperscript{112} Vienna Convention on the Law of Treaties, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980), Article 32.
\item \textsuperscript{116} Ibid, 157.
\item \textsuperscript{117} Ibid, 157.
\end{itemize}
environment can alleviate the use of force.\textsuperscript{118}

In not mentioning substituted decision-making, the \textit{CRPD} establishes that there should be no disability-specific exceptions to decision-making models and that limitations should be subject to the same high level of scrutiny that occurs in general health care settings. If any limitation must take place, it must be a matter of individual assessment, applied restrictively and consistently with other rights and freedoms of the \textit{CRPD}. In respect to medical treatment it seems that general health care policy has accepted that in general, persons cannot be treated against their wishes.\textsuperscript{119} The \textit{CRPD} seems to encourage States Parties to scrutinise the exceptional nature of interventions on similar strict considerations by breaking with the connotation that involuntary treatment is necessary for persons with psychosocial disabilities.

If States Parties do not immediately reject substituted decision-making, it may be argued that in the interim, substituted decision-making must be amended to respect self-direction, for example as expressed in advance directives. For persons with psychosocial disabilities this is a new approach because substitute decision-making is a key feature of mental health law. It will pose significant challenges to States Parties to introduce this idea into domestic mental health legislation.\textsuperscript{120}

\textbf{5.2.2.5 Conclusions on Article 12}

The content of Article 12 shows many parallels to the statements in Articles 1 and 5 and it seems that Article 12 substantiates the understanding of equality and non-discrimination in respect to legal capacity and informed consent. Article 12 aims to foster substantial equality for persons with disabilities by strongly protecting their legal capacity which is crucial to being recognised as an agent of rights. The \textit{CRPD} addresses legal capacity as a central element to equality before the law and links it to the protection of non-discrimination, including the denial of reasonable accommodation.

\textsuperscript{118} See, for example, Robert Hayes et al, ‘Evidence-Based Mental Health Law: The Case for Legislative Change to Allow Earlier Intervention in Psychotic Illness’ (2007) 14(1) \textit{Psychiatry, Psychology and Law} 35, 39.

\textsuperscript{119} This will be further addressed in section 9.1.3.1 below.

\textsuperscript{120} See Chapters Eight to Ten below.
Article 12 exemplifies the understanding of equality and non-discrimination of persons with disabilities as addressed in the previous section. Similar to the consideration that psychosocial disability should not be presumed to be detrimental to human rights realisation, Article 12 sets out that psychosocial disability should not be presumed to lead to legal incapacity.

In addition, Article 12 calls for States Parties to introduce measures to support the exercise of legal capacity. This is formulated as a positive obligation in regards to a civil and political right that traditionally has been perceived as amounting to freedom from State interference only. While it identifies many important safeguards, Article 12 remains silent on exceptions and limitations that would justify differential treatment. Omitting to mention the concept of substituted decision-making in regards to decision-making of persons with psychosocial disabilities is significant given the extent to which substituted decision-making dominates disability or mental health law.

5.3 Article 14: the Liberty and Security of the Person

Article 14 of the CRPD: Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
   (a) Enjoy the right to liberty and security of person;
   (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

Article 14 is an important provision for persons with psychosocial disabilities. It protects the liberty and security of the person and explicitly states “that the existence of a disability shall in no case justify a deprivation of liberty”.

Detention under mental health legislation is a deprivation of liberty. According to Article 14, it seems that detention under specific mental health legislation can no longer be justified under international human rights considerations because mental health legislation applies to persons with
psychosocial disabilities based on the existence of psychosocial disability.

The drafting process of the CRPD supports this position. As mentioned above, the preparatory work of the CRPD is relevant to its interpretation. During the discussion of the text of Article 14 (then Article 10), the working text of the CRPD provided that:

1. States Parties shall ensure that persons with disabilities:
   a) Enjoy the right to liberty and security of the person, without discrimination based on disability.

Some States Parties, including Australia, suggested amending this provision to the effect that States Parties shall ensure the right to liberty and security of the person, without discrimination ‘solely’ based on disability. If the word ‘solely’ had been incorporated, there could have been more room to argue that civil detention on the basis of disability in conjunction with additional criteria would be legitimate. Such wording could have implied that the nature of psychosocial disability is characterised by features that render differential treatment of persons with psychosocial disabilities necessary.

Mental health legislation that differentiates between persons based on psychosocial disabilities in combination with other criteria, such as a need for treatment or considerations of dangerousness was specifically mentioned during the drafting process. The World Network of Users and Survivors of Psychiatry and the Support Coalition International have argued that allowing Article 14 to be limited by the introduction of the word ‘solely’ would

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121 See above section 2 above.
125 There still is room to argue that differentiation based on disability in conjunction with other criteria is indirect discrimination.
open the door for States to deprive persons with disabilities of their liberty for being ‘a danger to society,’ which is discriminatory because persons without disabilities are not subject to the same standard. If there is no crime, a State cannot lock up [a] person who is not considered mentally ill or intellectually disabled. [Persons with disabilities] should not be subject to a different standard. There is a moral obligation to move society toward inclusiveness. If a person with a disability is deprived of liberty, that imposes a social disadvantage and therefore, under the social model, that is discrimination.\footnote{127}

Inclusion International has commented that “[i]nstitutionalization is very destructive to [persons with disabilities] and leads to dehumanization of both [persons with disabilities] and staff, leading to abuse. Institutions take over the core of a person’s life […] and are a costly form of segregation”.\footnote{128} It was argued that the inclusion of the word ‘solely’ in Article 14 would create “a loophole allowing States to deprive [persons with disabilities] of liberty based on another reason”.\footnote{129} Save the Children insisted that “a drastic revision is needed to ensure that institutionalization and perceived incapacity will be halted”.\footnote{130}

The suggestion to include the word ‘solely’ was rejected and the Human Rights Council agrees that, as currently worded, Article 14 poses a "radical departure from the pre-existing human rights position".\footnote{131} This departure presents the strongest argument that the CRPD considered the special situation of persons with psychosocial disabilities and decided to extend its full and strong protection of equality and non-discrimination to persons with psychosocial disabilities.\footnote{132}

In 2009, the Human Rights Council stated that it has recognised that specific mental health legislation authorises deprivations of liberty on grounds of

\footnotesize{\begin{tabular}{ll}
\textbf{127} & Ibid. \textbf{128} & Ibid. \\
\textbf{129} & Ibid. \textbf{130} & Ibid. \\
\end{tabular}}
mental disability and that this contravenes the *CRPD*.\[^{133}\] The Human Rights Committee has emphasised that the legal grounds for detention of any person must be “de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.”\[^{134}\]

Because the significance of Article 14 was discussed during the drafting sessions, in particular when the word 'solely' was dropped from the draft text of the *CRPD*, States Parties that signed and ratified the *CRPD* must have known that specific mental health legislation enabling the deprivation of liberty on the basis of psychosocial disabilities is in conflict with Article 14. Again, it is surprising that so many States Parties embraced signing or ratifying the *CRPD*, given this crucial, controversial and radical provision.

5.4 Article 17: the Protection of the Integrity of the Person

Article 17 protects the physical and mental integrity of the person. In stark contrast to the detailed provision of other provisions of the *CRPD*, Article 17 does not include further clarification. Article 17 provides:

**Article 17 of the *CRPD*: Protecting the integrity of the person**

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 17 is the only provision in the *CRPD* that consists of one short statement. The involuntary treatment of persons with psychosocial disabilities was discussed under Article 17 during the drafting of the *CRPD*,\[^{135}\] but it does not mention involuntary treatment nor does it explicitly permit or prohibit it. This is a negotiated


\[^{134}\] Ibid, 49.

During the negotiation process, it was suggested that legal safeguards should be incorporated concerning the involuntary treatment of persons with disabilities into Article 17. The following text of Article 17 was suggested in the 7th session of the drafting process of the CRPD:

1. States Parties shall protect the integrity of the person of persons with disabilities on an equal basis with others.

2. States Parties shall protect persons with disabilities from forced interventions or forced institutionalization aimed at correcting, improving or alleviating any actual or perceived impairment.

3. In cases of medical emergency or issues of risk to public health involving involuntary interventions, persons with disabilities shall be treated on an equal basis with others.

[4. States Parties shall ensure that involuntary treatment of persons with disabilities is:
(a) Minimized through the active promotion of alternatives;
(b) Undertaken only in exceptional circumstances, in accordance with procedures established by law and with the application of appropriate legal safeguards;
(c) Undertaken in the least restrictive setting possible, and that the best interests of the person concerned are fully taken into account;
(d) Appropriate for the person and provided without financial cost to the individual receiving the treatment or to his or her family.]

While this approach would have been a means of facilitating protection into systems that currently have no or minimal legal safeguards, it could also have been interpreted as meaning that the CRPD justifies involuntary treatment on the ground of disability. The discussion of draft Article 17 was marked by “intense and protracted” debate. In particular, the fourth paragraph was debated as to whether or not it should be included and hence placed in brackets. The Chair of the 7th session of the drafting process stated:


Ibid, 608.

It appears to me that the middle ground we are searching for must point clearly to a paradigm shift but we do not yet have consensus about how to best provide restrictions around the use of involuntary treatment in the Convention. Part of the difficulty in addressing these issues is that the ground covered overlaps in part with measures already contained in the Convention relating to legal capacity, freedom from torture, liberty and security, the right to live in the community and health care services.\textsuperscript{140}

In the end, all amendments to the first line of Article 17 were dropped during the 8\textsuperscript{th} session of the drafting process of the CRPD. Anna Lawson, in commenting on the discussions during the drafting of Article 17, pointed out that specific limitations that apply only to people with mental impairments “would have been totally unacceptable to the IDC” (International Disability Causus).\textsuperscript{141} It would have allowed for forced administration of anti-depressants on persons with psychosocial disability, while there was agreement that forced cochlear implants on deaf persons are impermissible.\textsuperscript{142} Thus, the drafting discussion on Article 17 discussed the different service responses to physical and psychosocial disabilities and embraced the position of ending such differentiation.

The silence of Article 17 on involuntary measures is significant as it does not explicitly allow for the differential treatment of persons with psychosocial disabilities even though a number of representatives in the drafting sessions wanted to include a reference to that effect. But there was agreement that the CRPD marks a ‘paradigm shift’ in the treatment of persons with disabilities and, in the end, there was agreement not to include any reference into the text of Article 17 that could be interpreted as justifying involuntary treatment and the differential treatment of persons with psychosocial disabilities.\textsuperscript{143} Rather, when Article 17 is

\textsuperscript{140} Chair’s Closing Remarks on Revisions and Amendments at the Seventh Session of the Ad Hoc Committee on the UN Convention on the Rights of Persons with Disabilities, <www.un.org/esa/socdev/enable/rights/ahc7chairclose.htm> at 1 July 2011.


\textsuperscript{142} See ibid, 609.

\textsuperscript{143} See ibid, 609. The amendments did not explicitly mention differentiation on the ground of psychosocial disability, but the content of the amendments used terminology that is well-established in mental health legislation.
interpreted in light of the Preamble, objective, purposes and other provisions of the CRPD, it strongly suggests that the CRPD does not justify the involuntary treatment of persons with psychosocial disabilities based on psychosocial disability.

It would not be surprising that by dropping sentences 2 to 4, Article 17 may be interpreted to the effect that is does not add any real protection to persons subjected to involuntary treatment. But the purpose, general principles and content of the CRPD as well as its discussions in the negotiating process can, and should be, considered for the interpretation and application of Article 17. At the very least, Article 17 must lead to continuous scrutiny of State practice on involuntary treatment schemes. Most importantly, the silence of Article 17 cannot be interpreted as facilitating disability-specific differential treatment since such an interpretation would conflict with the purpose and content of the CRPD.

5.5 Article 25: the Right to Health

Article 25 of the CRPD: Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

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(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

The CRPD adopted the wording of Article 25 in its long formulation as “the right to the enjoyment of the highest attainable standard of physical and mental health” as expressed in the *UDHR*, the *ICESCR* (Article 12) and some other complementary thematic treaties. This formulation encompasses the important obligations on States Parties to provide accessible health services and the underlying determinants to health.

Since Article 25 is built upon the well-established right to health, the interpretation and application of the right to health under other treaties is relevant to the interpretation and application of this right under the CRPD. The right to health has experienced significant development over the last years, in particular since the former Commission on Human Rights appointed Paul Hunt as a Special Rapporteur on the Right to Health in 2002. The Special Rapporteur has taken a stance on the right to health that is, at large, consistent with the aims and purpose of the CRPD.

In his report to the Commission on Human Rights in 2003, the Special

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146 *Universal Declaration of Human Rights*, GA Res 217A (III) of 10 December 1948, UN Doc A/810 (1948)

Rapporteur addressed the right to mental health. He has noted that “most mental disorders can be managed, treated and, in many cases, prevented”. He has observed that “in many States mental health care often consists primarily of large psychiatric institutions, with limited provision of community-based treatment and care”. He also has pointed out the “stigma and discrimination surrounding mental disorders, as well as the real or deemed incapacity of persons with mental disorder to take decisions on account of their illness”. He argues that the combination of these interrelated issues makes persons with psychosocial disabilities particularly vulnerable to human rights violations.

In 2005, the Special Rapporteur addressed mental disability in much more detail, criticising human rights violations concerning persons with intellectual and psychosocial disabilities, persons in segregated service settings and residential institutions, prisoners and indigenous persons. Amongst other human rights violations, he has criticised the administration of treatment to psychiatric patients without their informed consent. After having pointed out that new models of community-based services and support systems have demonstrated success, he noted in that context:

"Persons once thought incapable of making decisions for themselves have shattered stereotypes by showing that they are capable of living independently if provided with appropriate legal protections and supportive services. Moreover, many persons once thought permanently or inherently limited by a diagnosis of major mental illness have demonstrated that full recovery is possible."

The Special Rapporteur’s 2005 report picked up many themes that the Committee on Economic, Social and Cultural Rights already addressed. But the Special

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149 Ibid para 92.
150 Ibid para 93.
151 Ibid para 93.
153 Ibid para 11.
154 Ibid para 12.
155 Ibid para 9.
156 Ibid para 15.
Rapporteur elaborates on what these themes mean in the context of mental health and he includes many practical examples. He clarifies, for example, that facilitating accessible health services means that mental health services should be within safe physical and geographical reach, that mental health care should be subsidised or covered by health insurance, that persons with psychosocial disabilities should participate in decisions about their own treatment and care and that care should be exercised not to presume a lack of capacity to make decisions or to participate in the decision-making process.157

Succeeding Paul Hunt as Special Rapporteur on the Right to Health, Anand Grover addressed informed consent specifically in his report to the General Assembly in 2009. He has emphasised the “deeply rooted power imbalances and structural inequalities”158 in the relationship to health care providers and has recognised the challenges that these power imbalances pose to communication.159 He has urged health care providers “to be cognizant that, according to their duty to act in the best interests of the patient, they are key players in protecting informed consent”.160 In regards to legal capacity, he has clarified that patients’ decisions contrary to professional advice have no bearing on legal capacity161 and that the exercise of legal capacity may require supportive measures.162

Factsheet No 31 (2009) on the Right to Health163 elaborates on persons with psychosocial disabilities and informed consent. It points out that the medical treatment of persons with psychosocial or intellectual disabilities without their free and informed consent is “a clear and serious violation of their right to health”.164 Thus, the awareness that the human rights situation of persons with psychosocial disabilities needs improvement has increased during the period of office of the Special Rapporteur on the Right to Health. Both reports of the Special Rapporteur on the Right to Health complement each other and focus on identifying what

157 Ibid para 46.
159 Ibid para 17.
160 Ibid para 7.
161 Ibid para 10.
162 Ibid para 10. He has addressed the situation of vulnerable groups, but has not specifically elaborated on the position of persons with psychosocial disabilities.
164 Ibid, 17.
measures States Parties have to take in order to realise the human rights of persons with psychosocial disabilities.

5.6 Concluding Thoughts

The CRPD now provides one comprehensive and up to date human rights instrument. It arose as a response to pre-existing shortcomings in the human rights protection of persons with disabilities. This Chapter argues that Articles 1 and 5 have strengthened the rights to equality and non-discrimination, including the idea that persons with disabilities must share equal opportunities to exercise their human rights and fundamental freedoms. It argues that the CRPD extends its detailed protection to persons with psychosocial disabilities and shows a commitment to equality and non-discrimination to a degree that is more than a theoretical statement of principle. In particular, the CRPD requires States Parties to recognise persons with psychosocial disabilities as equal subjects of rights and to provide them with support and reasonable accommodation.

In line with the social model of disability, the CRPD mandates that individuals with psychosocial disability must not be defined by their disability. Rather, individual impairments must be understood in their social context in order to scrutinise whether prejudices, misconceptions or misunderstandings pose barriers to the human rights realisation of persons with psychosocial disabilities. Thus, the CRPD safeguards against presumptions that psychosocial disability justifies human rights limitations.

This Chapter also argues that Article 12 emphasises that persons with psychosocial disabilities must be presumed to have legal capacity. Any response to individual impairments must respect the will and preference of the person with psychosocial disability. In stark contrast to pre-existing international human rights clarification, the CRPD refrains from identifying if, or in what circumstances, differential treatment can be justified. In particular, it refrains from recognising the MI Principles, mentioning substituted decision-making and identifying grounds for involuntary treatment or detention. The interpretation and application of Articles 14 and 17 support the view that the CRPD challenges the pre-existing justifications for the differentiation of persons with psychosocial disabilities because of the nature of their disability.
The remaining challenge for an analysis of the CRPD is to clarify how to interpret that silence given the frustration arising from the “apparent acceptance of the prevailing critique of medical power, and simultaneous affirmation of the deeply felt humanism of psychiatric medicine”.\footnote{Penelope Weller, ‘Lost in Translation: Human Rights and Mental Health Law’ in Bernadette McSherry and Penelope Weller (eds), Rethinking Rights-Based Mental Health Laws (Hart Publishing, Oxford & Portland, 2010) 51, 71.} The CRPD has ambitious aims and demands that mental health services must be available, accessible, acceptable and of good quality. It will require significant State efforts to achieve that and it will be challenging for States Parties to respond to persons with psychosocial disabilities on the basis of support, rather than intervention. This applies in particular when governments currently struggle with providing access to services due to shortages in service provision. States Parties who are now confronted with the idea that specific mental health legislation is discriminatory will have to engage in significant legislative reconsiderations, carefully considering how to ensure that mental health services remain functional and well-coordinated with other services, such as the police who frequently respond first-hand to individuals in severe mental health crisis. These kinds of challenges are, however, not new to the international human rights framework. Rather, Paul Hunt argues that:

While human rights have a constructive contribution to make to prioritization, they are unlikely to provide neat answers to highly complex issues, any more than do ethics, economics or general theories of justice. They are likely to rule out some processes and some choices, leaving a number of options, all of which are legitimate.\footnote{Paul Hunt, Report of the Special Rapporteur on the Right to Health to the General Assembly, 62\textsuperscript{nd} sess, UN Doc A/64/214 (8 August 2007) para 31.}

The subsequent Chapters of this thesis will address what processes and options might be ruled out when looking at Australian mental health legislation in light of the CRPD and what legitimate options remain. Before examining such options the next Chapter will first provide the background to domestic mental health legislation and human rights.
CHAPTER 6

6 The Background to Australian Mental Health Legislation and Human Rights

This Chapter assesses the background to Australian mental health legislation and human rights. First, this Chapter outlines the development of domestic mental health legislation since the early 1990s. In the early 1990s an influential report on mental health and human rights triggered a process of mental health service reform with the aim to improve the human rights situation of persons with psychosocial disabilities. Then, this Chapter reviews this reform development and its influence on the domestic mental health legislation. It compares the findings of Chapters Two and Three with the domestic mental health reform developments prior to 30 March 2007, the day when Australia signed the CRPD. Chapters Two and Three identified a number of shortcomings in the international human rights realisation of persons with psychosocial disabilities prior to the CRPD. This Chapter analyses how the domestic mental health reform process and the international human rights framework prior to the CRPD have faced common shortcomings in the human rights realisation of persons with psychosocial disabilities.

6.1 A National Inquiry into the Human Rights of Persons with Mental Illness

In 1993, the release of the National Inquiry into Human Rights and Mental Illness (the Burdekin Report) significantly influenced mental health law in Australia. The findings of this Inquiry are commonly referred to as the findings of the Burdekin Report, named after Brian Burdekin, the Federal Human Rights Commissioner in the years 1986 to 1994 who initiated and chaired the Inquiry. The Inquiry was formally announced in June 1990 and was initiated as a result of 12 months

preliminary research into mental health and human rights. This preliminary research indicated:

Widespread ignorance about the nature and prevalence of mental illness in the community;

Widespread discrimination;

Widespread misconceptions about the number of people with a mental illness who are dangerous; [and]

A widespread belief that few people affected by mental illness ever recover.\(^2\)

The subsequent full Inquiry was the first national inquiry that comprehensively assessed the human rights situation of persons with mental illnesses in Australia. The findings of this Inquiry serve as a useful starting point for the analysis of domestic mental health legislation and the human rights realisation of persons with psychosocial disabilities.

The Burdekin Report assessed and compared mental health legislation and other relevant legislation throughout Australia. This assessment followed a rights-based approach with reference to Australia’s international human rights obligations, in particular the MI Principles.\(^3\) The Inquiry also evaluated the effects of deinstitutionalisation on the human rights realisation of persons with psychosocial disabilities.\(^4\) It conducted extensive public hearings in all Australian States and Territories as well as private hearings, informal meetings and public forums for consumers. Brian Burdekin estimated that oral evidence and written submissions from carers, community organisations, mental health professionals and government authorities amounted to input from over 1300 witnesses.\(^5\)

The Report resulted in a damning finding of numerous severe human rights

\(^2\) Ibid, 4. In reference to all four bullet points.
\(^3\) Ibid, 5.
\(^5\) Ibid.
breaches and it concluded with recommendations for urgent enactment. The Report sparked a public debate, brought attention to mental health as a human rights issue and “brought forth how the experience of societal stigma and disempowerment by the mental health system caused, in many cases, far more suffering than the mental illnesses themselves”\(^6\). The Burdekin Report stressed the significance of improving mental health care by estimating the number of Australians who had a mental illness at the time of the Inquiry to be at approximately 1.5 percent of the population and those who will develop some form of mental disorder at some point in their life to be at one in five persons.\(^7\)

6.2 **Some Major Findings of the Burdekin Report**

The following observations from the Burdekin Report were central to the Inquiry and they are important to this thesis. The Burdekin found:

- widespread discrimination and misunderstanding of mental illness;
- minimal service provision and inadequate service funding;
- lack of consumer participation, lack of social inclusion and unequal opportunities in many areas of life;
- lack of treatment alternatives and voluntary forms of treatment;
- demands on family, carers and close persons;
- severe human rights breaches in many areas of life; and
- poor service response to the psychosocial disability of children and adolescents.

The following subsections elaborate on each of these points.

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\(^6\) Graeme Browne and Martin Hemsley, “Consumer Participation in Mental Health in Australia: What Progress is Being Made?” (2008) 16(6) *Australasian Psychiatry* 446, 446.

6.2.1 Widespread Discrimination and Misunderstanding of Mental Illness

The Burdekin Report found that persons with psychosocial disabilities were among the most vulnerable and disadvantaged persons in Australia.\(^8\) The Report identified that persons with psychosocial disabilities frequently suffered from “discrimination and stigmatisation based on ignorance, labelling and inaccurate stereotypes”.\(^9\) The Report stated that:

Evidence to the Inquiry confirmed that the level of understanding in the community about mental illness is abysmal. There is widespread fear about the behaviour of people affected by mental illness – based largely on ignorance, misconceptions and myths. This fear is sometimes reflected and reinforced by selective reporting in the mass media, which contributes to stigmatisation, marginalisation and discrimination.\(^10\)

The situation was particularly bad for persons with psychosocial disabilities who were already disadvantaged for other reasons, such as elderly people, homeless people, women, children and adolescents, people with dual and multiple disabilities, people in rural and isolated areas, Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds as well as forensic patients and prisoners. Aboriginal and Torres Strait Islander people were found to be massively over-represented in prison and police custody.\(^11\) In rural areas, mental health services generally lacked inpatient facilities and proper transfers to city hospitals.\(^12\) Rural areas also had to cope with unfilled vacancies and strains on existing health professionals.\(^13\)

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\(^8\) Ibid, 11.
\(^9\) Ibid, 13.
\(^10\) Ibid, 199 f.
\(^11\) Ibid, 940.
\(^12\) Ibid, 557 and 678 ff.
\(^13\) Ibid, 679.
6.2.2 Minimal Service Provision and Inadequate Service Funding

The Burdekin Report strongly criticised the state of service provision in mental health institutions and community care. Prior to the Burdekin Report, Australian mental health care experienced 30 years of deinstitutionalisation. Harvey Whiteford and William Buckingham have commented that this process of deinstitutionalisation “saw the number of psychiatric beds decrease from 30,000 to 8,000”\(^\text{14}\) while Australia’s population doubled in size.\(^\text{15}\) The Burdekin Report stated that deinstitutionalisation had not been as beneficial as intended because it had not been accompanied by sufficient alternative mental health services.\(^\text{16}\) The Report found that mental health services were minimal, sometimes leaving prison as an avenue for treatment.\(^\text{17}\) Many persons with mental illness also experienced inappropriate discharge procedures from inpatient care and felt that the system failed to provide even minimal support after release.\(^\text{18}\)

In addition, service coordination between inpatient and community mental health services was inadequate or non-existent.\(^\text{19}\) Most community mental health services lacked systematic follow-up procedures or systematic retraining of psychiatric hospital staff to work with people in non-institutional settings in the community.\(^\text{20}\) The absence of adequate, affordable and secure accommodation intensified inadequacies in community care.\(^\text{21}\) The Report found that the shift to community services resulted in “inadequate”\(^\text{22}\) and “disgraceful”\(^\text{23}\) services and that deinstitutionalisation had “largely failed”\(^\text{24}\) with community mental health services


\(^{15}\) Ibid, 396.


\(^{17}\) Ibid, 760.

\(^{18}\) Ibid, 281 f.

\(^{19}\) Ibid, 916 f.

\(^{20}\) Ibid, 916.

\(^{21}\) Ibid, 337.

\(^{22}\) Ibid, 184 and 916.

\(^{23}\) Ibid, 916.

being “grossly underfunded and underdeveloped”.\textsuperscript{25}

\subsection*{6.2.3 Lack of Treatment Consumer Participation, Lack of Social Inclusion and Unequal Opportunities in Many Areas of Life}

The Burdekin Report found that persons with mental illness were often left dependent upon others. The Report stated that:

One of the fundamental difficulties experienced by people with mental illness is the degree to which they must depend on those around them.\textsuperscript{26}

Clearly, many barriers prevent people with psychiatric disabilities from participating in the advocacy and decision-making processes which directly affect them.\textsuperscript{27}

The Burdekin Report found that these experiences largely stem from stigmatisation and marginalisation based on the use of psychiatric labels.\textsuperscript{28}

Many witnesses recounted the loss of their 'identity' once a diagnosis had been made. They felt that society saw only their label, and with this they ceased to have the same needs, emotions and rights to make decisions about their lives.\textsuperscript{29}

The Burdekin Report identified that the formulation of mental health legislation exacerbated the experience of persons with mental illness that they are excluded from participating in the decision-making in respect to many areas of life. The Report stated that:

In some cases, those responsible for drafting mental health legislation have not attempted a definition [of mental illness], leaving the matter in the first instance in the hands of medical practitioners who have the


\textsuperscript{26} Ibid, 447.

\textsuperscript{27} Ibid, 446.

\textsuperscript{28} Ibid, 444.

\textsuperscript{29} Ibid, 445.
effective decision-making power under the legislation. Ultimately, in these jurisdictions, the courts can settle questions of definition, applying a combination of expert evidence and common law principles. Upon close examination, however, many legislative formulations are little more than token gestures – marked by circularity of reasoning and apparently designed to intrude to a minimal degree upon the territory of psychiatrists.  

### 6.2.4 Lack of Treatment Alternatives and of Voluntary Forms of Treatment

The Burdekin Report criticised the lack of treatment alternatives to pharmaceutical treatment and to involuntary forms of treatment. The Report stated that:

> It is clear from evidence presented to the Inquiry that the restriction of access to psychologists results in important treatment options being denied to many individuals affected by mental illness. Perhaps even more importantly, preventive counselling and effective rehabilitation opportunities are being squandered.  

A number of witnesses had been unable to gain voluntary admission to a psychiatric facility when they felt they badly needed it. In some cases this denial of assistance had tragic results.

In respect to private medical services, the Burdekin Report commented that “[p]rivate inpatient care is virtually unobtainable by people who do not have private health insurance”. On Community Treatment Orders (CTOs) the Burdekin Report commented that “CTOs offer a form of involuntary treatment which is less restrictive than hospitalisation. If they become too intrusive, however, they are

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30 Ibid, 40.  
31 Ibid, 314 and 229.  
32 Ibid, 181.  
33 Ibid, 229.  
34 Ibid, 909. Australia has a dual system of health insurance: A national State controlled health insurance system, called Medicare which funds public hospital and basic medical care, as well as a private health insurance system for extra coverage.
likely to be resisted and additional safeguards may be necessary”. 35

6.2.5 Demands on Family, Carers and Close Persons

The Burdekin Report addressed the adverse consequences of the shift to community care for persons with psychosocial disabilities and their carers. The Report stated that:

For a great many individuals with mental illness, living at home with their parents or other relatives is the only affordable housing option.36

The Report addressed the emotional and financial costs of care.37 It also pointed out that “most families are simply unable to provide the skilled support which many sufferers need – and which is their right”.38 These shortcomings in mental health services caused “sometimes unbearable pressures on other family members who feel powerless to assist”39 the individual with psychosocial disability. At the same time, the Report stressed the effect of living with family for the person with mental illness. The Report stated that:

Living with family entails another significant disadvantage for mentally ill people themselves: it prevents them becoming independent.40

6.2.6 Severe Human Rights Breaches in Many Areas of Life

The Burdekin Report heard of “frequent accounts of sufferings compounded by inappropriate or inadequate responses”41 to mental health crisis. The Report found numerous shortcomings in the administration of treatment, such as the insufficient considerations of known side-effects of psychotrophic drugs,42 their over-
prescription or the lack of monitoring and evaluation of medication. In a number of cases, the Burdekin Report pointed out that the treatment of illness seemed to have had worse effects than the illness itself. The Report also stressed the severe effects of detention on the lives of persons with psychosocial disabilities. The Report stated that persons with psychosocial disabilities have expressed a strong resentment to detention, in particular when they lacked immediate and effective avenues to challenge their detention. The Burdekin Report found that the lack of immediate and effective avenues to challenge detention was frequently based on administrative reasons.

Besides the direct effects of involuntary treatment and detention, the Burdekin Report noted that persons with mental illness experienced significant indirect effects of involuntary mental health services. The Report stated that persons who are subject to involuntary mental health services faced several barriers to social inclusion in many areas of life, including access to information, education, employment, recreation, leisure and transport. The Report addressed in particular barriers to employment. Barriers to employment included the lack of access to vocational and educational training, the debilitating effects of psychiatric illness and treatments, inflexible job designs and negative employer and community attitudes. The Report found that the lack of opportunities to obtain and maintain employment has caused increased inequality and poverty for persons with psychosocial disabilities. Such kinds of social exclusion resulted in a number of human rights violations or unequal standing in society in respect to many areas of life.

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43 Ibid, 243.
44 Ibid, 244.
45 For example, ibid, 227 and 243.
46 Ibid, 236.
47 For example, ibid, 230 and 236.
48 Ibid, 236.
49 Ibid, 227 ff.
50 See for example, ibid, 197. This list is not exhaustive.
51 Ibid, 921.
6.2.7 Poor Service Response to the Psychosocial Disabilities of Children and Adolescents

The Burdekin Report found that the Australian mental health system failed to recognise, assess and treat children and adolescents suffering from psychosocial disability. This is a significant shortcoming given that the Report stated that approximately 15 percent of young people experience mental health problems and 50 percent of mental illnesses first affect young people between the ages of 16 and 18. Children and adolescents were placed in “highly inappropriate facilities – sometimes at great personal risk”. 53 For example, children and adolescents were placed in remand detention facilities or police cells where they did not receive any health assessment or follow-up treatment for extended periods of time. 54

6.3 Criticisms of Key Considerations in Mental Health Legislation

In respect to the use and design of mental health legislation, the Burdekin Report criticised the language, structure and substance of domestic mental health legislation. 55 The Report found that the language used in mental health legislation was generally hard to understand, even for persons with legal expertise. 56

The Report also found that the relevant legislation was insufficiently guided by objectives and principles. 57 In some instances mental health legislation did not incorporate any objectives or principles at all. 58 This lack of guidance made it difficult to understand the legislation or to apply it consistently. 59 In respect to mental health legislation that included objectives and principles, the Burdekin

54 Ibid, 626 ff.
56 In particular in respect to the mental health legislation of Queensland and Tasmania. Ibid, 895.
57 Ibid, 896.
58 That applied to the mental health legislation of the Northern Territory and Western Australia.
Report found that these ideas were not always sufficiently translated into the substantive provisions of the respective mental health legislation. This conflict arose in particular when mental health legislation aimed to apply restrictively or on a voluntary basis, but incorporated no definition of mental illness and broadly applicable criteria for detention or wide-ranging clinical discretion on involuntary treatment. The Report criticised in particular that involuntary measures could be justified too readily based on considerations of therapeutic need or dangerousness.

The Burdekin Report also found that automatic review processes, procedural safeguards and appeal or complaints mechanisms were inadequate. The Report criticised in particular the lack of independent review of clinical decision-making. Overall, the Report stated that:

One fundamental problem is the language of most existing laws; both the form and substance of the legislation work against the assertion of rights by people with mental illness.

6.4 Comparison to the Experiences in the International Human Rights Framework prior to the CRPD

The Burdekin Report addressed issues similar to the concerns that have marked the international human rights debate on disability and psychosocial disability specifically prior to the CRPD. These are:

- the experience of stigmatisation and marginalisation;
- the experience of being dependent upon others,

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60 This applied to most jurisdictions. Ibid, 896.
61 This applied to most jurisdictions. Ibid, 897.
63 Ibid, 793 and 897.
64 Ibid, 902.
65 Ibid, 898 f.
66 Ibid, 898.
67 Ibid, 895.
69 See ibid, 446 f. and sections 5.1.5 and 5.1.1 above.
• the experience of non-existing or insufficient service provision, in particular the lack of funding for responsive access to services;\textsuperscript{70}

• the experience of exclusion and societal barriers posing a disabling factor to the lives of persons with psychosocial disabilities;\textsuperscript{71}

• the experience of assumptions into diagnoses or the use of labels as justification for differential treatment;\textsuperscript{72}

• the experience of shortcomings in the human rights realisation of persons with disabilities when services revolve around the medical concept of disability and best interest considerations;\textsuperscript{73}

• the experience of carers providing essential services, accommodation and support without adequate training and external assistance;\textsuperscript{74}

• the experience of strains on interpersonal relationships in an environment of dependency and force;\textsuperscript{75}

• the experience that the human rights realisation of persons with psychosocial disabilities focused on the need of protection from certain interventions rather than the achievement of equal opportunities to exercise rights;\textsuperscript{76} and

• the effect of these experiences leading to continuing inequality and dependency in respect to many areas of life.\textsuperscript{77}

The Burdekin Report also showed that in many respects domestic mental health legislation failed to meet the requirements of the \textit{MI Principles}. For example, the \textit{MI Principles} require that domestic mental health legislation must apply restrictively on the basis of clinically recognised criteria of mental illness.\textsuperscript{78} Most

\textsuperscript{70} See sections 2.3.2, 5.1.6 and 6.2.4 above.

\textsuperscript{71} See sections 3.6.1.1, 4.4.6.3, 5.1.6 and 6.2.1 above.


\textsuperscript{73} See sections 3.6.1.2, 5.1.2 and 6.2.1 above.

\textsuperscript{74} See sections 1.5.1.6, 3.6.4, 4.4.2 and 6.2.6 above.

\textsuperscript{75} See sections 3.6.1.1 and 6.2.5 above.

\textsuperscript{76} See section 3.7.3, 3.7.4, 5.1.5 and 6.3 above.

\textsuperscript{77} See sections 3.6.4, 3.7.4, 4.4.6.2, 6.2.1 and 6.2.6 above.

\textsuperscript{78} See \textit{Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care}, GA Res 46/119, UN GAOR, 46\textsuperscript{th} sess, 75\textsuperscript{th} plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), Principle 1(1).
domestic mental health laws failed to define mental illness,\textsuperscript{79} to the effect that persons who did not have an illness that could be treated, could nevertheless be subjected to involuntary detention and “treatment”.

The \textit{MI Principles} also guided mental health legislation to apply on the basis of informed consent to psychiatric treatment. As addressed earlier, there has been significant criticism of the \textit{MI Principles} in respect to the principle of informed consent because the \textit{MI Principles} allow for a person with mental illness to be treated without informed consent if he or she unreasonably refuses treatment and the \textit{MI Principles} could be interpreted too broadly as to what constitutes “unreasonable refusal” to treatment.\textsuperscript{80} However, the Burdekin Report found that domestic mental health legislation throughout Australia did not adequately clarify the requirements for informed consent to general psychiatric treatment.\textsuperscript{81} Also, the Burdekin Report pointed out that the \textit{MI Principles} incorporate stronger procedural safeguards and review and appeal mechanisms than domestic mental health legislation, in particular in respect to persons with psychosocial disabilities who received community treatment.\textsuperscript{82}

The fact that domestic mental health legislation failed to meet the requirements of the \textit{MI Principles} has been a significant shortcoming, in particular when bearing in mind that the \textit{MI Principles} have been criticised as providing a minimum standard of human rights protection that may be susceptible to systematic flaws.\textsuperscript{83}

\begin{footnotes}
\item[80] See section 3.4.3 above.
\item[82] See ibid, 901.
\item[83] See ibid, 891 and 908 and section 3.4.5 above.
\end{footnotes}
6.5 The Reactions to the Burdekin Report and Subsequent Developments in Policy-Making

6.5.1 First Wave of Reform Developments in the Years 1991-1998

In response to the adoption of the *MI Principles*, the Australian governments adopted the National Mental Health Strategy in 1992. The National Mental Health Strategy comprised the Mental Health Statement of Rights and Responsibilities 1991,\(^8^4\) the National Mental Health Policy 1992\(^8^5\) and the National Mental Health Plan 1992.\(^8^6\)

The *Mental Health Statement of Rights and Responsibilities* 1991 spelled out the rights and responsibilities of consumers, carers and advocates. The *National Mental Health Policy* 1992 was a joint statement by the Health Ministers of the Commonwealth, States and Territories of Australia. The Policy aimed to set a clear direction for the future development of mental health services. It focused on ensuring the rights of persons with psychosocial disabilities, developing measures of prevention and promotion as well as linking mental health services with other services and into the general health system.

The *National Mental Health Plan* 1992 provided specific strategies to assist in the implementation of the *National Mental Health Policy* 1992. The Plan included the strategy of developing legislation that was consistent with the *MI Principles*, the international human rights standard at that time.\(^8^7\) In 1996, a Rights Analysis Instrument\(^8^8\) was developed in order to measure whether the State and Territory mental health legislation complied with the *MI Principles*.


Like many international commentators on the *MI Principles*, Neil Rees has criticised their use in guiding the drafting of domestic mental health legislation. In 2003, he argued that the *MI Principles* posed a compromise solution and provided minimal protection when compared with other human rights instruments. He pointed out that using the *MI Principles* to measure the compliance of legislation was flawed from the outset and that they were interpreted in isolation with a focus “upon quantitative measurement while much can be measured only qualitatively”. Rees also pointed out that the rights assessment was done by panels largely comprised of people without legal expertise.

However, the first wave of reform developments in mental health services delivery resulted in some significant changes. The state of Victoria, for example, significantly changed its mental health service structure between 1993 and 1998. During that time, all separate psychiatric institutions either shut down or started the process of closure and all public, non-forensic mental health services were transferred to the general health system. Community treatment became the “first treatment option, with hospitalisation as a last resort”. In Victoria, a range of inpatient, residential and community-based mental health services, including mental health crisis assessment teams, replaced institutions and general hospitals set up special units for hospitalisation. But Valerie Gerrand has summarised the deficits of Victorian mental health reform during the first wave of reform developments in the following words:

A different problem was ensuring that services were adequately funded to meet rising demand. After the conservative government’s 1996 re-election, mental health reform lost priority and ways to match funding with service demand remained undeveloped. The impact was

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89 See section 3.4 above.
91 Ibid, 36.
92 Ibid, 36.
94 Ibid, 259.
95 Ibid, 260.
96 Ibid, 267.
97 Ibid, 260.
greatest for the community mental health clinics, which provided the continuing care that is the cornerstone of a community-oriented service system. These services became overwhelmed by the increase in client numbers, with unfortunate results. An example is over-reliance on medication as the primary and often sole method of treatment, without use of additional psychosocial interventions known to assist recovery.98

6.5.2 Second Wave of Reform Developments in the Years 1998-2003

The Second National Mental Health Plan 199899 for the years 1998 to 2003 provided new strategies to implement the National Mental Health Policy 1992. The Second National Mental Health Plan 1998 aimed at improving the promotion of mental health, the prevention of mental illness, the development of partnerships in service reform and the quality and effectiveness of service delivery.100 The Plan called for improved national service coordination, shifting the focus of service delivery onto the consumer, increased consumer participation in treatment decisions and the planning and evaluation of services.101 However, the Plan did not mention the Burdekin Report, the MI Principles nor international human rights.102 The Plan sparked criticism of the decline in Australian governmental interest in human rights – in general and in respect to mental health care.103

In 2003, the Mental Health Council, the peak non-governmental association for consumers, carers, professional associations and health care providers, reviewed national policy reform and the state of mental health services.104 The Mental Health Council commented on the national achievements in moving mental

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98 Ibid, 266. Further references omitted.
100 Ibid, 6.
101 Ibid, 7, 10, 2 and 16.
102 The Second National Mental Health Plan 1998 mentions “international obligations” when it discusses improved linkages between sectors, governments and external stakeholders. Ibid, 4.
103 Graham Thornicroft and Vivian Betts, International Mid-Term Review of the Second National Mental Health Plan for Australia (Commonwealth Department of Health and Aged Care, Canberra, 2002), 34.
health services from institutional forms of care to community services. The Council stated that:

The overwhelming perception of those who currently use or provide services is that we have now arrived at a position of ‘OUT OF HOSPITAL, OUT OF MIND!’  

Services are characterised by: restricted access; variable quality; poor continuity; lack of support for recovery from illness; and, protection against human rights abuses.

The report of the Mental Health Council blamed lack of government commitment to genuine reform, rather than a failure of policy for this outcome. The Council stated that:

Currently, 62% of persons with mental disorder do not utilise mental health services. Reported reasons include: stigma associated with mental disorders; fearfulness of medical treatments; poor distribution and costs associated with specialist services; and, inappropriate mix of medical and psychosocial services provided by government-financed systems.

The report found that in 2001, 4.4% of all deaths in those less than 75 years of age were the result of suicide.

6.5.3 Third Wave of Reform Developments in the Years 2003-2008

The Third National Mental Health Plan 2003 for the years 2003 to 2008 built on the policy developments of the First and Second National Mental Health Plans. The Third Plan moved back to addressing human rights in the context of mental

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105 Ibid, ii.
106 Ibid, 1. There seems to have been an understanding that the human rights protection of persons with mental illness has been detrimental to their lives, similar to the concern that human rights protection may result in leaving people to “rot with their rights on”. This idea will be discussed in section 8.5 below.
107 Ibid, ii.
109 Ibid, 3.
health care. It noted that concern over open human rights abuses had shifted to human rights abuses through neglect.\textsuperscript{111} The Plan stressed in particular the need to provide access to timely and effective services and the need to strengthen mechanisms that facilitate the genuine participation of consumers, families and carers in decision-making at all levels.\textsuperscript{112}

In 2005, the Mental Health Council of Australia, the Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission released a joint report on mental health care.\textsuperscript{113} The executive summary of the report has criticised the fact that

after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected.\textsuperscript{114}

In 2006, the Senate's Select Committee on Mental Health reiterated the previous findings of human rights concern\textsuperscript{115} and identified the “urgent need for reform in the area of mental health”.\textsuperscript{116} The Committee declared mental health a National Health Priority Area and called for further reform of the National Mental Health Strategy. It recommended increased funding to the mental health sector, the development of mental health strategies and improved advocacy, monitoring and research.\textsuperscript{117} The Committee also specifically addressed the need to improve staff resources for needed accessibility to services and adequate services delivery.\textsuperscript{118} The Committee made the observation that:

\textsuperscript{111} Ibid, 7.
\textsuperscript{112} Ibid, 14.
\textsuperscript{113} Mental Health Council of Australia and the Brain and Mind Research Institute, Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia (Mental Health Council of Australia, Canberra, 2005).
\textsuperscript{114} Mental Health Council of Australia and the Brain and Mind Research Institute, Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia: Summary (Mental Health Council of Australia, Canberra, 2005), 12.
\textsuperscript{115} The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, Interim Report (Commonwealth of Australia, Canberra, 2006), 14 ff.
\textsuperscript{116} The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, Final Report (Commonwealth of Australia, Canberra, 2006), 2.
\textsuperscript{117} The Senate's Select Committee on Mental Health, A National Approach to Mental Health: From Crisis to Community - Final Report (Canberra, 2006), 5 ff.
\textsuperscript{118} Ibid, 9 ff.
The dominant medical model is hampering improvement in mental health care. Psychiatry, while central to the treatment of mental illness, by its own admission is not always able to explain many of the causes and pathways of mental illness. The Committee discerned much frustration among consumers and carers that, despite the persistence of the mysteries of the mind, psychiatric responses often seem rigid and unaccommodating of alternative approaches. Pharmaceutical treatments are certainly improving but their use is also growing at extremely rapid rates, as is Commonwealth expenditure under the Pharmaceutical Benefits Schedule yet psychologists qualified to deliver evidence-based ‘talking therapies’ are significantly under-utilised in publicly-funded mental health care.\textsuperscript{119}

6.5.4 Fourth Wave of Reform Developments Since 2008

The National Mental Health Policy 2008 replaced the National Mental Health Policy 1992. The National Mental Health Policy 2008 recognises that “[p]eople with mental health problems and mental illness are vulnerable to human rights violations in the community and in a variety of services due to stigma, discrimination and the absence of legal protection”.\textsuperscript{120} The Policy’s Priority Area 1 has shifted the focus of policy development on social inclusion and recovery, including a comprehensive national stigma reduction strategy.\textsuperscript{121} The Policy states that “[p]eople’s rights to meaningful community participation and to consent to or refuse treatment should be protected and dignity, privacy and respect safeguarded”.\textsuperscript{122}

The Fourth National Mental Health Plan 2009 for the years 2009 to 2014\textsuperscript{123} provides a new strategy to implement the National Mental Health Policy 2008. The Plan emphasises that Australia has national and international human rights

\textsuperscript{119} The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, First Report (Commonwealth of Australia, Canberra, 2006), 19.
\textsuperscript{120} Australian Health Ministers, National Mental Health Policy 2008 (Mental Health Branch: Commonwealth Department of Health and Family Services, Canberra, 2009), 13.
\textsuperscript{121} Ibid, iv.
\textsuperscript{122} Ibid, 13.
\textsuperscript{123} Australian Health Ministers, Fourth National Mental Health Plan 2009-2014 (Mental Health Branch: Commonwealth Department of Health and Family Services, Canberra, 2009).
obligations and that all mental health legislation should meet human rights demands.\textsuperscript{124} In regards to decision-making on medical treatment, the Plan points out that:

Consumers are the central group. They need the health organisations responsible for their care to make information available that allows them to understand treatment options, make informed decisions and participate actively in their care. While there are few examples of such practice being adopted in Australian mental health services, there are multiple innovations in this direction developing overseas and in areas outside mental health within Australia.\textsuperscript{125}

6.6 An Evaluation of the Policy Developments since the Burdekin Report

There are some important themes that can be observed from the national policy developments relating to mental health service delivery. The Burdekin Report identified central issues of concern in the domestic human rights realisation of persons with psychosocial disabilities. The subsequent policy developments have addressed some of these issues, but domestic mental health policy reform did not comprehensively pursue the recommendations of the Burdekin Report. The following subsections elaborate on the persisting shortcomings in mental health service delivery and identify some parallels in the observations on the international human rights law as outlined in the previous Chapters.

6.6.1 Ongoing Discrimination and Misunderstanding of Psychosocial Disability

First, and similar to the international human rights situation of persons with psychosocial disabilities prior to the \textit{CRPD}, the domestic human rights situation of persons with psychosocial disabilities has been marked by substantial differentiation on the ground of diagnostic criteria.

The Burdekin Report aimed to reduce the widespread discrimination

\textsuperscript{124} Ibid, 50.  
\textsuperscript{125} Ibid, 55.
against persons with psychosocial disabilities and the misunderstanding of mental illness,\(^\text{126}\) yet one persistent finding in the national policy reform development is that discrimination is still widespread, not only in relation to the perception of individuals and society at large, but also in relation to law. Since the early 1990s, all of the National Mental Health Plans explicitly aimed to reduce the effects of discrimination and stigmatisation. Their strategies included developing programmes aimed at the equal inclusion of persons with psychosocial disabilities into society. These reform developments have introduced important educational programmes about psychosocial disability which have aimed to reduce stereotypes against persons with psychosocial disabilities and fears in persons with psychosocial disabilities to identify with their disability. The CRPD requires Australia to continue improving such reform developments because it requires States Parties to remove attitudinal barriers to the human rights realisation of persons with psychosocial disabilities. However, the development of the CRPD was based on the idea that changing general attitudes towards psychosocial disability is an important, but not sufficient move towards facilitating change.

### 6.6.2 Lack of Access to Services

Second, the domestic mental health reforms have not comprehensively pursued the recommendation of the Burdekin Report’s call for facilitating adequate access to services. The Burdekin Report strongly criticised the reality that persons with psychosocial disabilities experienced difficulties in accessing services prior to acute symptoms and that domestic mental health services did not offer adequate alternatives to involuntary treatment. The national policy documents after the Burdekin Report introduced a comprehensive strategy to improve mental health services.\(^\text{127}\) Yet, all policy developments came with deep frustration about the

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\(^\text{126}\) See section 6.2.1 above.

\(^\text{127}\) There are also a number of federal policy documents on mental health care. These documents are not addressed in this Chapter because this part of the thesis focuses on examining what national obligations arise for Australia after having signed and ratified the CRPD. However, policy documents on mental health care in New South Wales and Victoria have expressed similar concern as the national policy documents.
ongoing and significant shortcomings in respect to accessing services.  

Harvey Whiteford and William Buckingham have stated that there were substantial changes to mental health service delivery, in particular between 1993 and 2002 when health insurance companies extended their policies to cover mental health services and the total spending on mental health services increased by 65%. However, when taking into account the parallel growth in overall government health spending during that time mental health services have not been sufficiently supported to overcome structural disadvantages and the shift to general practitioners delivering a high number of mental health related consultations has not resulted in sufficient improvement of mental health services. Harvey Whiteford and William Buckingham have stated that “[c]onsumers, carers and advocates point to persisting problems with access to acute care, continuity of care and the availability of rehabilitation services”.  

Various commentators on the state of mental health services have criticised the fact that mental health services have been inadequate in that they have been applied too rigidly and failed to meet the demands of individual health considerations. Involuntary measures in mental health care have been designed to apply restrictively, while persons with psychosocial disabilities have not been provided with effective, voluntary-based alternatives. As a result, mental health services have neglected those who fail to meet the strict requirements of receiving services but need access to services prior to developing acute symptoms as well as those who received services but have felt that they do not get the service response that meets the demands of their individual condition.  

The Mental Health Council of Australia and the Brain and Mind Research Institute have stated that the lack of access to mental health services has resulted

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128 For example: Mental Health Council of Australia and the Brain and Mind Research Institute, Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia (Mental Health Council of Australia, Canberra, 2005), 35; Harvey A Whiteford and William J Buckingham, ‘Ten Years of Mental Health Service Reform in Australia: Are We Getting it Right?’ (2005) 182(8) Medical Journal of Australia 396, 399.


130 Ibid, 399.

131 Ibid, 399, with further references.

132 See section 6.5 above.
in the “serious and systematic neglect”\textsuperscript{133} of persons with psychosocial disabilities and fostered their unequal standing in society.\textsuperscript{134} This neglect seems to have stemmed from governmental disinterest in genuine service reform and governmental lack of commitment to funding alternative services.\textsuperscript{135}

The \textit{CRPD} has responded to the fact that governmental neglect of the human rights of persons with disabilities contributed to ongoing human rights shortcomings and calls for States Parties to provide reasonable accommodation to ensure that persons with disabilities equally enjoy their human rights and fundamental freedoms.\textsuperscript{136} The \textit{CRPD} emphasises that States Parties have to become proactive in order to ensure that persons with disabilities receive support that enables them to exercise rights.\textsuperscript{137} It addresses the shortcomings of domestic mental health reform by clarifying that Australia needs to provide accessible services to persons with psychosocial disabilities.

The ongoing focus of mental health services on involuntary measures may have also deterred individuals with psychosocial disabilities from seeking mental health services when they could have benefited from using such services. In particular, the association of mental illness with dangerousness and the loss of control over personal decision-making may have had a deterrent effect in relation to contacting mental health services. In 2010, the Senate’s Community Affairs References Committee has emphasised that shortcomings in accessing services can result in tragic outcomes for persons with psychosocial disabilities.\textsuperscript{138} The report of the Senate’s Community Affairs References Committee has addressed suicides in Australia and has noted that “at least six lives are taken by suicide every day”.\textsuperscript{139} In addition, “suicide was identified as the 14th leading cause of death

\begin{itemize}
\item \textsuperscript{133} Mental Health Council of Australia and the Brain and Mind Research Institute, \textit{Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia} (Mental Health Council of Australia, Canberra, 2005), 36.
\item \textsuperscript{134} Patrick McGorry, ‘Mental Health and Human Rights’ (Speech delivered at the Castan Centre 10th Anniversary Dinner, 20 October 2010).
\item \textsuperscript{135} See Sev Ozdowski, ‘Foreword - Time for Governments to Act on Mental Health Care’ (2005) 14(3) \textit{Health Sociology Review} (Special Issue: Closing Asylums for the Mentally Ill: Social Consequences) 203, 203.
\item \textsuperscript{136} See section 4.4.6.3 and 5.1.6 above.
\item \textsuperscript{137} See section 4.4.7 and 5.1.7 above.
\item \textsuperscript{138} The Senate - Community Affairs References Committee, \textit{The Hidden Toll: Suicide in Australia} (Commonwealth of Australia, Canberra, 2010).
\item \textsuperscript{139} Ibid, xiii.
\end{itemize}
as 1.5 per cent of all deaths in 2008”. While these numbers do not reflect whether these individuals were affected by psychosocial disability, the report of the Senate’s Community Affairs References has stressed that mental health services need to provide more assistance and support, require more staff and follow-up services after release from acute mental health services.\(^{141}\)

### 6.6.3 Slow Recognition of the Principle of Informed Consent to Mental Health Treatment

Third, domestic mental health reform has not aimed to incorporate the principle of informed consent in mental health service delivery. The assessment of the human rights situation of persons with psychosocial disabilities prior to the *CRPD* showed that international human rights law has been slow in recognising that persons with psychosocial disabilities may have had their decision-making capacities undermined by broadly applicable laws.\(^{142}\) The development of the *CRPD* was a response to the experience of persons with disabilities who claimed that their abilities have been undervalued and undermined which has resulted in significant inequality.\(^{143}\) The *CRPD’s* specifications in Article 12 strongly protect the legal capacity of persons with disabilities and state that an individual who may not be fully capable of exercising rights should be supported in decision-making.\(^{144}\)

Similarly, the Burdekin Report stressed that persons with psychosocial disabilities need to be the driver of decision-making – at least wherever possible. The Report criticised the significant lack of consumer participation in decision-making on treatment, aimed to establish consumer participation, but also stated that, in principle, consumer participation is not enough to ensure that individuals with psychosocial disabilities who are capable of decision-making will be in a position to have their decisions respected. Rather, the Report stated that the decision-making process of a person with mental illness should be based on the principle of informed consent in order to ensure equal standing in society.

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140 Ibid, 15.
141 Ibid, xiii.
142 See sections 2.3.4 and 3.7.4 above.
143 See section 5.1 above.
144 See section 5.2 above.
The Burdekin Report did not state that respect for the capacity of persons with psychosocial disabilities should trump other considerations. By reference to the *MI Principles*, the Report followed the recommendations of the *MI Principles* which affirm that the decision-making of a person with psychosocial disability may be overridden, if decision-making is considered unreasonable. The Report shied away from formulating the fine line between overriding and respecting the will of a person who might have deficits in decision-making. However, the Report stressed how important it is to start the decision-making on treatment on the basis of the informed consent of the person with psychosocial disability in order to avoid persons with psychosocial disabilities being systematically excluded from decision-making that directly affect them.\(^{145}\) This approach has been in line with the international human rights law which has guided States Parties to approach the involuntary treatment and detention of persons with psychosocial disabilities with respect to the individual’s decision-making capacities and other circumstances.

However, the subsequent policy documents largely avoided this recommendation of the Burdekin Report. The first wave of policy developments after the release of the Burdekin Report stressed consumer participation, rather than respect for the individual’s capacity to make decisions. Only after 2008, have policy documents started to address the notion that there should be equal respect for the decision-making capacities of persons with psychosocial disabilities. In the meantime, moves that have aimed to place the consumer at the heart of decision-making have had limited success because mental health policy has stressed consumer *participation* only.

During the drafting of the *CRPD*, persons with disabilities highlighted their experiences of not being the drivers of decision-making that immediately affects them.\(^{146}\) They identified the ways in which such experiences have resulted in significant and systematic shortcomings to the realisation of their human rights and fundamental freedoms. The *CRPD* has responded to the risk of persons with disabilities being considered an object of welfare, rather than the subject of


\(^{146}\) See section 4.4.3 above.
Thus, the CRPD stresses that existing abilities must be supported, rather than overridden, to ensure that persons with disabilities have the opportunity to live a life with equal rights and responsibilities.

Domestic mental health reform has not sufficiently emphasised the central importance of respecting informed consent in mental health settings. A recent statement of the Commonwealth Department of Health and Family Services indicates that the Department has recognised that other nations have started bringing decision-making in mental health care on a par with treatment decisions in general health care. The Department refers to the multiple innovations from overseas that aim to place the consumer at the heart of decision-making and allow for their informed consent to treatment decisions.

The Fourth National Mental Health Plan 2009 acknowledged that Australia has been hesitant to follow that direction of reform, but the Plan has stressed the importance of placing the individual with psychosocial disability at the centre of decision-making and providing him or her with support to make self-directed decisions. These are ideas that the Burdekin Report addressed in the early 1990s – and still domestic mental health service delivery focuses on involuntary measures that serve to override existing capabilities, rather than to support them.

6.6.4 Lack of Genuine Service Reform towards Equalisation

Fourth, all national policy documents since the early 1990s and numerous reports have aimed to bestow rights on persons with psychosocial disabilities in mental health service delivery. However, as mentioned above, mental health service delivery has not achieved consumer participation, let alone the genuine
empowerment of persons with psychosocial disabilities.\textsuperscript{153}

The first wave of policy reform showed strong efforts towards changing mental health services. The First National Mental Health Strategy addressed central issues of the Burdekin Report, set up a statement of rights and responsibilities for consumers\textsuperscript{154} and started the difficult process of translating policy change into the legislative framework. The Strategy built upon the \textit{MI Principles} and it was subject to the same criticism as the \textit{MI Principles}. Yet, the Strategy provided a rights-based and consumer-focused framework.

However, the second wave of policy reform seems to have counteracted that trend, in particular in respect to bestowing rights on individuals with psychosocial disability. The \textit{Second National Mental Health Plan 1998} repeated the previous aim of ensuring the rights of persons with psychosocial disabilities and it called for further service improvements. However, the Plan’s guidance in relation to mental health legislation included subtle, but significant differences.

The first important difference in the \textit{Second National Mental Health Plan 1998} is that the Plan did not provide a genuine rights-based framework. The Plan generally refrained from using the terminology of ‘rights’ and it did not empower persons with psychosocial disabilities with substantive rights which may alter the course of treatment and place the individual with psychosocial disabilities at the heart of decision-making. When the Plan addressed rights, it did not perceive rights-achievement as bestowing substantive rights onto the person with psychosocial disabilities to ensure that mental health services centre around the individual with psychosocial disabilities. Rather, rights-achievement seems to have focused on matters of confidentiality and access to the fair review of intervention to ensure that interventions are applied restrictively and are subject to procedural safeguards. Also, the Plan shifted the focus of policy reform back on ‘consumer participation’ – which is less than requiring substantial consumer involvement that can direct the outcome of decision-making.

\textsuperscript{153} Mental Health Council of Australia and the Brain and Mind Research Institute, \textit{Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia: Summary} (Mental Health Council of Australia, Canberra, 2005), 36.

In respect to decision-making on treatment, the Plan did not address situations in which the individual may seem to be ‘unreasonable’ or ‘incapable of decision-making’ – criteria which have been frequently used in debates on substituted decision-making in mental health care. Rather, the Second National Mental Health Plan 1998 granted persons with psychosocial disabilities at the most a right to participation, regardless of individual abilities or circumstances. In contrast, the Burdekin Report called for consumer participation as a minimum requirement. Thus, it seems that the Second National Mental Health Plan 1998 fostered the assumption that persons with psychosocial disabilities are incapable of (reasonable) decision-making and not subjects of rights.

There is a second important difference in the Second National Mental Health Plan 1998. Throughout the formulation of the Second National Mental Health Plan 1998, the role of consumers was simultaneously given to carers or other decision-makers, often including mental health professionals. The Plan addressed the role of consumers almost exclusively with the phrase “consumers and carers”, even in respect to gaining access to services.\(^{155}\) The Plan stated this in such broad terms that carers effectively had the same standing as the individual concerned. This applied also to decision-making on treatment, as the Plan called for “improved participation of consumers and carers in decision-making”.\(^{156}\) By using this formulation, the Second National Mental Health Plan 1998 further lowered the potential impact of consumer participation because the consumer became just one of many drivers of decision-making. The only times when the Second National Mental Health Plan 1998 addressed the role of consumers without simultaneously mentioning “and carers” is when the Plan discussed the key role of consumers in planning and evaluating services and in measuring service outcomes.\(^{157}\) The Burdekin Report called for the substantial involvement of consumers in making decisions that directly affect them. In contrast, the Second

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156 Ibid, 3.
157 Ibid, 16 and 20. Outcomes are defined “as measurable change in the health of the consumer which is attributable to an intervention” (Australian Health Ministers, *Second National Mental Health Plan* (Mental Health Branch: Commonwealth Department of Health and Family Services, Canberra, 1998), 27.) The involvement in service planning and service evaluation does not directly affect making decisions concerning treatment and detention.
National Mental Health Plan 1998 which guided the formulation of mental health legislation moved back to not mentioning the substantive rights of consumers that reach beyond a level of expressing consumer experiences for service evaluation.

In stark contrast to these two observations on the Second National Mental Health Plan 1998, the development of the CRPD was a response to the experience of persons with disabilities who have been subject to the decision-making of others. The CRPD takes the view that others deciding on the treatment of persons with psychosocial disabilities results in systematic shortcomings to the human rights realisation of persons with disabilities, even if the decision-making of others is driven by good intent.\textsuperscript{158} The CRPD aims to ensure that the individual with disability is recognised as a subject of rights and driver of decision-making.\textsuperscript{159}

It also seems that domestic mental health service reform has been driven by a rationale that may have hindered the development of responsive services. Mental health service reform has not sufficiently aimed to equalise mental health services with general health services and to establish services for those who need access to them.\textsuperscript{160} In other words, it seems that while mental health service reform aimed to improve the delivery of services, the reform developments have not aimed to adopt the rationale that mental health care must be open to those who wish to enter services. Rather, mental health policy service reform has been driven by the rationale that mental health service delivery is about dealing with people who need intervention.

In 2010, Patrick McGorry, who was appointed the Australian of the Year in 2010 for his outstanding contributions to the youth mental health reform,\textsuperscript{161} has pointed out that the general health service system is still significantly different to mental health services. He has referred to the differences of service response in

\textsuperscript{158} See sections 3.6.2 and 5.1.5 above.
\textsuperscript{159} See section 5.1.5 above.
\textsuperscript{160} During the consultation process of the review of mental health legislation, many consumer and carer representative also have criticised the difficulty to access services in acute episodes. See for example, Australian Capital Territory Government, Options Paper on the Review of the Australian Capital Territory Mental Health (Treatment and Care) Act 1994 (November 2007), 23.
\textsuperscript{161} See <www.australianoftheyear.org.au/recipients/?m=patrick-mcgorry-2010> at 1 July 2011.
respect to a woman with a lump in her breast.\textsuperscript{162} He has stated that the woman would not face significant barriers to accessing a medical examination. She would not have to expect significant waiting periods for an examination and the Medicare health insurance system would give a rebate for the examination and treatment. McGorry has noted that there would be a high expectation within Australian society that the general health care system must respond to that woman’s health concerns as soon as possible. In comparison, McGorry has pointed out that the same woman would face significant barriers to accessing mental health services, if she suspected she might have depression.\textsuperscript{163} This example was also used by the Mental Health Council of Australia which commented that:

If a woman has a breast lump, the person is encouraged to get advice as soon as possible from a doctor to find out if it is cancer. If it’s serious, treatment is provided early to get the best result. In mental health, people are sent away and told to come back only when the lump has spread and when the problem is worse if not overwhelming. Then some services might be provided. This is a dysfunctional system, known to fail in cancer and in heart disease. The whole mindset in mental health must change to early intervention, particularly for young people and those with alcohol and drug problems”\textsuperscript{164}

Similarly, the \textit{CRPD} calls for States Parties to establish and maintain support mechanisms and service provision to persons with psychosocial disabilities as a matter of human rights realisation, in particular the right to health. While the Mental Health Council of Australia calls for ‘early intervention’, implying that mental health services need to be imposed on persons with psychosocial disabilities, the \textit{CRPD} would stress the equal opportunity to access services.

\subsection*{6.6.5 Ongoing Reliance on Family, Carers and Close Persons}

Fifth, and following up on the previous two observations, the domestic mental health service delivery has the shortcoming that mental health policy reform

\begin{flushright}
\textsuperscript{162} Patrick McGorry, ‘Mental Health and Human Rights’ (Speech delivered at the Castan Centre 10th Anniversary Dinner, 20 October 2010).
\textsuperscript{163} Ibid.
\end{flushright}
strengthened the involvement of consumers and carers in service delivery and planning on an equal basis.\textsuperscript{165} The move to improve the rights of carers on an equal basis to the consumer seemed to have been a response to the needs of family, carers and friends to get support from mental health services, if the person with psychosocial disability does not receive adequate access to mental health services. However, this rationale deflects the state’s responsibility to provide public health services to individuals. Thus, due to a systematic lack of mental health services, carers have been left with the responsibility of dealing with their relatives or close persons who have a psychosocial disability.

The \textit{CRPD} considers the social environment of the individual with psychosocial disabilities and values the support of family, carers and close persons, but it does not support the idea that family, carers and close persons have the right, nor responsibility, to ensure that an individual with disabilities receives adequate services. Rather, the \textit{CRPD} places the individual with disability at the heart of all decision-making and aims to ensure that it is the State Party’s responsibility to establish that mental health services are available, accessible and responsive to diverse groups of persons who may otherwise experience difficulties in respect to accessing services. The \textit{CRPD} considers that it is the responsibility of States Parties to continuously improve these services as a matter of human rights realisation.

\textbf{6.6.6 Focus on Human Rights Protection rather than Human Rights Realisation}

Sixth, it seems that the domestic understanding of human rights aggravated the lack of genuine service reform. The Burdekin Report stressed that it is important to protect persons with psychosocial disabilities from unjustified interventions in human rights, but the Report also stressed that persons with psychosocial disabilities need equal standing in society to enjoy many other basic human rights. However, subsequent mental health service reform has lacked the political will to realise the human rights of persons with psychosocial disabilities. Instead, the

\textsuperscript{165} See, Harvey A Whiteford and William J Buckingham, ‘Ten Years of Mental Health Service Reform in Australia: Are We Getting it Right?’ (2005) 182(8) \textit{Medical Journal of Australia} 396, 398.
human rights protection of persons with psychosocial disabilities has been interpreted to be detrimental to the overall wellbeing of persons with psychosocial disabilities or mental health service delivery in general. In particular, the *Second National Mental Health Plan* 1998 seems to be based on the idea that intervention realises rights through ensuring treatment and that human rights protection may hinder the efficiency of mental health services.

The Burdekin Report criticised the rationale of interfering in basic human rights in order to realise human rights. The Report criticised the vagueness of these kinds of considerations and their susceptibility to abuse, if they are not subject to a high level of scrutiny and control. The Report called for effective safeguards to prevent active human rights violations and it strongly called for accessible mental health services and the funding of these services as a matter of human rights realisation. Beyond that, the Report called for additional services that assist persons with psychosocial disabilities to enjoy equal standing in society as the prerequisite to full human rights realisation.

However, mental health reform has struggled with realising these central ideas of the Burdekin Report. Alternative services to involuntary treatment have been neglected, even though the Burdekin Report explained why alternative services are quintessential to the human rights realisation of persons with psychosocial disabilities. The focus of mental health reform has aimed at ensuring that involuntary measures apply subject to vigorous scrutiny and control, to the effect that mental health services have become barely accessible to those who do not meet the strict requirements of mental health deterioration that are necessary to justify involuntary measures. The shift to involuntary treatment in the least restrictive environment was not accompanied with sufficient resources nor was there clarity as to how to deliver voluntary-based care.\(^{166}\) In the end, the focus on involuntary measures has facilitated the option of using involuntary care as the

primary form of care, leaving systematic gaps in care to many people who need mental health services before deterioration to a point where they can access intensive services. Services other than involuntary ones have remained scant and uncoordinated.

6.6.7 Concluding Thoughts

The national policy developments show how difficult it is to realise international human rights standards in domestic service delivery through policy documents. Numerous national policy documents have long been calling for urgent action towards improving mental health services in respect to international human rights standards. However, these policy developments have resulted in only marginal change within a period of 15 years.168

Deficits in realising international human rights within mental health service provision have resulted from the period of time when the Australian government declined to commit fully to international human rights. The Second National Mental Health Plan 1998 evolved during the time when the government showed little interest in a commitment to international human rights.169 However, the Second Plan built upon themes identified in the preceding National Mental Health Plan. The First National Mental Health Plan 1992 referred to the international human rights standard of the MI Principles and identified target areas that need to be improved. The Second National Mental Health Plan 1998 elaborated on these target areas and expanded into three additional areas of focus. These additional areas of focus were the promotion of mental health and the prevention of mental illness, the development of partnerships in service reform and the quality and

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167 See The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, Interim Report (Commonwealth of Australia, Canberra, 2006), 55. The Senate - Select Committee on Mental Health stated that involuntary admissions and treatment are common, referring to one facility in which 83% of patients are under involuntary orders and suggesting that the number of people treated against their will is higher.

168 See also Graeme Browne and Martin Hemsley, ‘Consumer Participation in Mental Health in Australia: What Progress is Being Made?’ (2008) 16(6) Australasian Psychiatry 446, 448. Browne and Hemsley stated that “the very significant challenges faced in fostering participation, notably difficulty in altering attitudes of professionals and service providers, provision of adequate and accurately targeted funding, power sharing and addressing systemic barriers, are not always well addressed, even with good will and enthusiasm”.

169 See section 6.5.2 above.
effectiveness of service delivery.\textsuperscript{170}

Thus, the content of the \textit{Second National Mental Health Plan} 1998 was built on a strategy that was aimed at realising the international human rights standard in respect to mental health care at that time. The succeeding National Mental Health Plans followed a consistent approach and these Plans re-emphasised the need to respect international human rights standards. The \textit{Second National Mental Health Plan} 1998 stands out in the line of these policy developments in that it emphasises that persons with psychosocial disabilities should not be the driver of decision-making. Thus, the \textit{Second National Mental Health Plan} 1998 failed to articulate a political message towards human rights realisation that may have had an important role to play in calling for systematic change of service delivery. However, the government’s decline of interest in international human rights commitment does not seem to have changed other important elements of the strategy of the \textit{Second National Mental Health Plan} 1998.

This indicates that the reason why the national policy documents have not lead to systematic improvement in the human rights protection of persons with psychosocial disabilities may not only be a result of the \textit{Second National Mental Health Plan} 1998’s lack of references to international human rights standards. Preceding and succeeding policy documents that explicitly refer to international human rights standards have faced similar limitations in realising their content. It seems that the reasons for the shortcomings in the realisation of the human rights of persons with psychosocial disabilities result from the continued lack of access to mental health services.\textsuperscript{171}

Apart from the question whether or not the actions taken after 1991 have been sufficient to meet international human rights standards, there is concern whether these steps can still be considered adequate. The understanding of disability has gone through a paradigm shift in the last two decades which is reflected in the \textit{CRPD}. The \textit{CRPD} significantly affects key issues of domestic mental health legislation – up to the point of questioning the existence of specific mental health laws itself as discriminatory state practice. Chapters Eight to Ten will


\textsuperscript{171} This idea will be followed up in the subsequent Chapter.
explore these issues when they assess whether the current Australian mental health acts comply with the CRPD. Chapter Seven first outlines Australia’s commitment to the CRPD and the effects of international human rights commitment on domestic law, in particular in light of Australia’s declaration to the CRPD.
CHAPTER 7

7 Australia’s Commitment to the CRPD and International Human Rights Law

This Chapter assesses Australia’s commitment to the CRPD and the effects of international human rights on domestic law. It outlines the ways in which Australia has supported the CRPD and the Optional Protocol to the CRPD. This outline highlights that Australia has supported the drafting, enforcement and monitoring of the CRPD. This Chapter also addresses Australia’s declaration to the CRPD which clarifies Australia’s understanding of Articles 12, 14 and 17 of the CRPD. The declaration is relevant to domestic mental health law and policy because it explicitly allows for the differential treatment of persons with mental disabilities in exceptional circumstances.

This Chapter then discusses in what ways Australia’s commitment to international human rights commitment is reflected within domestic law. It assesses whether international human rights law can invalidate domestic legislation if legislation does not comply with domestic or international human rights standards. It also assesses whether international human rights arguments can influence the development of the common law, statutory interpretation and administrative decision-making. It argues that there are a number of shortcomings in using international human rights to influence domestic law.

This Chapter also highlights the significance of these shortcomings in respect to ensuring the rights and freedoms of the CRPD, in particular when the CRPD addresses the rights and freedoms of persons with psychosocial disabilities. When this Chapter addresses these shortcomings, it draws upon the findings of Chapters Four and Five and applies them to the current domestic settings. Chapters Four and Five assessed the purpose and objectives of the CRPD and its substantial provisions that are particularly relevant to psychosocial disability and the development of domestic mental health law and policy.
7.1 Australia’s Commitment to the CRPD

7.1.1 Australia’s Support of the CRPD

In 2001, the General Assembly of the United Nations set up the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities to consider whether the United Nations should adopt a disability specific human rights treaty and how to draft the treaty, if it should be adopted.\(^1\) Several delegates represented Australia\(^2\) in all sessions of the Ad Hoc Committee and contributed to the discussions.\(^3\) Thus, Australia supported the development of the CRPD.

On 30 March 2007, the day the CRPD opened for signature, Australia immediately signed the CRPD and swiftly ratified it on 17 July 2008.\(^4\) The then Commonwealth Attorney-General, Robert McClelland, welcomed the ratification of the CRPD. He has stated that “[r]atifying the Convention clearly demonstrates the Rudd Government’s international commitment to ensuring people with disability are treated equally and not as second-class citizens”.\(^5\) The speed with which Australia signed and ratified the CRPD has supported the enforcement and monitoring of the CRPD. The following reasons support this claim.

First, swift commitment has symbolic value. It implies that Australia has considered it necessary to support the CRPD without delay and to implement it

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with legal commitment. Australia’s commitment to the CRPD may also encourage other States Parties to ratify the CRPD.

Second, each States Party that ratified the CRPD is expected to submit regular reports to the Committee on the Rights of Persons with Disabilities. The States Parties have to report on the measures which they have taken to give effect to the CRPD. They also have to report on the progress that has resulted from these measures. These reports assist the Committee in identifying what measures have been successful and can be recommended to other States Parties. The first report is due two years after the CRPD has become legally binding to the respective States Party. Subsequent reports are due every four years. Australia was the 30th country in the world which ratified the CRPD. On 3 December 2010, Australia submitted its initial report to the Committee on the Rights of Persons with Disabilities. The Committee will discuss Australia’s report as one of the first twelve reports that have been submitted to the Committee. Thus, Australia’s early support of the CRPD assists the Committee in substantiating its findings on the implementation of the CRPD and its recommendations to other States Parties.

7 The CRPD entered into force on the 30th day after the 20th States Party ratified, or acceded to, the CRPD. On 30 April 2008, Ecuador ratified the CRPD as the 20th States Party. In respect to those States Parties that have consented to be bound by the CRPD, either prior to, or on 30 April 2008, the reports to the Committee are due two years after the CRPD entered into force on 30 May 2008. In respect to those States Parties that consented to be bound by the CRPD after 30 April 2008, the reports to the Committee are due two years and 30 days after the day the States Party ratified, or acceded to, the CRPD. See ibid, Article 45. A member state of the United Nations can ratify the CRPD if that member state has taken part in the negotiations of the CRPD. If a member state of the United Nations has not taken part in the negotiations of the CRPD, the member state can accede to the CRPD according to Article 15 of the Vienna Convention on the Law of Treaties, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980). The consent to be bound to a treaty may also be expressed by acceptance and approval (Vienna Convention on the Law of Treaties, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980), Article 11), but in respect to international human rights treaties accession and ratification are the prevalent means of consenting to be bound to the treaty.
10 Australian Government - Attorney-General's Department, Australia's Initial Report under the Convention on the Rights of Persons with Disabilities, UN Doc CRPD/C/AUS/1 (2 December 2010)
Third, Australia consented to be bound by the provisions of the CRPD when it ratified the treaty.\(^\text{12}\) Thus, Australia is obliged to respect, protect and fulfil the human rights set out in the CRPD.\(^\text{13}\) This includes Australia’s obligation to establish mechanisms for the implementation and monitoring of the CRPD at the domestic level.\(^\text{14}\) As addressed in Chapter Four,\(^\text{15}\) this is a significant addition to international human rights obligations that are placed upon States Parties which have ratified the CRPD because the CRPD “is the first human rights treaty that contains detailed provisions on the establishment and functioning of national monitoring and implementation frameworks”.\(^\text{16}\) Australia’s initial report to the Committee on the Rights of Persons with Disabilities stated that the Commonwealth Attorney-General’s Department and the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs have been designated as the joint focal point within Government for matters relating to the implementation of the CRPD.\(^\text{17}\) The Australian Government also funded Non-Governmental Organisations to submit a Shadow Report on Australia’s progress against the CRPD. Thus, Australia’s swift ratification of the CRPD has already resulted in measurable outcomes in respect to the implementation and monitoring of the CRPD at the domestic level.\(^\text{18}\)


\(^{15}\) See section 4.4.4 above.


\(^{17}\) Australian Government - Attorney-General’s Department, Australia’s Initial Report under the Convention on the Rights of Persons with Disabilities, UN Doc CRPD/C/AUS/1 (2 December 2010), 60.

\(^{18}\) Ibid, 60.
7.1.2  *Australia’s Support of the Optional Protocol to the CRPD*

Australia also rapidly acceded to the Optional Protocol to the Convention on the Rights of Persons with Disabilities on 21 August 2009. The Optional Protocol allows for the Committee on the Rights of Persons with Disabilities to consider claims of persons with disabilities who believe that their rights and freedoms as set out under the *CRPD* have been violated. Thus, Australia has accepted that the Committee on the Rights of Persons with Disabilities can consider claims of persons under Australian jurisdiction. Prior to the ratification of the Optional Protocol, the Australian Government conducted a National Interest Analysis to assess whether Australia should accede to the Optional Protocol. The National Interest Analysis recommended the Australian Parliament accede to the Optional Protocol on the basis that:

Accession to the Optional Protocol will give people with disability an opportunity to contest the implementation and application of the human rights set out under the Convention. This would render Australia more accountable for its Convention obligations and further promote disability rights within Australia.

The early accession to the Optional Protocol also allowed for Australia to nominate a member to the Committee on the Rights of Persons with Disabilities. Ronald McCallum has been one of the twelve members on the Committee on the Rights of Persons with Disabilities. He represents Australia’s commitment to the *CRPD*. In the history of Australia’s commitment to international human rights treaties, this level of early and substantial support of the *CRPD* is remarkable.

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22. Ibid. See at 5.

23. When his first term ended on 31 December 2010, he was re-elected for a second term until December 2014.
### 7.1.3 Australia’s Declaration to the CRPD

Australia ratified the CRPD with a declaration. The Vienna Convention on the Law of Treaties does not define the meaning of a declaration. It provides that a state can enter an international treaty with a reservation to exclude or modify the legal effect of certain provisions of the treaty.\(^\text{24}\) Yet, customary international law has established that States Parties can also enter a treaty with a declaration. In contrast to a reservation, which serves to limit the legal effect of certain international treaty provisions, a declaration is an interpretative announcement.\(^\text{25}\) When a States Party enters an international treaty with a declaration, the States Party expresses the wish to be bound to the relevant provisions of the treaty, but clarifies its understanding of certain provisions. Australia’s declaration to the CRPD states:

**Declaration:**

Australia recognizes that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards;

Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards;

Australia recognizes the rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, nor impact on Australia’s health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.

The paragraphs of this declaration relate to Articles 12, 17 and 14 respectively. The first paragraph declares Australia’s understanding that substituted decision-

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\(^{25}\) See, for example, Alina Kaczorowska, Public International Law (Routledge, 4th ed, Oxon & New York, 2010), 105 ff.
making does not conflict with the CRPD if it is necessary as a matter of last resort and subject to legal safeguards. Chapter Five argued that in not mentioning substituted decision-making, Article 12 implies that the individual’s right to exercise legal capacity should be subject to the same high level of scrutiny that occurs in general health settings.\textsuperscript{26} The decision not to mention substituted decision-making was significant to the drafting of the CRPD\textsuperscript{27} because the CRPD challenges the connotation that decision-making on medical treatment must allow for disability-specific exceptions.\textsuperscript{28} The CRPD departed from the pre-existing international human rights standards which allowed for substituted decision-making because the CRPD responded to the experience of persons with disabilities who claimed that these standards have been applied too broadly and despite their capacity to make decisions.\textsuperscript{29} The CRPD aims to ensure that persons with disabilities have a right to be supported in decision-making which guarantees that persons with disabilities who are capable of making decisions are recognised as equal subjects of rights.\textsuperscript{30}

Australia’s declaration explicitly allows for substituted decision-making or fully supported decision-making and thus conflicts with the inspirational nature of Article 12. However, it responds to the fact that substituted decision-making currently exists in domestic law and that despite changes to substituted decision-making models there may continue to be circumstances in which a third person has such an active role to play in the decision-making process that he or she becomes the immediate contact person and the formal decision-maker in practice, even if that person acts according to the person’s will and preferences. It also acknowledges that the difference between fully supported and substituted decision-making is difficult to define in law and practice because the CRPD introduced supported decision-making as a new model of decision-making which still needs to evolve. Thus, the fact that Australia mentions substituted decision-making does not conflict with Australia’s immediate obligations which arise from the interpretation and application of Article 12, in particular because Australia’s declaration does not

\begin{flushleft}
\textsuperscript{26} See section 5.2.2.4 above.
\textsuperscript{27} See section 5.2.2.4 above.
\textsuperscript{28} See section 5.2.2.5 above.
\textsuperscript{29} See sections 4.4.1 and 5.1.2 above.
\textsuperscript{30} See sections 4.4.6 and 5.1.5 above. In particular, the CRPD implies that the human rights realisation of persons with psychosocial disabilities is not inherently limited while pre-existing limitation clauses may have had such an effect.
\end{flushleft}
mention that fully supported and substituted decision-making applies to persons with disabilities on other grounds that could be applied to persons without disabilities.

However, the declaration is concerning when it sets out the grounds for resorting to substituted decision-making. The statement that exceptions apply when they are necessary as a matter of last resort and subject to legal safeguards does not add new ideas into the interpretation of Article 12. Article 12 protects the individual’s capacity to make decisions to the fullest degree possible. Despite this, the declaration fails to require that substituted decision-making applies only to those who are incapable of making decisions or who are temporarily impaired or suspected to be impaired in decision-making. Rather, the declaration implies that capacity considerations are not necessary for substituted decision-making that apply in exceptional circumstances. Article 12(4) is also more specific than Australia’s declaration on defining what legal safeguards must apply to all measures that relate to the exercise of legal capacity. In contrast to the details set out in Article 12(4), Australia’s declaration has shortened the legal safeguards which aim to prevent abuse. It neglects in particular those specifications which are new or require Australia to become proactive towards ensuring that fair and individualised procedures are in place. Thus, Australia has not clarified the interpretation of Article 12 but confused the interpretation of Article 12 by equating substituted decision-making to fully supported decision-making and applying the same safeguards to them which are less specific than the ones incorporated in Article 12. The vague terminology of Australia’s declaration conflicts with the CRPD’s careful approach towards challenging the use of substituted decision-

31 That is, unless the declaration is interpreted to limit the scope of Article 12. In order to exclude or modify the legal effect of Article 12, Australia should have ratified the CRPD with a reservation, rather than a declaration. Thus, the fact that Australia ratified the CRPD with a declaration implies that Australia does not intend to limit the scope of Article 12.

32 Such formulations would reflect a more nuanced approach towards defining the exceptional circumstances. They would raise concern, but at least respect Article 12, while the current formulation conflicts with Article 12.

33 That is, if Article 12(4) of the CRPD will be interpreted to allow for substituted decision-making in exceptional cases – an idea which is controversially discussed.

34 See the full text of Article 12 in section 5.2 above.

35 Such as the requirement that all measures relating to the exercise of legal capacity respect the rights, will and preferences of the person.

36 Such as the requirement that all measures relating to the exercise of legal capacity have to be tailored to the person’s circumstances.
Similarly, the second paragraph of Australia’s declaration breaks the silence of Article 17 when Australia states that persons with mental disabilities can be subjected to involuntary treatment. This statement conflicts with the CRPD because it applies different human rights standards in particular to those persons who have a mental disability. Thus, it allows for the use of mental disability as the primary criterion for differentiation. Chapter Five argued that the CRPD deliberately departed from the traditional differentiation between physical and mental disabilities in the application of human rights standards. An earlier draft of Article 17 addressed forced interventions, emergency interventions and issues of risks to public health. These issues are common features of mental health legislation, but the earlier draft of Article 17 did not set up disability-specific considerations in relation to persons with mental disabilities. Rather, the suggested amendments responded to certain risks or needs for interventions alone in order to avoid the categorical differentiation of persons with disabilities. In contrast to this, Australia’s declaration links the justifications for interventions to mental disability.

Further, the second paragraph of Australia’s declaration adopts terminology which was deliberately dropped during the drafting sessions on Article 17. The former draft Article 17 stated that involuntary treatment may be “undertaken only in exceptional circumstances”, “in the least restrictive setting possible” and “in accordance with procedures established by law and with the application of appropriate legal safeguards”. Australia’s declaration adopts similar terminology, when it allows for involuntary treatment which is necessary as a matter of last resort and subject to legal safeguards. But it repeats only some ideas of two of the

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37 See section 5.1.4 above.
38 See section 5.1.1 above.
39 See the former draft of Article 17 in section 5.4 above.
40 See section 5.4 above.
41 See section 5.4 above and in particular Sentence 4(b) and (b) of the former draft Article 17 which stated that: “States Parties shall ensure that involuntary treatment of persons with disabilities.
42 See the former draft of Article 17(4)(b) and (c) in section 5.4 above. The former draft of Article 17(4) was also more disputed than the former draft of Article 17(1)-(3). See section 5.4 above.
six suggested amendments to Article 17. The ideas contained in those two sentences clarified the exceptional circumstances in which involuntary treatment may apply. They were originally embedded in statements which protected persons with disabilities from forced interventions and stressed that involuntary treatment needs to be accompanied with the “active promotion of alternatives”, the obligation to finance “appropriate” services and the aim to fully take into account the best interests of the person concerned. These six sentences aimed to ensure that States Parties take measurable efforts towards avoiding involuntary treatment. They increased the level of justifications for involuntary treatment because they substantiated the exceptional nature of interventions and stressed that persons with disabilities should be treated on an equal basis with others. The suggested amendments to Article 17 were dropped because they did not reflect the new human rights standard of the CRPD and the CRPD deliberately departed from providing any terminology that can be used to justify why certain limitations in the realisation of human rights may be permissible.

In contrast to the former draft Article 17, Australia’s declaration falls short of the protections required and it lowers the level of justifications for interventions because it repeats only those elements of the suggested amendments to Article 17 which served to justify interventions. Australia’s declaration also changes the wording of the former draft Article 17 to the effect that persons with disabilities can be compulsorily treated when their “treatment is necessary”. In contrast to this, the second sentence of the suggested amendments to Article 17 protected persons with disabilities from forced medical treatment which aimed at “correcting, improving or alleviating” their disability. Australia’s declaration clarifies that involuntary treatment can be applied, if it alleviates the individual’s health. This change reflects the medical model of disability and contrasts with the paradigm shift of the CRPD which aims at ensuring that persons with disabilities are not medically treated against their will because of their disability. Overall, the language of Australia’s declaration reflects the pre-existing human rights standard

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43 See the former draft of Article 17(4)(b) and (c) in section 5.4 above.
44 See section 5.4 above.
46 See section 5.4 above.
which the *CRPD* deliberately challenged.

Thus, the second paragraph of Australia’s declaration conflicts with the objectives and purpose of the *CRPD* because it reflects the medical model of disability\(^{47}\) and singles out persons with mental disability as a group of persons who can be subject to coerced treatment.\(^ {48}\) According to Article 19 of the *Vienna Convention*, a States Party can ratify the treaty with a reservation only if it is compatible with the object and purpose of the treaty. If Australia had ratified the *CRPD* with a similar worded reservation, instead of a declaration, the formulation would be incompatible with the objectives and purpose of the *CRPD* and thus be invalid.

The third paragraph of Australia’s declaration relates to Article 14 which is relevant to persons with disabilities who are restricted in their liberty of movement. However, Australia’s declaration predominantly clarifies the rights of immigrants with disabilities and does not provide further insight into the effect of Article 14 on persons with psychosocial disabilities. Further details of the declaration will be discussed in Chapter Ten when this thesis addresses the impact of the *CRPD* on the involuntary treatment and detention of persons with psychosocial disabilities as set out in current domestic mental health legislation.

### 7.2 Human Rights in the Australian Legal System

The impact of international treaties on domestic law and practice varies between different countries. International treaty law requires the States Parties of a treaty to give effect to its commitment within domestic law.\(^ {49}\) However, there are different ways of giving effect to international treaty obligations within domestic jurisdictions and the international community leaves it to the States Parties to decide on how they will give effect to international obligations within their domestic law.

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\(^{47}\) See section 4.4.1 above.

\(^{48}\) See sections 5.1.1, 5.1.4, 5.1.5 and 5.4 above.

7.2.1 No Direct Effects of International Human Rights Obligations

In the early years of international human rights development, Australia was actively engaged in the development of human rights and a strong supporter of the UDHR. At that time, Australia promoted the binding effect of international human rights commitment with immediate and effective enforcement mechanisms. However, Annemarie Devereux comments that “[t]he ebullience of 1948 had given way to a cautious non-committal stance”.

Australia does not automatically incorporate international human rights into domestic law. Unlike other countries, Australia does not have a constitutional provision or national human rights legislation that adopts international human rights obligations into domestic law with immediate and direct effect as soon as it ratifies a treaty. Neither does Australia transform international treaty provisions as superior law into its legislation pending one Act of Parliament.

The Federal Parliament has enacted legislation to give effect to some of the

51 Ibid, 17.
52 Ibid, 2.
53 In Austria and the Netherlands, for example, the ratification of an international human rights treaty results in the direct enforcement of the treaty within the domestic legislation with supremacy – that is, to the effect that international law overrides other domestic law if there is a conflict between the international treaty and domestic law. According to Article 25 of its Constitution (“Grundgesetz”), Germany incorporates international treaties into domestic law as ordinary law to the effect that international treaty obligations apply directly within the domestic legal framework. They do not override domestic statutory law, but international human rights treaties can inform the interpretation and application of constitutional human rights which can render domestic legislation invalid.
54 The Australian Constitution protects rights for individuals, but they are limited to the right to vote, the right to a trial by jury, the denial of federal legislative power with respect to religion and the prohibition against discrimination on the basis of State of residency, see Sev Ozdowski, ‘Why We Need an Australian Bill of Rights Now’ (2007) 43 Just Policy 22, 22.
55 Federal human rights legislation and its use to give effect to international human rights indirectly will be discussed in section 7.2.4 below.
56 Accession to an international treaty has the same effect as ratification of an international treaty. See http://conventions.coe.int/Treaty/EN/v3Glossary.asp at 1 July 2011.
57 Transforming international treaty obligations into domestic law as superior law means that the law which reflects the international treaty obligations overrides other legislation, if there is a conflict between the two pieces of legislation.
58 Transforming international treaty obligations into domestic law as ordinary law means that the law which reflects the international treaty obligations would not override other legislation, if there is a conflict between the two pieces of legislation.
59 This approach would allow for Australia making a deliberate choice to transform international human right treaties into domestic law, rather than incorporating them automatically.
international human rights treaties to which it is a party. For example, the Federal Parliament enacted the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) which established the Human Rights and Equal Opportunity Commission (now known as the Australian Human Rights Commission) to give effect to human rights and equal opportunities in employment. The Australian Human Rights Commission provides education and raises public awareness about human rights and handles complaints of discrimination and breaches of human rights. It also researches human rights issues and contributes to policy developments and provides legal advocacy on human rights issues.

When the Australian Human Rights Commission investigates and conciliates complaints of discrimination, it considers the *Racial Discrimination Act 1975* (Cth), the *Sex Discrimination Act 1984* (Cth), the *Disability Discrimination Act 1992* (Cth) and the *Age Discrimination Act 2004* (Cth). In its Schedules, the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) recognises inter alia the ICCPR, the CRC, the Declaration on the Rights of Mentally Retarded Persons and the Declaration on the Rights of the Disabled. Thus, these international human rights instruments can guide the findings of the Australian Human Rights Commission. However, many international treaty obligations remain unincorporated into Australian domestic law, in particular the rights set out in the ICESCR. Also, the Australian Human Rights Commission has no determinative

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60 See *Human Rights and Equal Opportunity Commission Act 1986* (Cth), Long Title.
62 See ibid, 5.
powers and it cannot respond to complaints against a State or Territory or non-State authority. Philip French and Rosemary Kayess have stated that:

[The Australian Human Rights Commission] may receive a complaint in relation to breach of an international instrument ... but may only respond to it within its limited functions. If it is not capable of conciliation, apart from taking up the matter in its general policy and education functions, the Commission’s only alternative is, through the Attorney-General, to refer the matter to Parliament for attention.

French and Kayess have concluded that:

In the absence of direct incorporation of a specific obligation by other means, [international human rights] obligations have an essentially ‘soft law,’ or policy status in municipal Australian law.

Thus, under national jurisdiction international human rights treaties cannot be enforced with immediate or imminent effect. As a result, persons under Australian jurisdictions cannot claim rights and freedoms of an international human rights treaty, unless Australia gives effect to international treaty provisions within domestic law in other ways. The following subsections address in what ways Australia gives indirect effect to international treaty obligations.

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70 Ibid. See also Human Rights and Equal Opportunity Commission Act 1986 (Cth), s 3.
72 Ibid, 61.
74 Ryszard Piotrowicz and Stuart Kaye, Human Rights in International and Australian Law (Butterworth, Chatswood, 2000), 199 f; Hilary Charlesworth referred to the adoption of international law into Australian law as the 'transformation approach,' see Hilary Charlesworth, 'International Law and the High Court' (2005) 68 Precedent 20, 20. By considering international law as a distinct legal system to domestic law, Australia follows the dualist model of international law, see for example, Horta v Commonwealth (1994) 181 CLR 183.
7.2.2  **Indirect Effects on Law Reform**

Australia gives effect to its international human rights commitment through reviewing domestic legislation that seem to be affected by international treaty obligations and adjusting it accordingly.\(^\text{75}\) However, the process of translating international human rights obligations into domestic legislation can be protracted and complex. If Australian Parliament decides to comply with international human rights obligations, it has to identify what legislation is affected by these obligations. Parliament needs to evaluate whether domestic legislation complies with international human rights obligations. If domestic legislation does not comply with international human rights obligations, Parliament needs to review how to ensure compliance with these obligations. All of these steps may come with errors of understanding, interpreting and applying international human rights obligations. Also, unforeseen circumstances can legitimise ongoing human rights violations until the legislation is reviewed again, unless the reviewed legislation clearly guides the decision-maker who interprets and applies the law to give effect to international human rights obligations.

When human rights standards are not incorporated as superior law into domestic law, law reform may be stymied and Parliament may deliberately depart from international human rights obligations. This may be particularly contentious when Parliament deals with politically unpopular issues concerning groups of persons who have shared a history of being subject to discrimination. The previous section on the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) indicated that Australia has incorporated human rights into domestic legislation, in particular into non-discrimination legislation, hence this concern may be limited.

However, the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) recognises the *ICCPR*,\(^\text{76}\) but it does not recognise the *ICESCR*,\(^\text{77}\) even though Australia ratified the *ICESCR*. This approach implies that Australian

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\(^{75}\) See Hilary Charlesworth, 'International Law and the High Court' (2005) 68 Precedent 20, 20.


Parliament decided not to give effect to the *ICESCR* within domestic law when it adopted and reviewed the *Human Rights and Equal Opportunity Commission Act 1986* (Cth). This may result in significant shortcomings to the human rights realisation of persons within Australian jurisdictions.\(^78\)

### 7.2.3 *Indirect Effects on the Development of the Common Law and Administrative Decision-Making*

Australia can also give effect to international human rights treaty obligations by implementing domestic law in a manner that complies with these obligations because international human rights treaty obligations can inform the interpretation and application of domestic law.

In 1948, Dixon J of the High Court of Australia established that international law which is not incorporated into domestic law is a *source of common law*\(^79\) if it has become globally accepted as part of customary international law.\(^80\) But subsequently, domestic courts have been hesitant to use international human rights law as a source of interpreting domestic law.\(^81\) This hesitant approach changed slowly in 1992, when the High Court of Australia stated in *Mabo v Queensland (No 2)*\(^82\) that Australia’s international human rights commitment can influence the development of the common law. Justice Brennan, in delivering the majority decision, commented that

> international law is a legitimate and important influence on the development of the common law, especially when international law declares the existence of universal human rights.\(^83\)

Justice Brennan implies that the development of the common law cannot overrule

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\(^78\) See section 7.3.3 below.

\(^79\) *Chow Hung Ching v The King* (1948) 77 CLR 449 at 478.


\(^81\) See, for example, *Western Australia v Ward* (2002) 213 CLR 1 at 389 per Callinan J.

\(^82\) 175 CLR 1 (3 June 1992).

\(^83\) *Mabo v Queensland* (No 2) (1992) 175 CLR 1 (3 June 1992) at 42 per Brennan J (Mason CJ and McHugh J agreeing). See also *Dietrich v The Queen* (1992) 177 CLR 292 at 319 per Brennan J who clarified that international law serves as a legitimate influence on the common law as it can be used to express contemporary values (Mason CJ, McHugh J and Toohey J disagreeing at 306 and 360 respectively).
“clear and unambiguous words”\(^{84}\) of domestic statutory law. In respect to established principles of the common law he states that the Court is not free to adopt rules that accord with contemporary notions of justice and human rights if their adoption would fracture the skeleton of principle which gives the body of our law its shape and internal consistency.\(^{85}\)

But he continues to point out that it is not possible, a priori, to distinguish between cases that express a skeletal principle and those which do not, but no case can command unquestioning adherence if the rule it expresses seriously offends the values of justice and human rights (especially equality before the law) which are aspirational of the contemporary Australian legal system.\(^{86}\)

Thus, Brennan J accepted that international human rights can influence the development of the common law.\(^{87}\) Thus, the common law can serve to give effect to international human rights treaty obligations in Australia.

In 1995, the majority opinion of the High Court of Australia reiterated the position that international human rights can inform the development of the common law in *Minister of State for Immigration and Ethnic Affairs v Teoh*.\(^{88}\) The Court also extended this position to administrative decision-making and supported the view that the ratification of a treaty creates a “legitimate expectation”\(^{89}\) that administrative decision-makers will act in accordance with international treaty obligations, even if Australia has not adopted international human rights commitment into domestic law. Thus, in the absence of any domestic law expressing the contrary, international law can be used to influence the application

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\(^{84}\) *Mabo v Queensland (No 2)* (1992) 175 CLR 1 at 15 using the words of Mason CJ and McHugh J who agree with Brennan J. See also *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365 at 425 per Kirby J and *Re Woolley; Ex parte Applicants M276/2003* (2004) 225 CLR 1 at 71 per Kirby J.

\(^{85}\) *Mabo v Queensland (No 2)* (1992) 175 CLR 1 at 29 per Brennan J.

\(^{86}\) *Mabo v Queensland (No 2)* (1992) 175 CLR 1 at 29 per Brennan J.

\(^{87}\) See also *Environment Protection Authority v Caltex Refining Co Pty Ltd* (1992) 178 CLR 477 at 499 per Mason CJ and per Toohey J.

\(^{88}\) (1995) 183 CLR 273 at 287 per Mason CJ and Deane J, with Toohey J agreeing at 298 and McHugh J dissenting at 306.

\(^{89}\) *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273 at 287 per Mason CJ and Deane J, with Toohey J agreeing at 298 and McHugh J dissenting at 306.
of the law. In *Re Minister for Immigration and Multicultural Affairs; Ex parte Lam*,

some members of the High Court criticised this position, but the Court has not overturned the decision.

However, the decision in *Al-Kateb v Godwin* followed an “extraordinarily narrow approach” towards interpreting statutory language. The High Court of Australia addressed the question whether the language of the *Migration Act 1958* (Cth) was ambiguous when it provides that non-citizens unlawfully in Australia must be kept in immigration detention until they are removed from Australia as soon as reasonably practicable. The case concerned a stateless person who could not be removed from Australia because no other country would accept him. The minority opinion of the High Court stressed that the *Migration Act 1958* (Cth) was not applicable to the circumstances of a stateless non-citizen who could not be removed from Australian territory within the reasonably foreseeable future. Yet, the majority opinion of the High Court allowed for his indefinite detention. The majority found that the statutory language was unambiguous and clear in providing that he must be kept in immigration detention. Justice McHugh, in the majority, stated that while the result is “tragic”, “the Parliament is entitled to protect the nation against unwanted entrants by detaining them in custody.” He explained that:

> It is not for courts, exercising federal jurisdiction, to determine whether the course taken by Parliament is unjust or contrary to basic human rights. The function of the courts in this context is simply to determine whether the law of the Parliament is within the powers conferred on it by the Constitution.

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91 *Re Minister for Immigration and Multicultural Affairs; Ex parte Lam* (2003) 214 CLR 1 at 28-34 per McHugh and Gummow JJ. Further discussion at 38-39 per Hayne J and at 44-48 per Callinan J.
94 *Migration Act 1958* (Cth), s 196 in conjunction with s 198.
95 *Al-Kateb v Godwin* (2004) 219 CLR 562 at 584 per Gleeson CJ.
96 *Al-Kateb v Godwin* (2004) 219 CLR 562 at 580 per McHugh J and at 661 per Callinan J.
The decision has sparked criticism towards the scope of statutory interpretation\textsuperscript{100} and refreshed the debate whether Australia should incorporate a national bill of rights.\textsuperscript{101} In April 2010, the Australian Government indicated its intent not to introduce a national Human Rights Act in the short term.\textsuperscript{102}

Thus, human rights can influence the interpretation and application of statutory laws. However, the High Court of Australia has placed significant limitations on using human rights-based arguments for the development of the common law and administrative decision-making.

\subsection*{7.2.4 Indirect Effects on Domestic Human Rights Interpretation}

In recent years, Australia has adopted human rights legislation in the Australian Capital Territory and the state of Victoria: the \textit{Human Rights Act 2004 (ACT)} and the \textit{Charter of Human Rights and Responsibilities Act 2006 (Vic)}. Both acts explicitly refer to international human rights law as a legitimate source for interpreting the respective human rights legislation.\textsuperscript{103} Thus, the domestic human rights legislation reflects Australia’s international human rights commitment.\textsuperscript{104}

The \textit{Human Rights Act 2004 (ACT)} states that the Act is not exhaustive of the human rights of an individual and it explicitly allows for extending the scope of the Act to consider other, interrelated rights as established by international treaties.\textsuperscript{105} Similarly, the \textit{Charter of Human Rights and Responsibilities Act 2006 (Vic)} allows for extending the explicitly included rights and freedoms of the Charter to recognise human rights under international law.\textsuperscript{106} Thus, domestic human rights

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{101} See, for example, Dan Meagher, 'The Significance of Al-Kateb v Godwin for the Australian Bill of Rights Debate' (2010) 12(1 & 2) \textit{Constitutional Law & Policy Review} 15.
\item\textsuperscript{103} \textit{Human Rights Act 2004 (ACT)}, ss 7 and 31; \textit{Charter of Human Rights and Responsibilities Act 2006 (Vic), ss 5, 32(2) and 44(2).
\item\textsuperscript{104} The Australian state of Victoria does not have international human rights obligations. However, Victoria can use Australia's international human rights obligations as guidance to substantiate federal human rights commitments.
\item\textsuperscript{105} \textit{Human Rights Act 2004 (ACT), s 7.}
\item\textsuperscript{106} \textit{Charter of Human Rights and Responsibilities Act 2006 (Vic), s 5.}
\end{itemize}
\end{footnotesize}
legislation can be interpreted and applied broadly to give effect to interrelated international human rights obligations, including the human rights and fundamental freedoms of the CRPD.

However, the Victorian Supreme Court has been wary of departing from the literal meaning of statutory language as it may interfere with parliamentary powers to legislate. In 2006, in *Royal Women’s Hospital v Medical Practitioners Board* (Vic).\(^{107}\) President Maxwell of the Victorian Supreme Court confirmed the view that international law may be used as guidance for statutory interpretation\(^ {108}\) and for developing the common law\(^ {109}\) or as indication of contemporary values.\(^ {110}\) President Maxwell acknowledged the relevance and importance of human rights principles and human rights discourse. He stated that:

> The Court will encourage practitioners to develop human rights-based arguments where relevant to a question in the proceeding … Practitioners should be alert to the availability of such arguments, and should not be hesitant to advance them where relevant. … Since the development of an Australian jurisprudence drawing on international human rights law is in its early stages, further progress will necessarily involve judges and practitioners working together to develop a common expertise.\(^ {111}\)

The decision in *Kracke v Mental Health Review Board & Ors*\(^ {112}\) illustrates the way in which international human rights can inform the understanding of domestic human rights legislation and guide the interpretation other domestic legislation.\(^ {113}\) In *Kracke v Mental Health Review Board & Ors*, the *Charter of Human Rights and Responsibilities Act 2006* (Vic) was central to challenging an involuntary treatment order under mental health legislation. The Victorian Mental

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107 *Royal Women’s Hospital v Medical Practitioners Board* (Vic) [2006] VSCA 85.
108 *Royal Women’s Hospital v Medical Practitioners Board* (Vic) [2006] VSCA 85 at [75].
109 *Royal Women’s Hospital v Medical Practitioners Board* (Vic) [2006] VSCA 85 at [76].
110 *Royal Women’s Hospital v Medical Practitioners Board* (Vic) [2006] VSCA 85 at [77].
111 *Royal Women’s Hospital v Medical Practitioners Board* (Vic) [2006] VSCA 85 at [71 f].
113 The Australian state of Victoria does not have international human rights obligations, but it can use Australia’s international human rights obligations as guidance to interpret and apply federal human rights.
Health Review Board failed to review an involuntary treatment order of Gary Kracke within the specified statutory period. The Mental Health Review Board was statutorily required to conduct an initial review\textsuperscript{114} of the involuntary treatment order within eight weeks, but Gary Kracke’s involuntary treatment order was not reviewed for more than two years and his community treatment order was not reviewed for more than a year. Justice Bell, the President of the Victorian Civil and Administrative Tribunal, identified the relevant international human rights treaties and jurisprudence that underpin the interpretation of the \textit{Charter of Human Rights and Responsibilities Act 2006} (Vic). He analysed in what ways these findings inform the interpretation and application of the Victorian mental health legislation. Ian Freckelton and Simon McGregor have commented that:

\begin{quote}
The major initial contribution of the \textit{Kracke} decision was the template which it created for analysing the relevance of the Charter, not just to decisions of the Mental Health Review Board, but also to the interpretation of the \textit{Mental Health Act 1986} (Vic) and the decision-making of a number of bodies with features in common with the Board.\textsuperscript{115}
\end{quote}

Justice Bell considered that the Victorian Charter cannot interfere with parliamentary powers by overriding statutory law,\textsuperscript{116} but he stated that the Charter is important to the “general framework for the operation of the law and the exercise of the administrative power of government”.\textsuperscript{117} He established that it requires three steps to apply the Charter to assess if state legislation is incompatible with human

\begin{itemize}
\item \textsuperscript{114} Subsequently, involuntary treatment orders must be periodically reviewed every 12 months.
\item \textsuperscript{116} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at [45] (in reference to Lord Hoffmann in \textit{R v Secretary of State for the Home Department; Ex parte Simms} [2000] 2 AC 115 at 131: “Parliamentary sovereignty means that Parliament can, if it chooses, legislate contrary to fundamental principles of human rights. The \textit{Human Rights Act 1998} will not detract from this power. The constraints upon its exercise by Parliament are ultimately political, not legal. But the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general and ambiguous words. This is because there is too great a risk that the full implications of the unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual”.
\item \textsuperscript{117} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at [22].
\end{itemize}
First, the Court must engage with the question if the legislation affects the human rights of an individual and it must identify the scope and nature of the affected human rights. Second, the Court must assess, if the human rights limitation is proportionate and justified. Third, if the limitation is not justified, the Court must assess if it is possible to interpret the legislation in a way that is compatible with human rights. This requires taking into account the purpose of the legislation and assessing if the legislation can be reinterpreted to achieve human rights compliance while fulfilling the purpose of the legislation. If it is not possible to interpret the legislation compliant with human rights, the Supreme Court of Victoria must assess if it should make a declaration of inconsistent interpretation.

Justice Bell confirmed that international human rights commitment that has not been incorporated into domestic law can also influence administrative decision-making. This is in line with recent findings in the common law and academic opinion on the use of international human rights law within the Australian domestic law.

However, Justice Bell concluded that extending the time frame for review

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118 Kracke v Mental Health Review Board & Ors [2009] VCAT 646 at [537].
119 The same applies to public authorities as defined in the Charter of Human Rights and Responsibilities Act 2006 (Vic), s 4.
120 Kracke v Mental Health Review Board & Ors [2009] VCAT 646 at [539 ff]. The same applies to public authorities as defined in the Charter of Human Rights and Responsibilities Act 2006 (Vic), s 4.
123 See Kracke v Mental Health Review Board & Ors [2009] VCAT 646 at [667 ff. and 742 ff].
124 According to section 36(2) of the Charter of Human Rights and Responsibilities Act 2006 (Vic), See Kracke v Mental Health Review Board & Ors [2009] VCAT 646 at [800 ff].
125 Kracke v Mental Health Review Board & Ors [2009] VCAT 646 at [22]. In this case, the decision-making of the Mental Health Review Board as public authority according to Charter of Human Rights and Responsibilities Act 2006 (Vic), s 4.
126 See section 7.2.3 above.
did not invalidate the involuntary orders. He stressed that “must means must”\textsuperscript{128} when the mental health legislation requires that review must take place within eight weeks, but he concluded that the order for involuntary treatment could be upheld. He stated that the purpose of the Victorian mental health legislation is beneficial because it subjects persons to involuntary treatment only “when necessary in their own medical interests”\textsuperscript{129} and it serves to provide for the care, treatment and protection of mentally ill people “who do not or cannot consent”.\textsuperscript{130} Justice Bell upheld the involuntary orders because they are “beneficial”\textsuperscript{131} and the necessity for treatment still existed.\textsuperscript{132} He stated that

Mr Kracke is on involuntary and community treatment orders because the medical authorities have personally examined him, against the criteria in s 8(1), and found he needs that treatment. As the Board did not conduct the reviews required within the specified times, an important statutory safeguard on these decisions failed in that respect. This does not mean Mr Kracke does not need the medical treatment which has been judged necessary. It means the safeguard failed in that respect.\textsuperscript{133}

The decision in \textit{Kracke v Mental Health Review Board & Ors}\textsuperscript{134} emphasised how important international human rights are for developing domestic law, but it also showed that the impact of international human rights obligations on domestic law is limited. Justice Bell discussed at length why the Mental Health Review Board should have reviewed the involuntary order against Mr Kracke in time. He identified that Mr Kracke’s human rights were affected and he stressed why the review procedure is an important means to safeguarding the rights of an individual who is subject to the involuntary mental health orders. However, the treatment order remained valid because the medical advice found that treatment was necessary.

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{128} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 699.
\item \textsuperscript{129} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 706.
\item \textsuperscript{130} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 708.
\item \textsuperscript{131} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 710.
\item \textsuperscript{132} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 710.
\item \textsuperscript{133} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646 at 714. The requirements of s 8(1) of the \textit{Mental Health Act} 1986 (Vic) are listed in Table 18 (Appendix).
\item \textsuperscript{134} \textit{Kracke v Mental Health Review Board & Ors} [2009] VCAT 646.
\end{enumerate}
\end{footnotesize}
In 2010, the decision in *R v Momcilovic*\(^{135}\) overturned the Kracke decision in respect to the scope of interpreting statutory provisions.\(^{136}\) In *Kracke v Mental Health Review Board & Ors*, Bell J allowed for the interpretation of a statutory provision in the spirit of contemporary values as expressed in human rights legislation. Justice Bell accepted that there is scope for reinterpreting the wording of statutory provisions, if the reinterpretation complies with the purpose of the legislation\(^{137}\) and if such reinterpretation is based on legal reasoning derived from the Victorian human rights legislation. In contrast, the Court of Appeal of the Supreme Court of Victoria did not allow for leniency towards reinterpreting the wording of statutory provisions. The Court unanimously stated that the legislation must be interpreted in conjunction with common law principles of statutory interpretation and the *Interpretation of Legislation Act 1984* (Vic).\(^{138}\) However, when the Court addressed the scope of statutory interpretation, it adopted the narrow approach of the High Court of Australia. As discussed above,\(^{139}\) the majority opinion of the High Court in *Al-Kateb v Godwin*\(^{140}\) considered that the literal wording of a statutory provision is decisive.

The consequences of these different positions are significant. For example, if statutory provisions grant rights to the wife or husband of a person,\(^{141}\) the approach followed by Bell J allows for scope to argue that partners in de-facto relationships or same sex relationships may have equal rights. It could be argued that differential treatment affects the right to equal recognition before the law of partners in de-facto or same sex relationships. The *Charter of Human Rights and Responsibilities Act 2006* (Vic) protects equality before the law without discrimination.\(^{142}\) The United Nations has recognised that differentiation on the

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\(^{135}\) [2010] VSCA 50.


\(^{137}\) This is based on s 32(1) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) which states: "So far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights".

\(^{138}\) *R v Momcilovic* [2010] VSCA 50 at [35].

\(^{139}\) See section 7.2.3 above.


\(^{141}\) The example of reinterpreting the terms "wife" and "husband" is based on the facts of the decision in *Ghaidan v Godin-Mendoza* [2004] 2 AC 557. The subsequent discussion is not based on that decision.

\(^{142}\) *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 8.
ground of sexual orientation\textsuperscript{143} and marital status\textsuperscript{144} constitutes discrimination. Victoria has adopted legislation which recognises de-facto and same sex relationships similar to heterosexual marriage.\textsuperscript{145} Justice Bell’s approach would allow for assessing whether the interpretation of \textit{wife} or \textit{husband} as partner would comply with the purpose of the relevant legislation. If there are grounds for reasoning that Victoria supports marriage and de-facto relationships to be treated equally and not to exclude same sex commitments, then it may be argued that the purpose of legislation which grants rights to married persons may grant these rights to de-facto or same sex partners. The strength of arguing for such an outcome would depend on Parliamentary intent, the purpose of the legislation and the rights at stake, rather than the words “husband” or “wife”.

Thus, for example, the purpose of regulating the entry of non-citizens into Australia\textsuperscript{146} can be used to argue that differentiation may be justified. National immigration law has granted marriage and de-facto relationships\textsuperscript{147} almost equal standing and it respects existing family bonds when regulating who can enter or remain in Australia.\textsuperscript{148} Yet, it requires different evidence as to whether the mutual commitment to a shared life in a de-facto relationship is indeed genuine and continuous.\textsuperscript{149} It may be argued that the rationale for differentiation in respect to de-facto relationships is in line with the purpose of ensuring that only those individuals can enter and remain in Australia as family member who intend to have


\textsuperscript{145} See, for example, \textit{Relationships Act} 2008 (Vic), s 5. In respect to national legislation see, for example, \textit{Family Law Act} 1975 (Cth), s 4AA; \textit{Same Sex Relationships (Equal Treatment in Commonwealth Laws--General Law Reform) Act} 2008 (Cth); \textit{Same-Sex Relationships (Equal Treatment Law Superannuation) Act} 2008 (Cth).

\textsuperscript{146} See \textit{Migration Act} 1958 (Cth), s 4.

\textsuperscript{147} That applies to the same of a different sex, see \textit{Migration Act} 1958 (Cth), s 5BC.

\textsuperscript{148} See \textit{Migration Act} 1958 (Cth), s 5G. Section 5G supports a broad understanding of family members.

\textsuperscript{149} See \textit{Migration Act} 1958 (Cth), s 5BC.
a relationship with an Australian citizen that lasts into the future.\textsuperscript{150} Thus, it can be argued that differentiation is demonstrably justified. However, the purpose of the legislation would not indicate why differential treatment may be demonstrably justified, if same sex partners have entered a registered relationship which is similar to traditional marriage in respect to the genuine commitment and the process of separation.

The narrow scope of statutory interpretation that was used by the majority of the High Court in the decision in \textit{Al-Kateb v Godwin}\textsuperscript{151} would limit the template that Justice Bell used in \textit{R v Momcilovic}\textsuperscript{152} and it would not allow for reinterpreting the term “husband” or “wife”. Similar to the majority decision in \textit{Al-Kateb v Godwin}, the Supreme Court of Victoria considered that the literal meaning of a legislative provision is binding, regardless as to whether the reinterpretation would conflict with the purpose of the legislation. When this approach is applied to the terms of \textit{husband} and \textit{wife}, it would not allow for extending rights to de-facto \textit{partners}. The \textit{Relationships Act 2008 (Vic)} recognises same-sex \textit{relationship agreements} as an equivalent to marriage, but it adopts the terminology of \textit{agreements} and \textit{relationships}, rather than marriage. Literally taken, there is little scope to argue that the terms \textit{husband} and \textit{wife} could be interpreted to apply to de-facto relationships or same sex commitments.

Julie Debeljak has criticised the Court of Appeal’s decision in \textit{R v Momcilovic}.\textsuperscript{153} In particular, she argues that the Supreme Court acted against the parliamentary expressed intent of the \textit{Charter of Human Rights and Responsibilities Act 2006 (Vic)} when it adopted such a confined approach towards statutory interpretation. In reference to the Explanatory Memorandum to the Victorian Charter, she states that the object of the Victorian Charter was to “ensure that courts and tribunals interpret legislation to \textit{give effect} to human rights”.\textsuperscript{154} She points out that the Victorian Parliament adopted the wording of Section 32(1) of

\textsuperscript{150} The \textit{Migration Act 1958 (Cth)} is precisely worded, leaves little scope for reinterpretation and it has been amended to comply with the \textit{Same-Sex Relationships (Equal Treatment in Commonwealth Laws--General Law Reform) Act 2008 (Cth)}.

\textsuperscript{151} (2004) 219 CLR 562.

\textsuperscript{152} [2010] VSCA 50.

\textsuperscript{153} [2010] VSCA 50.

\textsuperscript{154} Julie Debeljak, ‘Who is Sovereign Now? The Momcilovic Court Hands Back Power over Human Rights that Parliament Intended it to Have’ 22(1) \textit{Public Law Review} 15, 30, with further references.
the *Charter of Human Rights and Responsibilities Act 2006* (Vic) as suggested by the Victorian Committee. Section 32(1) states that “[s]o far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible human rights.” The Victorian Committee aimed to allow for judges to depart from literal interpretations to ensure human rights compliance, if it does not conflict with the purpose of the legislation.\(^{155}\) In summary, Julie Debeljak states:

> The *Momcilovic* Court has sanctioned a rights-reductionist method to the statute-related Charter mechanism, undermined the remedial of the s32(1) interpretation obligation, sidelined the core issue of justification for limitations of rights, and considerably muted the institutional dialogue envisaged under the Charter. … [T]his is all done despite clear parliamentary intent to the contrary.\(^{156}\)

The debate on the scope of statutory interpretation illustrates that domestic courts and administrative decision-makers can use international human rights arguments when implementing domestic law. However, the domestic courts have been wary of using human rights-based arguments to shape the interpretation of domestic legislation to give indirect effect to international human rights obligations.

### 7.2.5 Conclusions

The previous sections have indicated that international human rights have limited influence on Australian domestic law. On a federal level, international human rights obligations have not been incorporated into national legislation. Australian courts can still use human rights-based arguments for statutory interpretation and developing the common law. Administrative decision-makers can apply the law accordingly. However, the domestic courts have adopted a precautious approach towards using human rights-based arguments. This applies even with respect to Victoria which has adopted human rights legislation into its state legislation to guide human rights compliance. The Supreme Court of Victoria has taken a conservative role in furthering human rights-based arguments within the legitimate

\(^{155}\) Ibid, 31, with further references.

\(^{156}\) Ibid, 16.
use of statutory interpretation. Administrative decision-makers are guided by this approach.\textsuperscript{157} Thus, international human rights compliance is still predominantly the responsibility of Australian Parliaments.\textsuperscript{158} The following consequences arise.

7.3 Shortcomings in Using International Human Rights Law within the Domestic Legal Framework

7.3.1 Non-Enforceability of Human Rights

Parliaments can determine and limit the enforceability of human rights. While this reflects important democratic values, the degree to which Australian Parliaments can do so is exceptional for modern Western democracies. Western democracies are grounded on the supremacy of the elected sovereignty. They endorse a separation of the state powers between the legislature, executive and judiciary, but the interpretation and application of an enforceable Bill of Rights can be justified as an element of the checks and balances between state powers, rather than the monopoly of judiciary.\textsuperscript{159} However, the domestic human rights discourse has shied away from embedding human rights into a legal framework which could at least challenge Parliamentary decision-making. Michael Kirby states that:

Effectively, Australia is now the only advanced Western country that must face the challenges of the present age, and the changes in the institutions of government, without a constitutional, or even statutory, charter of rights to temper political autarchy with occasional judicial reminders of fundamental freedoms that must be respected.\textsuperscript{160}

The changes that came with the introduction of human rights legislation in the Australian Capital Territory and Victoria have not significantly changed the use of human rights-based arguments outside of law reform and administrative decision-making.

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{157} Charter of Human Rights and Responsibilities Act 2006 (Vic), s 32; Human Rights Act 2004 (ACT), s 40B.
\item\textsuperscript{158} The Parliaments of the Australian States and Territories are not bound by international human rights commitments.
\item\textsuperscript{159} See, for example, Julie Debeljak, ‘Rights Protection Without Judicial Supremacy: A Review of the Canadian and British Models of Bills of Rights’ (2002) 26 Melbourne University Law Review 285.
\end{enumerate}
\end{footnotesize}
According to the Victorian Charter, which is stronger than the respective human rights legislation of the Australian Capital Territory, new legislation must be compatible with human rights legislation and public authorities must respect human rights accordingly. However, according to both human rights acts it is in Parliament’s discretion to comply with human rights standards. Also, all rights in both jurisdictions are subject to “reasonable limits” that “can be demonstrable justified in a free and democratic society”.

So far, domestic courts have been guided to use human rights for the interpretation and application of statutory provisions only if there is ambiguity and scope for reinterpretation. However, individuals cannot claim that judges consider such reinterpretation and address it in their reasoning. Rather, it is at the discretion of the judge.

If a human rights breach is found, both jurisdictions that incorporate human rights legislation, do not provide individuals with enforceable rights which could invalidate orders or grant individuals with substantial remedies. Thus, the human rights legislation at state and territory level does not grant individuals the prospect of having restrictions in their human rights revoked. Rather, the main outcome of a human rights claim is a ‘declaration of incompatibility’ or a ‘statement of inconsistent interpretation’ which must be flagged to Parliament for reconsideration. However, such declarations have no effect on the validity of the legislation and Parliament may depart from them.

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162 See, for example, Mike Salvaris, ‘Economic and Social Rights: The Victorian Charter’s Unfinished Business’ (2007) 43 Just Policy 30, 30.
164 Charter of Human Rights and Responsibilities Act 2006 (Vic), s 7; Human Rights Act 2004 (ACT), s 28. This formulation may reflect the view that most international human rights are not protected in absolute terms. However, this formulation is broader than formulations which the Human Rights Committee or the Siracusa Principles used to express limitations of human rights. See section 5.1.3 above.
165 See, for example Mike Salvaris, ‘Economic and Social Rights: The Victorian Charter's Unfinished Business' (2007) 43 Just Policy 30, 30 f.
166 In this context, the focus on ‘restrictions’ of rights seems appropriate because the domestic human rights protection incorporates on civil and political rights.
If the outcome of claiming respect for human rights does not result in an invalidation of the measure which is found to conflict with the individual’s human rights, it may be that individuals feel discouraged to pursue claims, unless they are in a sufficiently privileged position that they can afford the costs and efforts of claiming rights for law and policy change. Beth Gaze and Rosemary Hunter state that “the new system creates substantial barriers and disincentives to the effective enforcement of anti-discrimination law”. They comment that:

The role of Australian human rights agencies has been largely confined to education, policy development and impartial investigation and conciliation, and they have not been empowered to act directly to enforce the law using the complaints or any other mechanism.

More positive points of view stress the value of a ‘culture change’ in legal and ethical reasoning that is guided by human rights principles. However, there are insufficient incentives to State authorities to avoid human rights breaches or to adopt a precautious approach towards human rights issues because the consequences are not substantial enough to have a deterrent effect.

In respect to the CRPD, the shortcomings of the non-enforceability of human rights have significant consequences. Persons with disabilities claimed that they have experienced significant shortcomings in their human rights status despite many policy documents endorsing their best human rights achievements. The CRPD identified the need to provide a framework of human rights achievement that is subject to accountability and places the person with

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170 Beth Gaze and Rosemary Hunter, Enforcing Human Rights: An Evaluation of the New Regime (Themis Press, Leichhardt, 2010), 246. They also argue that “Australian anti-discrimination law relies almost solely on litigation by individuals for its enforcement. Other jurisdictions have incorporated measures such as positive action, contract compliance, responsive regulation and agency enforcement into their anti-discrimination regimes, but these have not been adopted here” (at 243).

171 Ibid, 243.

disability in a position to claim rights.\textsuperscript{174} The domestic human rights debate is vague in respect to the scope of its human rights, the degree to which human rights are binding and the justification to which human rights may be limited.\textsuperscript{175} Persons with disabilities whose human rights protection prior to the \textit{CRPD} was accompanied with intrinsic limitation clauses may continue to experience the same arguments as to why their human rights achievement cannot be pursued with equal scrutiny.\textsuperscript{176} This may be claimed because the justification for the limitation of human rights in the domestic context allows for a considerable scope of discretion. Also, the definition of human rights is not comprehensive – a factor which will be addressed later in this Chapter.\textsuperscript{177}

\subsection*{7.3.2 Delays in Achieving Human Rights Compliance}

If Parliament decides to give effect to international human rights standards through incorporating them into domestic legislation, the progress on human rights achievement can be protracted. The process of incorporating human rights into domestic legislation requires assessing all legislation and considering whether it should be reviewed.

Concern about this approach arises in particular in respect to the \textit{CRPD}. The \textit{CRPD} addresses the human rights and fundamental freedoms of persons with disabilities in much detail and in respect to all areas of life.\textsuperscript{178} Most significantly, the \textit{CRPD} has elaborated on economic, social and cultural rights and incorporated the concept of reasonable accommodation.\textsuperscript{179} Thus, Parliament does not just need to reconsider legislation that addresses disability discrimination. Rather, Parliament may have to reconsider \textit{all} legislation that affects the conditions for independent living and the comprehensive social inclusion of persons with disabilities. This process can be resource intensive and cause delays in realising the rights of persons with disabilities.

\textsuperscript{174} See section 3.7.2 above.
\textsuperscript{176} See section 5.1.4 above.
\textsuperscript{177} See section 7.3.3 below.
\textsuperscript{178} See section 4.4.1 above.
\textsuperscript{179} See sections 4.4.5 and 4.4.6 above.
Also, human rights realisation depends on Parliament’s willingness to adopt change and Parliament’s experience on how to best incorporate change into existing legislation. In respect to the CRPD, the Australian Government has indicated that legislative changes are not necessary to transform the CRPD into domestic law. After Australia signed the CRPD, the Australian Government conducted a National Interest Analysis to assess whether Australia should ratify the CRPD and what obligations would arise, if Australia ratified the CRPD. The National Interest Analysis found that:

Australia’s Commonwealth, State and Territory legislation, policies and programs currently comply with all immediately applicable obligations, and substantially achieve implementation of the progressively realisable obligations of the Convention. As such, there are no significant financial or regulatory implications of ratifying the Convention.\(^\text{180}\)

This implies that Australia considers that current mental health legislation complies with the CRPD and does not need to be changed to reflect the CRPD.

The CRPD responded to persons with disabilities’ experience of invisibility and the misunderstanding of disability when disability is not considered in its social context. In light of these experiences it may be surprising to see reform about disability rights high-ranking on the agenda of Parliamentarians, in particular if reform may become resource-intensive and comprise reviewing several statutes and policies in practice. In respect to contentious areas, such as the reform of mental health legislation, the prospect of reform enthusiasm and full compliance with human rights principles seems to be limited.

### 7.3.3 Focus on Formal Equality and Negative Human Rights

Both, the human rights legislation of Victoria and the Australian Capital Territory, have not incorporated human rights comprehensively. They do not incorporate economic, social and cultural rights, even though Australia has ratified the

Rather, they explicitly incorporate human rights only as civil and political rights, indicating that they are deliberately upholding the traditional differentiation of positive and negative human rights and rejecting the idea that individuals can claim proactive State or Territory efforts towards ensuring their human rights.

In particular in respect to persons with disabilities and the aim of achieving their substantive equality, this approach is likely to result in significant shortcomings to the human rights realisation of persons with disabilities. Chapter Four explained that the CRPD responded to the invisibility of persons with disabilities, their social exclusion and persisting direct and indirect discrimination in law. The CRPD takes the stance that the human rights of persons with disabilities cannot be realised without dedication to economic, cultural and social rights. The CRPD demands that services must be available, accessible, acceptable and of good quality. The domestic experience on mental health and human rights has shown that a lack of appropriate service provision was quintessential to shortcomings in domestic mental health care and that the human rights focus on civil and political rights only contributed to the persistence of shortcomings.

### 7.4 Concluding Thoughts

This Chapter argued that Australia has shown unprecedented support of an international human rights treaty when it was actively involved in the drafting of the CRPD and swiftly committed to the CRPD and its Optional Protocol. However, this Chapter also argued that Australia cut short the contentious issues that arise when...

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182 Charter of Human Rights and Responsibilities Act 2006 (Vic), s 3; Human Rights Act 2004 (ACT), s 5. That approach is in line with the national law, see section 7.2.2 above.
183 See section 4.4.6.1 above.
184 See also Sev Ozdowski, ‘Why We Need an Australian Bill of Rights Now’ (2007) 43 Just Policy 22, 25 who addresses more broadly the need to incorporate economic, social and cultural rights to protect individuals and minority groups.
185 See section 4.4.2 above.
186 See section 4.4.6.2 above.
187 See section 4.4.5 above.
188 See section 2.1.3.2 above.
189 See section 6.6.2 above.
190 See section 6.6.6 above.
the new human rights standard of the CRPD applies to persons with psychosocial disabilities because Australia added a declaration to its ratification of the CRPD which can be interpreted to uphold the status quo in mental health care. This approach is likely to discourage innovative approaches and rather uphold the current mental health practice.

This Chapter then argued that Australia has adopted a precautious approach to giving effect to international human rights within domestic law. It pointed out that Australia does not incorporate its international human rights commitment into domestic law with direct and immediate effect. Rather, Australia gives effect to its international human rights commitment indirectly through law reform, the development of the common law and the human rights compliant interpretation and application of statutory provisions. This Chapter argued that this approach applies even within those federal jurisdictions which have adopted human rights legislation because the domestic human rights acts do not provide individuals with enforceable rights. Thus, this Chapter concluded that international human rights compliance predominantly depends on law reform and judicial discretion to consider human rights-based arguments.

However, this Chapter pointed out that domestic courts have been wary of using human rights-based arguments to shape the interpretation and application of provisions which relate to contentious legal issues. Rather, they tend to uphold orders based on the literal interpretation of statutory provisions despite agreement that human rights breaches occurred. Thus, this Chapter argued that change predominantly depends on Parliamentary intent to reform law. However, when the Australian government implied in its declaration to the CRPD that the differential treatment of persons with psychosocial disabilities complies with the CRPD, there is little room for challenging the current interpretation and application of mental health acts and calling for legislative change.

Thus, this Chapter argues that Australian human rights law has limited use to ensure that persons with psychosocial disabilities can realise their human rights as expressed in the CRPD. This applies in particular in respect to positive rights which require State or Territory authorities to improve continuously access to mental health services or to consider alternatives to interventions because Australian human rights law focuses on respecting traditional civil and political
rights only.

The following two Chapters will draw together the findings on the background of the *CRPD* and the domestic experiences on human rights and mental health. They will apply the findings on the features and provisions of the *CRPD* to the domestic legal background of mental health care and examine, if the *CRPD* may indeed challenge or change the use and design of current domestic mental health legislation.
CHAPTER 8

8 The Justifications for Mental Health Legislation

This Chapter and the following two Chapters assess whether Australian mental health acts comply with the CRPD. Chapters Eight and Nine first discuss the fact that Australia set up separate legislative regimes which allow for the involuntary treatment and detention of persons with mental illness. They assess whether or not the Australian mental health acts are discriminatory in light of the CRPD. Chapter Eight starts this assessment with exploring the justifications for mental health legislation. Then, Chapter Nine discusses whether there are alternative legislative responses to persons with psychosocial disabilities which further the human rights standards of the CRPD.

Thus, Chapter Eight first discusses the use of psychosocial disability as a criterion for differentiation. It outlines the Australian mental health acts' definitions of mental illness and their use of mental illness as a ground for differential treatment. Then, this Chapter follows the structure of Chapter Five which addressed the CRPD's specifications on equality and non-discrimination, as set out in its Preamble and Articles 1 and 5. Chapter Five concluded that the CRPD has extended its full protection to persons with psychosocial disabilities and protects them from presumptions concerning their abilities. It foreshadowed that the current Australian mental health acts conflict with the CRPD because they differentiate people on the ground of their mental illness. This Chapter discusses the question whether or not the domestic mental health acts are discriminatory. Within that discussion, this Chapter considers the Australian experiences of mental health and human rights, as addressed in Chapter Six.

This discussion leads to the question whether or not subjecting persons with psychosocial disabilities to differential treatment on the ground of additional modifiers to mental illness can be justified. The previous Chapters discussed that the CRPD aims at delinking interventions from mental illness. This Chapter
assesses in detail whether specific grounds other than diagnostic criteria may justify the conclusion that there are objective, reasonable and proportionate justifications for subjecting persons with psychosocial disabilities to specific mental health legislation. Within that discussion, Chapter Eight first elaborates on arguments which support the idea that specific mental health legislation should be upheld to ensure the protection of others. Thus, this Chapter outlines the mental health acts’ definitions of ‘harm to others’. Then, it discusses whether or not the Australian mental health acts comply with the CRPD when they allow for the differential treatment of persons with mental illness when they present a risk of harm to others. In light of the Siracusa Principles,¹ other authoritative guidance on the interpretation and application of United Nations treaty law² and Article 14 of the CRPD, this Chapter argues that differentiation for the protection of others conflicts with the CRPD, in particular Article 14. Thus, this Chapter argues that Australian mental health acts currently conflict with the CRPD when they differentiate persons with psychosocial disabilities because they are mentally ill and pose a risk of harm to others.

Chapter Eight then discusses whether or not differential treatment may be justified if mental health legislation serves to protect the therapeutic interests of persons with mental illness. It outlines the mental health acts’ understanding of self-harm and argues that the limitations of the Siracusa Principles do not apply. It argues that the CRPD protects persons with psychosocial disabilities from coercion into treatment. It explores why mental health acts which respond to persons with psychosocial disabilities through involuntary treatment run the risk of hindering the substantial equality of persons with mental illness and their equal access to mental health services. This Chapter also discusses the idea of coercing people into treatment to ensure their treatment in light of Article 17 which protects the physical and mental integrity of persons with psychosocial disabilities. It argues that Article 17 requires Australia to depart from using coercive care as the primary response to mental illness.

² See Chapters Two and Three.
8.1 The Use of Terminology and Complementary Tables

It is necessary to clarify the use of terminology in this and the ensuing Chapters. Some of the domestic mental health acts differentiate between mental illness and mental disorder, mental dysfunction or mental disturbance, but the definition of mental illness is their common denominator. The differences in the understanding of these terms will be addressed when this Chapter outlines the scope of Australian mental health acts. However, in line with the Australian mental health law and policy debate, this and the following Chapters use the term ‘mental illness’ in order to address those individuals who fall within the application of Australian mental health acts.

Thus, when these Chapters assess the impact of the CRPD on Australian mental health legislation, they use the terminology of psychosocial disability and mental illness depending on their reference to the CRPD or to the Australian mental health acts. Occasionally, these Chapters refer to persons with mental conditions in order to depart from using the terminology of the CRPD or domestic mental health law. The choice of that terminology aims to reflect the ideology of the CRPD and the diversity of individual mental conditions. It addresses mental conditions beyond diagnostic criteria, but also understands mental health as going beyond long-term impairments. Thus, it is broader than the understanding of psychosocial disability and mental illness.

All Australian States and Territories have mental health legislation in place. The States and Territories use slightly different titles for their mental health legislation. In order to simplify the reading of this thesis, this Chapter occasionally refers to the State and Territory mental health legislation in short, as the mental health act of the respective State or Territory. The context or references in the footnotes include the full title of the respective State or Territory legislation.

This section also uses the following abbreviations for the Australian States or Territories when referring to the relevant legislation:

3 Mental Health (Treatment and Care) Act 1994 (ACT), Dictionary; Mental Health Act 2007 (NSW), s 4; Mental Health and Related Services Act 2009 (NT), s 14; Mental Health Act 2000 (Qld), s 12; Mental Health Act 2009 (SA), s 3; Mental Health Act 1996 (Tas), s 4; Mental Health Act 1986 (Vic), s 4; Mental Health Act 1996 (WA), s 4.

4 See Chapter Six above.
• Australian Capital Territory (ACT);
• New South Wales (NSW);
• Northern Territory (NT);
• Queensland (Qld);
• South Australia (SA);
• Tasmania (Tas);
• Victoria (Vic) and
• Western Australia (WA).

The following sections which refer to current domestic mental health legislation also include tables that complement their discussion. These tables compare some details of the domestic mental health legislation more comprehensively than the text. They are attached to the appendix to this thesis and the subsequent sections refer to the tables when they are relevant to the discussion.

8.2 Mental Health Acts: Their Purpose and Objectives

This Chapter first briefly outlines the Australian mental health acts’ purpose and objectives. The purpose and objectives provisions of Australian mental health acts provide insight into what interests the legislation serves to protect. Thus, they help identify the justifications for medical interventions. They cannot change the interpretation of unambiguous provisions within the mental health acts, but they guide the application of all subsequent legal provisions.

All Australian mental health acts serve to provide for the care, treatment and protection of persons with mental illness. The general principles of the mental health acts of the Australian Capital Territory, South Australia and Victoria also

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5 See section 7.2.1 above.
6 Mental Health (Treatment and Care) Act 1994 (ACT), s 7(a); Mental Health Act 2007 (NSW), s 3(a), 7(d); Mental Health and Related Services Act 2009 (NT), s 3(a); Mental Health Act 2000 (Qld), s 4; Mental Health Act 2009 (SA), s 6(a); Mental Health Act 1996 (Tas), s 6(a); Mental Health Act 1986 (Vic), s 4(1)(a); Mental Health Act 1996 (WA), s 5(a).
refer to the rehabilitation of persons with mental illness. The mental health acts of the Australian Capital Territory, New South Wales and Victoria include as a purpose the control of persons with mental illness. All of the domestic Mental Health Acts acknowledge respect for the rights of persons with mental illness. The Mental Health (Treatment and Care) Act 1994 (ACT) and the Mental Health Act (Qld) explicitly aim to protect the “human rights” of persons with mental illness. All other Acts refer to the protection of the “rights” or the “civil rights” of persons with mental illness or their “rights and freedoms”. These references are inspirational formulations. The Mental Health and Related Services Act 2009 (NT) and the Mental Health Act (Qld) refer to the MI Principles. By doing so, they clarify what standard of rights they aim to achieve. The Mental Health Act (WA) implies that it aims to follow the MI Principles as it includes references to the MI Principles in footnotes of the Act, yet this interpretation is less straightforward than the references to the MI Principles in the purpose and objectives.

The other Mental Health Acts do not substantiate what human rights standard – or rights standard – they aim to protect. For example, they do not include references to the international human rights treaties that Australia has signed or ratified. Any reference to ‘rights’ only is not conclusive as to whether it refers to international human rights, domestic human rights or the rights that are expressed within the mental health legislation. However, the Mental Health Acts of

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7 Mental Health (Treatment and Care) Act 1994 (ACT), s 7(a) and Mental Health Act 2009 (SA), s 6(a)(i). The Tasmanian legislation refers to the rehabilitation of persons with psychosocial disabilities only when addressing the situation of forensic patients, see Mental Health Act 1996 (Tas), Part 10 A. The legislation of all other Australian States and Territories do not explicitly refer to the objective of rehabilitation. However, they include provisions which imply that the legislation aims to ensure the rehabilitation of persons with psychosocial disabilities. (For example, Mental Health Act 2007 (NSW), ss 54(a), 56(1)(b), 105(a); Mental Health and Related Services Act 2009 (NT), ss 51(4), 91; Mental Health Act 2000 (Qld), s 124; Mental Health Act 1996 (WA), s 172. See also Tables 1 and 2 (Appendix).

8 Mental Health (Treatment and Care) Act 1994 (ACT), s 7(a), (d); Mental Health Act 2007 (NSW), s 3(a); Mental Health Act 1986 (Vic), s 2(a).

9 Mental Health (Treatment and Care) Act 1994 (ACT), s 7(a); Mental Health Act 2000 (Qld), s 8(a).

10 Mental Health Act 1986 (Vic), ss 4(1)(ac) and 4(2)(b).

11 Mental Health Act 2007 (NSW), s 3(d); Mental Health and Related Services Act 2009 (NT), s 3(a); Mental Health Act 1996 (Tas), s 6(a).

12 Mental Health Act 2009 (SA), s 6(a)(ii); Mental Health Act 1986 (Vic), s 4(2)(b) (“liberty” instead of “freedom”); Mental Health Act 1996 (WA), s 5(a).

13 Mental Health and Related Services Act 2009 (NT), s 3(b).
Queensland, Tasmania and Victoria stand out in that they state that persons with mental illness should have the same, or equal, rights to persons with physical illness.\textsuperscript{14}

The \textit{Mental Health and Related Services Act} 2009 (NT) incorporates the most detailed provisions on the objectives and the principles of the Act. These provisions also guide the interpretation of subsequent provisions of the mental health act.\textsuperscript{15} In particular, Section 8(c) requires that all provisions need to be interpreted or applied so that “the objective of treatment is directed towards the purpose of preserving and enhancing personal autonomy.”\textsuperscript{16} The \textit{Mental Health and Related Services Act} 2009 (NT) is the only mental health act that mentions personal autonomy. By doing so, the Act raises awareness of the impact of mental health legislation onto the personal lives of those who are subjected to the legislation. Also, it puts the consideration of respecting personal autonomy in line with other considerations, such as the consideration of protecting or ensuring the individual’s personal health or public safety.

Further on, the \textit{Mental Health and Related Services Act} 2009 (NT) requires in its principles that “every effort to avoid the person being admitted as an involuntary patient has been taken”.\textsuperscript{17} Thus, the \textit{Mental Health and Related Services Act} 2009 (NT) implies that there is a duty to provide for alternatives to involuntary treatment, even if they are more resource-intensive. In comparison, the \textit{Mental Health (Treatment and Care) Act} 1994 (ACT) and \textit{Mental Health Act} (NSW) state in their objectives and purpose that voluntary treatment is preferred to involuntary treatment.\textsuperscript{18} However, they do not clarify that voluntary treatment is a preferred option, if it costs more of an effort to administer it.

The \textit{Mental Health Act} (Qld) includes important elaboration on the principle of informed consent in its purpose and objectives. The Act provides that a person with mental illness must be presumed to have capacity to make decisions about

\textsuperscript{14} Mental Health Act 2000 (Qld), s 8(1)(a); Mental Health Act 1996 (Tas), s 6(e); Mental Health Act 1986 (Vic), s 5(a)(i).

\textsuperscript{15} Mental Health and Related Services Act 2009 (NT), s 8.

\textsuperscript{16} Mental Health and Related Services Act 2009 (NT), s 8(c).

\textsuperscript{17} Mental Health and Related Services Act 2009 (NT), s 10(a).

\textsuperscript{18} Mental Health (Treatment and Care) Act 1994 (ACT), s 7(b) and Mental Health Act 2007 (NSW), s 3(c).
assessments, treatment and the choice of an allied person.\textsuperscript{19} The \textit{Mental Health Act} (Qld) also emphasises the maintenance of supportive relationships\textsuperscript{20} and the provision of support and information to enable a person with mental illness to exercise rights.\textsuperscript{21}

The tables in the appendix provide further details on the purpose and objectives of the domestic mental health legislation.\textsuperscript{22}

\section*{8.3 Psychosocial Disability as a Criterion for Differentiation}

With the adoption of the \textit{CRPD}, the question arises whether or not Australian mental health acts which restrict the human rights of persons with mental illness are discriminatory because they differentiate between people based on their psychosocial disability.\textsuperscript{23} In order to assess whether Australian mental health acts are discriminatory, the understanding of mental illness in domestic mental health legislation needs to be explored.

\subsection*{8.3.1 Mental Health Acts: The Definition of Mental Illness}

\subsection*{8.3.1.1 Mental Illness}

All Australian mental health acts apply to persons with mental illness.\textsuperscript{24} However, the understanding of mental illness varies within the different jurisdictions.

The \textit{Mental Health Act} 2009 (SA) defines mental illness as “any illness or disorder of the mind”.\textsuperscript{25} It is the broadest definition of mental illness within the different jurisdictions because the other Acts define mental illness in reference to certain diagnostic criteria or mental impairments. The objects and guiding principles of the legislation state that the Act ensures that persons with serious

\footnotesize{\par
\textsuperscript{19} \textit{Mental Health Act} 2000 (Qld), s 8(b).
\textsuperscript{20} \textit{Mental Health Act} 2000 (Qld), s 8(f).
\textsuperscript{21} \textit{Mental Health Act} 2000 (Qld), s 8(c).
\textsuperscript{22} See Tables 1 and 2 (Appendix).
\textsuperscript{23} See section 5.1.1 above.
\textsuperscript{24} \textit{Mental Health (Treatment and Care) Act} 1994 (ACT), Dictionary; \textit{Mental Health Act} 2007 (NSW), s 4; \textit{Mental Health and Related Services Act} 2009 (NT), s 14; \textit{Mental Health Act} 2000 (Qld), s 12; \textit{Mental Health Act} 2009 (SA), s 3; \textit{Mental Health Act} 1996 (Tas), s 4; \textit{Mental Health Act} 1986 (Vic), s 4; \textit{Mental Health Act} 1996 (WA), s 4. See Tables 3 to 5 (Appendix).
\textsuperscript{25} \textit{Mental Health Act} 2009 (SA), s 3.}
mental illness receive a range of high-standard and recovery-focused services.\(^{26}\) However, neither the definition of mental illness nor the provisions concerning involuntary treatment require that a person has a *serious* mental illness.

In Queensland, Victoria and Western Australia the mental health acts define mental illness also in broad terms, but provide further elaboration. The *Mental Health Act 1986* (Vic) states that mental illness is a condition which is “characterised by a significant disturbance of thought, mood, perception or memory”.\(^{27}\) The *Mental Health Act 1996* (WA) and the *Mental Health Act 2000* (Qld) use similar descriptors.\(^{28}\) The mental health legislation of the Australian Capital Territory, New South Wales, the Northern Territory and Tasmania incorporate some additional diagnostic criteria into their definitions of mental illness.\(^{29}\) These provisions cover persons who have delusions, hallucinations or who engage in irrational or involuntary behaviour that indicates the presence of these symptoms.\(^{30}\) By referring to diagnostic criteria, the mental health acts imply that the expertise of mental health professionals is required. This applies in particular in respect to those mental health acts which refer to the presence of delusions and hallucinations. However, only the *Mental Health and Related Services Act 2009* (NT)\(^{31}\) and the *Mental Health Act 2000* (Qld)\(^{32}\) require that the definition of mental illness must accord with internationally accepted clinical standards and assessment.

All Acts that define mental illness in reference to diagnostic criteria require that the person has a *serious* or *significant* disturbance of thought, mood, perception or memory\(^{33}\) or a *serious* or *significant* impairment of mental

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\(^{26}\) *Mental Health Act 2009* (SA), s 6.
\(^{27}\) *Mental Health Act 1986* (Vic), s 8(1)(a). The *Mental Health Act 1986* (Vic) did not define mental illness until the Act was amended in 1995. Prior to 1995, the Act stated that mental illness is a form of mental disorder, but the terms ‘mental disorder’ and ‘mental illness’ were originally not defined in the Act. Rather, the understanding of mental illness could be derived from the criteria for involuntary treatment which required that interventions are necessary to protect the health and safety of that, or another, person as a measure of last resort, see *Mental Health Act 1986* (Vic), s 8.
\(^{28}\) *Mental Health Act 2000* (Qld), s 12; *Mental Health Act 1996* (WA), s 4. See also Tables 4 and 5 (Appendix).
\(^{29}\) In order to compare the slight variations in definition, see the details in Tables 3 to 5 (Appendix).
\(^{30}\) See Tables 6 and 7 (Appendix).
\(^{31}\) Mental Health and Related Services Act 2009 (NT), s 6(2).
\(^{32}\) *Mental Health Act 2000* (Qld), s 12(4).
\(^{33}\) See Tables 6 and 7 (Appendix).
functioning. Thus, these mental health acts apply only to persons with serious mental illness.\textsuperscript{34}

The tables in the appendix provide an overview of the respective definitions of mental illness and they compare the different jurisdictions in further detail.\textsuperscript{35}

\textit{8.3.1.2 Impairment of Mental Functioning}

The mental health acts of the Australian Capital Territory, New South Wales and the Northern Territory require that mental illness “seriously impairs, either temporarily or permanently, the mental functioning”\textsuperscript{36} of the person. However, only the \textit{Mental Health Act 1996 (WA)} clarifies that the impairment of mental functioning must relate to the person’s judgment or behaviour. The Act states that a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that \textit{impairs judgment or behaviour} to a \textit{significant} extent.\textsuperscript{37} The other Acts which require the person’s impairment in ‘mental functioning’ state that the ‘presence’ of symptoms characterises the individual's impairment in ‘mental functioning’.\textsuperscript{38} Thus, they focus solely on the \textit{presence} of symptoms, rather than requiring a separate assessment of the \textit{effect} of those symptoms onto the individual’s judgment or behaviour.

The \textit{Mental Health Act 1996 (Tas)} requires that the mental illness results in an impairment of the individual’s capacity for rational thought or capacity to control behaviour.\textsuperscript{39} However, these are just two of four alternatives for determining whether a person is mentally ill.\textsuperscript{40} The \textit{Mental Health Act 1996 (Tas)} also applies to persons whose mental illness results in a serious distortion of perception or thought or serious mood disorder.\textsuperscript{41}

\begin{flushleft}\textsuperscript{34} See also EC Fistein et al, 'A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions' (2009) 32(3) \textit{International Journal of Law and Psychiatry} 147, 153. \\
\textsuperscript{35} See Tables 3 to 7 (Appendix). \\
\textsuperscript{36} \textit{Mental Health (Treatment and Care) Act 1994 (ACT)}, Dictionary; \textit{Mental Health Act 2007 (NSW)}, s 4; \textit{Mental Health and Related Services Act 2009 (NT)}, s 4. \\
\textsuperscript{37} \textit{Mental Health Act 1996 (WA)}, s 4. Emphasis added. \\
\textsuperscript{38} \textit{Mental Health (Treatment and Care) Act 1994 (ACT)}, Dictionary; \textit{Mental Health Act 2007 (NSW)}, s 4; \textit{Mental Health and Related Services Act 2009 (NT)}, s 4. \\
\textsuperscript{39} \textit{Mental Health Act 1996 (Tas)}, s 4(b) and (d). \\
\textsuperscript{40} See Table 5 (Appendix). \\
\textsuperscript{41} \textit{Mental Health Act 1996 (Tas)}, s 4(a) and (c). \end{flushleft}
Thus, apart from the *Mental Health Act* 1996 (WA), the Australian mental health acts do not require that the mental illness significantly impairs the individual’s judgment or behaviour.

### 8.3.1.3 Mental Disorder, Mental Dysfunction or Mental Disturbance

Some mental health acts extend their scope of application beyond serious mental illness.\(^{42}\)

The *Mental Health (Treatment and Care) Act* 1994 (ACT) applies to mental illness and mental dysfunction. According to the *Mental Health (Treatment and Care) Act* 1994 (ACT), mental dysfunction means “a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.”\(^{43}\) This definition requires a high degree of impairment, but some of these terms are open to a broad interpretation when the Act does not refer to internationally accepted clinical standards, such as standards guided by the ICD-10\(^{44}\) or the DSM-IV-TR.\(^{45}\) Rather, mental dysfunction is incorporated into the mental health act as a concept which is broader than mental illness.\(^{46}\) The recent review of the *Mental Health (Treatment and Care) Act* 1994 (ACT) has clarified that jointly, the terms mental illness and mental dysfunction include intellectual disability, acquired brain injury, cognitive disorders, developmental disorders, behavioural disorders and substance-related disorders.\(^{47}\) These terms therefore cover untreatable conditions. This implies that mental dysfunction does not revolve around diagnostic criteria. Thus, the medical threshold is lowered, if not made obsolete.

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\(^{42}\) See Table 8 (Appendix).
\(^{43}\) *Mental Health (Treatment and Care) Act* 1994 (ACT), Dictionary.
The Mental Health and Related Services Act 2009 (NT) covers mental illness and mental disturbance.\textsuperscript{48} A mentally disturbed person is defined as a person whose behaviour is so irrational that it justifies the person being temporarily detained under the mental health act.\textsuperscript{49} Thus, the individual’s irrational behaviour may constitute mental disturbance. But the Act does not require that the mental disturbance is about the individual’s mental condition or its effect on that individual’s ability to act rationally. Rather, when the Act contrasts mental disturbance to mental illness, it implies that mental disturbance is a broader concept than mental illness. The Act may therefore be used to apply to persons who engage in challenging behaviour that may not be amenable to therapeutic interventions.\textsuperscript{50}

The mental health acts of New South Wales and Victoria apply to persons with mental illness and mental disorder.\textsuperscript{51} The Victorian Act does not define mental disorder, but clarifies that mental disorder includes mental illness.\textsuperscript{52} According to the Mental Health Act 2007 (NSW), a mentally disordered person is a person whose “behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary”\textsuperscript{53} for the protection of that individual or others from serious physical harm.\textsuperscript{54} Thus, similar to the mental health legislation of the Northern Territory mental disorder encompasses challenging behaviour beyond diagnostic criteria.

\textsuperscript{48} The provisions of the Mental Health and Related Services Amendment Bill 2011, if passed will include within the Act “complex cognitive impairment” as a condition that may also lead to involuntary detention and treatment.

\textsuperscript{49} See Table 8 (Appendix).

\textsuperscript{50} The mental health act of the Northern Territory refers to “internationally accepted clinical standards” only in respect to mental illness, see Mental Health and Related Services Act 2009 (NT), s 6(2).

\textsuperscript{51} Similarly, the mental health act of South Australia defines mental illness as any illness or disorder of the mind, see Mental Health Act 2009 (SA), s 3.

\textsuperscript{52} Mental Health Act 1986 (Vic), s 3.

\textsuperscript{53} Mental Health Act 2007 (NSW), s 15.

\textsuperscript{54} The Mental Health Act 2007 (NSW) allows for limited detention of mentally disordered patients only, unless continuing detention is reviewed and authorised. An assessment is required at least every 24 hours, detention may not exceed three days and there may be no more than three occasions in any calendar month, see Mental Health Act 2007 (NSW), s 31.
8.3.1.4 Exclusionary Criteria

All domestic mental health acts set out a number of exclusionary criteria. These are criteria which cannot be used exclusively to determine whether a person is mentally ill. Many of these criteria are based on the internationally recognised criteria of non-discrimination that are included in international human rights treaties. For example, a person should not be considered to be mentally ill solely because of his or her political or religious opinion, belief or activity or sexual preference, orientation or promiscuity. Other exclusion criteria include, for example, drug abuse, antisocial behaviour and intellectual disability.

By setting out exclusionary criteria, the domestic mental health legislation protects persons from potential abuse of powers under the mental health legislation. The degree to which the legislation safeguards the potential abuse of such powers depends on the content of the exclusionary criteria. The Mental Health Act 1996 (Tas) only mentions the latter category of exclusionary criteria: The Act states that “mental illness may not be based solely on antisocial behaviour, intellectual or behavioural non-conformity, intellectual disability or intoxication by reason of alcohol or a drug”. Thus, the Act does not name internationally recognised criteria of non-discrimination. Considering that Tasmania also does not have human rights legislation which could enforce, or at least guide, the human rights compliant interpretation and application of the Mental Health Act 1996 (Tas), the Tasmanian legislation provides limited safeguards to ensuring that the determination of mental illness excludes, or does not coincide with, discriminatory attitudes or political abuse.

The Mental Health (Treatment and Care) Act 1994 (ACT) sets out a number of exclusionary criteria, including internationally recognised criteria of non-

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55 See Tables 8 and 9 (Appendix).
56 See sections 1 and 2.1.1 above.
57 Mental Health (Treatment and Care) Act 1994 (ACT), ss 5, 10 f, Dict; Mental Health Act 2007 (NSW), ss 14 ff, Sched 1; Mental Health and Related Services Act 2009 (NT), ss 4, 6; Mental Health Act 2000 (Qld), s 12; Mental Health Act 2009 (SA), s 3, Sched 1; Mental Health Act 1986 (Vic), ss 3, 8; Mental Health Act 1996 (WA), ss 3, 4. The mental health acts of the Northern Territory and Queensland also include cultural opinion, belief or activity into the list of exclusion criteria.
58 See Tables 8 and 9 (Appendix).
59 Mental Health Act 1996 (Tas), s 4(2).
60 Mental Health Act 1996 (Tas), s 4(2). See also Table 7 (Appendix).
discrimination. However, the exclusionary criteria originally applied only to mental dysfunction. In 2006, the discussion on the Review of the Mental Health Act 1994 suggested that this was a drafting error. The Options Paper on the review explained that while these exclusionary criteria explicitly referred to mental dysfunction only, they also apply to mental illness because mental illness is a subset of mental dysfunction. In 2007, the mental health act was amended to clarify that a person cannot be “regarded as mentally dysfunctional or mentally ill” on the ground of the named exclusionary criteria.

The Mental Health and Related Services Act 2009 (NT) and the Mental Health Act 2000 (Qld) have the longest list of exclusionary criteria. Both of these Acts also state that a person’s prior mental illness or involuntary status does not suffice for finding a person to be mentally ill. This is a significant provision aimed at ensuring that persons with mental illness are re-assessed each time they are involuntarily treated or detained.

8.3.2 Discussion in Light of the Preamble and Articles 1 and 5

The domestic mental health acts set up separate legislative regimes which allow for the involuntary treatment and detention of persons with mental illness. The UDHR, the Human Rights Committee and the Siracusa Principles allow for human rights limitations, if they apply on objective, reasonable and proportionate

61 Mental Health (Treatment and Care) Act 1994 (ACT), s 5 considers a person not to be regarded as mentally dysfunctional or mentally ill only because of any particular philosophy; political or religious opinion, belief or activity; sexual preference, orientation or promiscuity; immoral or illegal conduct; alcohol or any other drug use; or antisocial behaviour.
64 See Mental Health (Treatment and Care) Amendment Act 2007 (A2007-43) (ACT) and Minister of Health, Explanatory Statement on the Mental Health (Treatment and Care) Amendment Bill 2007 (2007), 2. Emphasis added.
65 Exceptions apply to a continuous course of treatment.
67 See section 5.1.3 above. The author chose to adopt the terminology of the Siracusa Principles.
The mental health acts imply a narrow scope of application when they require that interventions apply only to those who experience a serious mental illness. Thus, they aim not to apply categorically to all persons with mental illness, but require an individualised assessment as to whether there are objective, reasonable and proportionate grounds for interventions. In other words, they aim to identify a group of people, but they imply that they do not differentiate them solely on the presence of a mental illness. However, this Chapter argues that Australian mental health acts conflict with the CRPD in the following ways when they define to whom they apply.

8.3.2.1 Mental Illness as a Ground for Differentiation

First, the CRPD has extended its full protection to persons with psychosocial disabilities. Thus, the CRPD protects persons with psychosocial disabilities from any unfavourable distinction, exclusion or restriction on the basis of their disability.

Prior to the adoption of the CRPD, the MI Principles and the World Health Organisation confirmed the view that differentiation is permissible for some kinds of mental illness. They identified the difficulties in setting up mental health legislation that does not apply categorically. In particular, they addressed the difficulties in defining mental illness in order to take into account the diversity and the complexity of mental health conditions. The MI Principles and the World Health Organisation guided States Parties to define mental illness in narrow terms.

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69 See section 5.1.3 above, in particular in respect to the different wording of the permissible limitations.
71 Section 8.4.3.1 below discusses the significance of the word “solely”.
72 See section 5.1.1 above.
75 See, for example, World Health Organization, Resource Book on Mental Health, Human Rights and Legislation (World Health Organization, Geneva, 2005), 20 ff. The MI Principles do not define mental illness. Rather, they list criteria which can or cannot be used to determine mental illness (Principle 4).
when mental health legislation allowed for the involuntary treatment and detention of persons with mental illness. All Australian mental health acts regulate the making of involuntary orders, but when they define mental illness the following concerns arise.

First, the *MI Principles* and the World Health Organisation stress that mental illness should be defined in reference to a clinically recognisable set of symptoms or behaviour. They aim to ensure that therapeutic interventions apply on objective grounds. The ICD-10 and the DSM-IV-TR describe internationally accepted and regularly updated clinical standards. These standards describe diagnostic criteria which identify mental disorder and they guide clinical practice with observations on the management of mental disorder. They recognise that not all factors which affect mental health result in illnesses that are treatable or in need of medical treatment. Thus, they address mental disorder broadly. The *MI Principles* and the World Health Organisation have accepted these clinical standards as a reference point or a set of terminology that can be incorporated into domestic mental health legislation. But the *MI Principles* and the World

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77 Principle 4(1) of the *MI Principles* stresses that mental health legislation should determine mental illness in accordance with internationally accepted medical standards.

78 The World Health Organisation refers to mental disorder when addressing persons who are subject to mental health legislation. The World Health Organisation promotes the benefits of mental health legislation which bestow rights on persons with mental disorder and prefers a broad understanding of the term mental disorder. It prefers the term of mental disorder to the term of mental illness because ‘mental disorder’ does not leave the connotation that the complex human conditions in mind are limited to a clear set of symptoms that can be diagnosed and treated. (World Health Organization, *Resource Book on Mental Health, Human Rights and Legislation* (World Health Organization, Geneva, 2005), 20 ff.). However, the World Health Organisation states that ‘mental disorder’ addresses mental health in terms that are clinically recognised which ensure that mental disorder does not apply to “social deviance or conflict alone”. See World Health Organization, *Resource Book on Mental Health, Human Rights and Legislation* (World Health Organization, Geneva, 2005), 21 with further references.


82 Alternatively, the domestic mental health legislation can name only a selection of diagnostic criteria to the effect that mental illness is defined more restrictively than in the ICD-10 or the DSM-IV-TR.
Health Organisation require States Parties to incorporate additional criteria in the definition of mental illness or the requirements for involuntary treatment in order to apply mental health legislation more restrictively.\textsuperscript{83}

Only the \textit{Mental Health and Related Services Act 2009} (NT) and the \textit{Mental Health Act 2000} (Qld) include a reference to a clinically recognisable set of symptoms or behaviour.\textsuperscript{84} Also, these two Acts are the only Australian mental health acts which comply with the other details of the \textit{MI Principles} on the determination of mental illness.\textsuperscript{85} All other mental health acts fall short in defining mental illness accordingly because they do not refer to all exclusionary criteria\textsuperscript{86} and they do not clarify that a person’s prior mental illness or involuntary status does not suffice in finding a person mentally ill.\textsuperscript{87} However, the mental health act of the Northern Territory applies beyond mental illness. Thus, only the \textit{Mental Health Act 2000} (Qld) complies with the suggestions of the \textit{MI Principles}.

Second, the World Health Organisation guides countries to define mental illness in terms that address the severity of mental illness in addition to the severity of the effect of mental illness on the individual’s ability to function or to behave.\textsuperscript{88} Most mental health acts do not require an assessment of the effect of mental illness on the individual’s ability to function or to behave. Only the \textit{Mental Health Act 1996} (WA) requires that the mental illness affects the individual’s judgment or behaviour to a significant extent. However, in order to comply with the guidance of the World Health Organisation, the Act would also need to clarify that mental illness requires a \textit{serious} disturbance of thought, mood, volition, perception,

\begin{itemize}
\item \textsuperscript{84} Mental Health Act 2000 (Qld), s 12(4); Mental Health and Related Services Act 2009 (NT), 6(2).
\item \textsuperscript{85} See Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, GA Res 46/119, UN GAOR, 46\textsuperscript{th} s ess, 75\textsuperscript{th} plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), Principle 4.
\item \textsuperscript{86} Ibid, Principle 4(3).
\item \textsuperscript{88} World Health Organization, Resource Book on Mental Health, Human Rights and Legislation (World Health Organization, Geneva, 2005), 20 ff. See in particular the examples on page 22.
\end{itemize}
orientation or memory.

Third, the definitions of mental illness within the different jurisdictions are inconsistent and difficult to understand. In 1993, the Burdekin Report stressed how important it is to incorporate a “clear and consistent definition of mental illness” in mental health acts. However, only the Mental Health Act 2000 (Qld) provides a comprehensive definition of mental illness which complies with the suggestions of the MI Principles and applies to mental illness only. The other mental health acts use different terminology in defining mental illness or apply beyond mental illness.

The mental health acts of New South Wales and Victoria use common terminology, but their application in practice varies. Spercer Zifcak has argued that in New South Wales the finding whether a person has a mental illness is based on the opinion of an ordinary person, while in Victoria, the finding whether a person is mentally disordered is subject to expert opinion. However, lay persons are more susceptible to finding a person mentally ill based on prejudice and a misunderstanding of mental illness than an expert who has been trained in determining mental illness. These kinds of differences in determining mental illness create uncertainty in understanding what is meant by the term.

Thus, in comparison to the MI Principles and the World Health Organisation’s guidance on defining mental illness, the domestic mental health acts do not ensure that involuntary orders apply on grounds that international

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90 See Spercer Zifcak, ‘The United Nations Principles for the Protection of People with Mental Illness: Applications and Limitations’ (1996) 3(1) Psychiatry, Psychology and Law 1, 3 in reference to the Victorian Mental Health Review Board and the New South Wales Mental Health Review Tribunal. The Victorian Mental Health Review Board stated that “mental illness is a term that should be understood by reference to the state of expert, professional knowledge in the medical and psychiatric arena” (at 3 with further references). The New South Wales Mental Health Review Tribunal decided that the mental health act’s “statutory definition of mental illness should be interpreted in a manner accessible to the ordinary person and hence that it is sufficient in determining that a person has a mental condition that a lay person would be satisfied that they had” (at 3 with further references).

91 However, the World Health Organisation recommends that lay person be involved in the periodic review of involuntary treatments in order to ensure that the reviewing body is independent and multidisciplinary, see World Health Organisation, Mental Health Policy and Service Guidance Package: Mental Health Legislation & Human Rights (World Health Organisation, Geneva, 2003), 26.

human rights discourse considers to be objective, reasonable and proportionate
grounds for differentiation.

Now, the CRPD places more scrutiny on the use of mental illness as a
ground for differentiation than the MI Principles and the World Health Organization
did. The CRPD has responded to the difficulties in defining disability and
recognises that persons with disabilities need protection from presumptions
concerning their abilities. It departs from the medical model of disability and
considers that medical findings about a person’s physical or mental condition do
not determine that person’s abilities to exercise his or her human rights. The
CRPD does not question the contributions and the scientific foundation of
psychiatric knowledge and does not oppose the validity of clinical criteria for
therapeutic purposes. However, it scrutinises their use towards differentiation
through the law. The CRPD was a response to the fact that people who have
been diagnosed with impairments have experienced discriminatory attitudes to
such a degree that their personhood has been called into question. Similarly, the
Burdekin Report found that persons with mental illness experienced such
widespread “discrimination and stigmatisation based on ignorance, labelling and
inaccurate stereotypes” that they were subjected to the decision-making of
others to the effect that they did not have equal standing in society.

The CRPD has extended its protection to persons with psychosocial
disabilities in order to subject their human rights realisation to the same high
level of scrutiny that the CRPD places on the human rights realisation of persons
with physical disabilities. Thus, the CRPD departs from accepting psychosocial
disability as an objective criterion for differentiation and it does not allow for

93 See sections 4.2 and 4.4.1 above.
94 See sections 4.2 and 5.2.1 above.
95 See sections 4.2, 5.1.1 and 5.1.2 above.
96 See section 5.1.2 above.
97 See sections 3.6.1.1 and 4.4.1 above.
99 See section 6.6.4 above.
100 See section 6.6.3 above.
101 See section 5.1.1 above
102 See section 5.1.5 above.
human rights interventions because of mental illness. Rather, the CRPD considers psychosocial disability as a criterion for increased protection and it departs from using mental illness as expressed in the pre-existing human rights framework when laws authorise the involuntary treatment and detention of persons with mental illness. Considering that most Australian mental health acts do not meet the standards of the MI Principles, they also conflict with the CRPD. They exemplify the difficulties of defining mental illness and show that mental illness has been defined broadly.

8.3.2.2 The Necessity for Treatment

Second, the CRPD has responded to the assumption that impairments need to be corrected in order to ensure the best interests of persons with psychosocial disabilities. The CRPD protects persons with psychosocial disabilities from presumptions concerning their abilities and their need for treatment.

Some mental health acts allow for discretion in defining mental illness through the necessity for treatment. The Burdekin Report was critical of the fact that domestic mental health acts adopted some definitions of mental illness which were “little more than token gestures – marked by circularity of reasoning.” In particular, the current mental health acts of South Australia and Western Australia show some circularity in reasoning when defining mental illness.

The Mental Health Act 1996 (WA) adopts the highest threshold for finding a person mentally ill because it requires that the mental illness must affect the individual’s judgment or behaviour to a significant extent. However, when the Act sets out the requirements for intervention, it considers a broad range of “self-inflicted harm”, including serious financial harm, serious harm to important

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103 See, however, sections 5.3 above and 8.4.3.1 below.
104 See section 5.1.1 above.
105 See section 5.1.2 above.
106 See sections 3.6.1.1, 4.4.1 and 5.2.1 above.
107 Mental Health Act 1996 (WA), Mental Health Act 2009 (SA), Mental Health Act 2007 (NSW), Mental Health Act 1986 (Vic).
personal relationships or serious damage to the reputation of the person.\textsuperscript{109} Despite the requirement that the self-inflicted harm needs to be “serious”, this is the lowest threshold of harm within the Australian mental health acts. This discrepancy in thresholds may result in a circularity of reasoning and it may compromise the high threshold for justifying interventions. For example, when a person has depression, the high threshold for impairment implies that a clinician must assess whether the person is significantly impaired in judging the need for treatment or in carrying out treatment because of the depression. Thus, the Act implies that interventions generally apply only to those with severe forms of depression. However, when the Act aims to protect an individual from self-inflicted harm, the Act runs the risk of starting the assessment on the basis of the risk. For example, authorities who apply the Act may respond to a person who has experienced serious financial harm. Then they might assess whether that individual has a mood disturbance\textsuperscript{110} which significantly affects his or her understanding and ability to control his or her finances. Considering that the Mental Health Act 1996 (WA) does not require that the mood disturbance is serious or assessed according to internationally accepted clinical criteria, the Act runs the risk of being applied broadly. That is, the Act could justify involuntary treatment for mild or moderate forms of depression. Thus, the interpretation of the term mental illness is not clear-cut and the Act may be applied broadly to persons who need to be protected from self-inflicted harm. This applies in particular when the Act protects individuals from kinds of harm that are difficult to interpret on objective grounds, such as the person’s reputation.

The provision in the Mental Health Act 2009 (SA) which relates to mental illness is also ambiguous. The Act does not define mental illness beyond the statement that mental illness is “any illness or disorder of the mind”.\textsuperscript{111} Its purpose and objectives state that the Act ensures that persons with serious mental illness receive a range of high-standard and recovery-focused services.\textsuperscript{112} Thus, the Act


\textsuperscript{110} Or a disturbance of thought volition, perception, orientation or memory, Mental Health Act 1996 (WA), s 4(1).

\textsuperscript{111} Mental Health Act 2009 (SA), s 3.

\textsuperscript{112} Mental Health Act 2009 (SA), s 6.
narrow the scope of application to persons with serious mental illness. However, the Burdekin Report pointed out that mental health acts did not sufficiently translate their objectives and principles into its substantive provisions.\(^{113}\) Thus, it is concerning that the Mental Health Act 2009 (SA) narrows the scope of its application when it addresses access to services, but it applies involuntary orders to persons with mental illness without requiring that the mental illness needs to be serious. Rather, the additional criteria for the involuntary treatment of a person with mental illness focus on assessing whether the person requires treatment.\(^{114}\)

The CRPD has responded to the fact that interventions have been justified on the assumption that persons with disabilities are in need of care and protection and that interventions result in better outcomes.\(^{115}\) However, the CRPD does not consider it reasonable to assume that persons with psychosocial disabilities need medical treatment to overcome their disability and it rejects the idea of coercing people into treatment.\(^{116}\) Rather, the CRPD has responded to the risk of others viewing individuals with disabilities solely through a medical lens and acting in their best interests.\(^{117}\) It aims to challenge discriminatory attitudes through delinking disability from the connotation that persons with disabilities need the help of others to ensure their welfare. The domestic mental health acts which allow for discretion in defining mental illness through the necessity for treatment conflict with the CRPD,\(^ {118}\) in particular when they allow for interpreting a person’s need for treatment broadly.

Several commentators have suggested that most Acts are applied in narrow terms.\(^ {119}\) However, the fact that these mental health acts can be applied in narrow terms does not change their discriminatory stance and the risk of being applied

\(^{113}\) See section 6.3 above.

\(^{114}\) Mental Health Act 2009 (SA), ss 21, 25.

\(^{115}\) See sections 3.6.1.1 and 5.1.2 above.

\(^{116}\) See section 3.6.1 above. The CRPD considers that mental health legislation which aimed to apply in exceptional cases only have not been applied to that effect because persons with mental illness did not have equal access to services. See sections 5.1.6 and 5.4 above.

\(^{117}\) See sections 3.6.1 and 4.4.7 above.

\(^{118}\) See section 8.3.1 above.

broadly. Both, the development of the CRPD and the Burdekin Report can be viewed as responses to the fact that mental health laws lacked the accountability and restrictions that are placed on laws that legitimately limit other people’s rights.\textsuperscript{120} Both found that mental health legislation which lacked accountability and adequate restrictions contributed to systematic shortcomings to the human rights realisation of persons with mental illness.\textsuperscript{121} In particular the CRPD rejects clinical discretion because it considers that others making decisions concerning a person’s need for treatment relied on the ‘good intentions’ of the decision-maker and left the individual cut off exercising his or her rights.\textsuperscript{122}

8.3.2.3 The Treatability of Mental Illness

Third, the Australian mental health acts which extend their scope of application beyond mental illness\textsuperscript{123} are also concerning because they place untreatable conditions and challenging behaviour under a health scheme. The World Health Organisation has expressed concerns towards including substance abuse, intellectual disability and untreatable personality disorder under the application of mental health laws which regulate involuntary treatment.\textsuperscript{124} The World Health Organisation considers that “there are major differences”\textsuperscript{125} between mental illness and intellectual disability. Also, it considers that there is a dispute as to the “validity and reliability of diagnosis of many subtypes of personality disorders”.\textsuperscript{126} Its guidance on mental health legislation has stated that:

If a particular condition is not responsive to treatment, or if no treatments are available, it is difficult to justify involuntary admission of persons with this condition to a mental health facility.\textsuperscript{127}

\textsuperscript{120} See 6.3 above.  
\textsuperscript{121} See sections 4.4.2 and 6.3 above.  
\textsuperscript{122} See sections 1 and 2.3.3 above.  
\textsuperscript{123} See section 8.3.1.3 above and Table 8 (Appendix).  
\textsuperscript{125} Ibid, 21.  
\textsuperscript{126} Ibid, 21.  
\textsuperscript{127} Ibid, 21. See, however, Paul Mullen, 'Dangerous and Severe Personality Disorder and in Need of Treatment' (2007) 190(49) British Journal of Psychiatry 3. Mullen argues that there are programmes which provide appropriate responses to persons with personality disorders. Chapter Ten elaborates on responses to persons with personality disorders and their medical treatment.
The Australian mental health acts allow for considerable flexibility in using mental health legislation in order to help individuals who could benefit from "coercive care". While there may be a "legitimate role of coercive care in medicine and in the social services", the use of coercion must apply restrictively. However, the Australian mental health acts are open to broad interpretation and may be used to extend mental health specific interventions for therapeutic reasons to those who cannot be treated and to those whose behavioural patterns may be a matter of choice rather than illness.

The CRPD has responded to the experiences of persons with psychosocial disabilities who claim that mental illnesses have been misunderstood because of stigmatisation and marginalisation. Stigmatisation may have been exacerbated because of the use of labels in diagnoses and because of the misrepresentation of persons with psychosocial disabilities in the media. The CRPD has recognised that mental health laws run the risk of perpetuating the belief that mental health is about dealing with dangerous behaviour. The powers of some mental health acts are limited in their extent and durability when they apply to persons who are not mentally ill, but the inclusion of socially ‘deviant’ or challenging behaviour in

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129 Ibid, vi.
130 Fistein and colleagues suggested that the application of the mental health acts in practice revolve around the question whether the individual needs treatment, see EC Fistein et al, 'A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions' (2009) 32(3) International Journal of Law and Psychiatry 147, 147.
131 See section 5.1.2 above. Recent reports have shown that persons with psychosocial disabilities are still one of the most marginalised groups worldwide and suffer from the lack of most fundamental rights. (Aaron A Dhir, 'Human Rights Treaty Drafting through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities' (2005) 41 Stanford Journal of International Law 181; Michael L Perlin, 'International Human Rights Law and Comparative Mental Disability Law: The Universal Factors' (2007) 34(2) Syracuse Journal of International Law and Commerce 333, 333 ff. with further references.)
134 For example Mental Health Act 2007 (NSW), s 31; Mental Health and Related Services Act 2009 (NT), ss 15, 42 ff.
mental health legislation is concerning when its guiding principles focus on the administration of medical treatment. It also fosters the connotation that mental health care is about controlling difficult people.\textsuperscript{135}

Tom Campbell has argued that the existence of mental health legislation reinforces the systematic discrimination against persons with psychosocial disabilities because significant interferences into basic human rights are being justified under a scheme that applies only to persons with psychosocial disabilities.\textsuperscript{136} He states that “there is something about ‘mental illness’ itself which invites a system of control and coercion”.\textsuperscript{137} This connotation fosters existing misconceptions about psychosocial disability and it may deter people with mental illness from entering mental health services.\textsuperscript{138} The \textit{CRPD} combats such kinds of presumptions into the effect of disability on the lives of individuals with impairments and their need for control and coercive treatment. Rather, the \textit{CRPD} aims at ensuring that those who need treatment have equal opportunities to access health services. It combats idea that persons with psychosocial disabilities need to be coerced into their treatment. Thus, the mental health acts which extend their scope of application beyond mental illness as a key criterion conflict with the \textit{CRPD}.

\textbf{8.3.2.4 The Prevalence of Differentiation}

Fourth, the \textit{CRPD} embraces persons with psychosocial disabilities as equal bearers of rights.\textsuperscript{139} It protects the equality of persons with psychosocial disabilities to an unprecedented degree because the \textit{CRPD} has refrained from incorporating clauses on exceptional differentiation.\textsuperscript{140} The \textit{CRPD} has taken this approach in response to the persistent shortcomings in the human rights realisation of individuals with psychosocial disabilities who have experienced that their human

\begin{footnotesize}
\begin{enumerate}
\item Tom D Campbell, ‘Mental Health Law: Institutionalised Discrimination’ (1994) 28(4) \textit{Australian and New Zealand Journal of Psychiatry} 554, 554.
\item Ibid, 556.
\item See also Tim Wand and Mary Chiarellla, ‘A Conversation: Challenging the Relevance and Wisdom of Separate Mental Health Legislation’ (2006) 15 \textit{International Journal of Mental Health Nursing} 119, 123 with further references.
\item See section 5.1.5 above.
\item See section 5.1.5 above.
\end{enumerate}
\end{footnotesize}
rights protection has focused on preventing unnecessary interventions while measures of support and reasonable accommodation have been neglected.\textsuperscript{141}

Anna Lawson points out that the primary health service response to psychosocial disability is treatment through medication with a belief that otherwise the health of persons with psychosocial disability will severely deteriorate and their general living conditions will decline.\textsuperscript{142} In response to that experience, persons with psychosocial disabilities have claimed that psychosocial disability can be indeed severe, but similar to the experience of persons with physical disability, severe disability calls for increased support and reasonable accommodation, rather than intervention that aims to prevent their disability.\textsuperscript{143}

The Australian mental health acts do not sufficiently respect the existing abilities of individuals with psychosocial disabilities. The Mental Health Act 1996 (WA) requires an assessment as to whether mental illness affects the individual’s judgment or behaviour, but the Act leaves the possibility of applying this assessment broadly.\textsuperscript{144} All other mental health acts do not sufficiently respect the existing abilities of individuals with psychosocial disabilities. Thus, they conflict with the CRPD because they override existing abilities, instead of supporting them. Hence, differentiation on the ground of mental illness, as incorporated in Australian mental health acts is not a proportionate limitation of rights because the acts do not sufficiently respect the individual skills of persons with mental illness.\textsuperscript{145}

\textsuperscript{141} See section 5.1.6 above.
\textsuperscript{142} See also Anna Lawson, ‘People with Psychosocial Impairments or Conditions, Reasonable Accommodation and the Convention on the Rights of Persons with Disabilities’ in Bernadette McSherry (ed), Law in Context Special Issue: International Trends in Mental Health Laws (The Federation Press, Leichhardt, 2008) 62, 68.
\textsuperscript{144} See section 8.3.1.2 above.
\textsuperscript{145} The mental health legislation of Queensland and the Northern Territory require genuine engagement with the person with mental illness, see section 8.2 above. However, these aims are not sufficiently reflected in the substantial provisions of the respective Act which authorise interventions. See sections 8.4 and 8.5 below as well as Tables 13 and 15 (Appendix).
8.3.3 Conclusions

This Chapter argues that in light of the CRPD, current mental health acts do not apply objective, reasonable and proportionate grounds for differentiation when they set out to whom they apply.

The CRPD opposes the view of differentiating people based on clinical criteria because it considers that medical determinations of impairments have not been applied objectively, but categorically. Australian mental health acts confirm the view that medical determinations can be a flawed means of assessing individual abilities when they are incorporated into laws. Mental health acts seem to apply on objective, medical grounds, but most of them leave considerable flexibility towards defining mental illness on subjective grounds, in particular when the person’s need for treatment can be applied broadly. Some of the Australian mental health acts shift the focus from assessing whether or not a person is mentally ill to assessing whether a person needs treatment. However, the CRPD was a response to the notion that the assessment of a person’s need for treatment is a vague criterion that can lead to prejudice and it protects persons with disabilities from medical treatment because of their disability.

The provisions of the CRPD indicate that the inclusion of people who cannot be treated or need social control is unreasonable because these kinds of interventions do not respond to an individual’s disability. Rather, they foster the connotation that persons with psychosocial disabilities must be as dangerous as those who need to be controlled for reasons other than mental illness. Also, they foster the connotation that persons with mental illness are as limited in participating in treatment decisions as those who need to be coerced and controlled because of their dangerous behaviour.

In addition, mental health laws which further the idea that mental health services revolve around the use of coercion do not respond appropriately to the existing abilities of persons with psychosocial disabilities. The CRPD aims to ensure that persons with psychosocial disabilities have equal access to health services, receive support and remain the subjects of rights. However, when mental health acts aim to apply more broadly to persons who could benefit from mental health care and treatment, they still revolve around the threat of compulsion. Thus,
mental health acts allow for extending the scope of their application to those who need treatment through intervention as a matter of last resort, but they do not respond to persons below that threshold in terms of support.\textsuperscript{146}

Thus, this Chapter argues that the current mental health acts are discriminatory when they set out to whom they apply. Many of them exemplify the risks of using mental illness as an objective, reasonable and proportionate ground for differentiation because they extend powers of medical intervention that respond to concerns beyond mental illness. This approach perpetuates pre-existing misconceptions about psychosocial disabilities.

### 8.4 The Protection of Others as a Criterion for Differentiation

Some authors have argued that mental health acts do not apply on discriminatory grounds because they consider additional criteria to that of a diagnosis of mental illness alone.\textsuperscript{147} They argue that these additional criteria ensure that involuntary detention and treatment under mental health acts apply in exceptional cases only and thus, the Australian mental health acts do not result in categorical differentiation. Rather, mental health acts allow for the identification of a particular group of persons and then enable an assessment of whether some individuals who fall into that group show the characteristics that legitimately allow for differentiation.

The existence of additional criteria may alter the discussion as to whether or not there are objective, reasonable and proportionate grounds for differentiation. Thus, this section assesses the justifications for mental health legislation which traditionally have been based on the rationale that mental illnesses are accompanied by special characteristics when compared to other kinds of illness or disability.\textsuperscript{148} This rationale is based on the presumption that the nature of these

\textsuperscript{146} Chapters Nine and Ten will further elaborate on this observation.


characteristics requires a different response to mental illnesses when compared to other health settings. It considers that some persons with mental illnesses are too ill to look after themselves, to understand their need for treatment and the effects of treatment – which leaves them at risk of being ‘dangerous’ to their own interests or the interests of others.\textsuperscript{149}

One rationale for mental health legislation considers that involuntary treatment can restore the health of the individual. Therapeutic interventions are based on the premise that they can help individuals with mental illness to understand their illness and control their behaviour in such a way that they no longer present a risk to themselves or others as a result of their mental illness. Also, involuntary treatment is thought to enable individuals to direct medical treatment decisions like other persons once they have regained their mental health. Thus, mental health legislation may be justified on the basis of ensuring the rights of others or the rights of the individual with mental illness.

This Chapter discusses whether this rationale complies with the \textit{CRPD}. The following section outlines the mental health acts’ understanding of harm to others and discusses the fact that the Australian mental health acts enable interventions to persons with mental illness who pose a risk of harming others. Subsequently, this Chapter outlines the mental health acts’ understanding of self-harm and discusses the perceived need for therapeutic interventions in light of the \textit{CRPD}.

\subsection*{8.4.1 Mental Health Acts: Harm to Others}

All Australian mental health acts allow for the involuntary treatment of persons with mental illness, if they pose a serious harm to others. The mental health acts of the Australian Capital Territory, the Northern Territory and New South Wales allow for involuntary treatment if the person with mental illness is \textit{likely} to do serious harm to others.\textsuperscript{149}

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to others.\textsuperscript{150} Such a likelihood must be based upon a belief on reasonable grounds.\textsuperscript{151} The Mental Health Act 2000 (Qld) allows for the involuntary treatment of a person with mental illness if a medical assessment confirms that the individual poses an imminent risk of harm to someone else.\textsuperscript{152} All other mental health acts allow for involuntary treatment which is necessary to prevent harm to others.\textsuperscript{153} This finding is subject to the opinion of a review body or medical expertise.\textsuperscript{154} The tables in the appendix outline the criterion of harm to others in the context of the respective mental health acts’ requirements for involuntary treatment.\textsuperscript{155}

Chapter Five set out how international human rights discourse allows for limiting individual human rights. In particular, the Siracusa Principles allow for limiting rights in order to protect public health and public interests, including the health of others.\textsuperscript{156} However, when mental health acts address the criterion of harm to others the following concerns arise.

\textbf{8.4.2 Discussion in Light of the Preamble and Articles 1 and 5}

\textbf{8.4.2.1 The Reliability of Risk Assessments and their Use in Legal Decision-Making}

First, when mental health acts allow for the involuntary treatment of a person with mental illness who poses a serious harm to others, concerns arise as to how to assess that risk. In the primary context of the management of offenders with mental illnesses, several commentators have argued that clinical judgment has

\begin{footnotesize}
\textsuperscript{150} Mental Health (Treatment and Care) Act 1994 (ACT), ss 11, 38; Mental Health and Related Services Act 2009 (NT), s 14; Mental Health Act 2007 (NSW), ss 14, 29. The act of the Northern Territory requires that the individual must in incapable of giving consent or has unreasonably refuses to consent to treatment, see Mental Health and Related Services Act 2009 (NT), s 14(b)(iii).

\textsuperscript{151} Ibid.

\textsuperscript{152} Mental Health Act 2000 (Qld), ss 13, 14.

\textsuperscript{153} Mental Health Act 2009 (SA), ss 21, 25; Mental Health Act 1996 (Tas), s 32; Mental Health Act 1996 (WA), s 26. The Mental Health Act 1986 (Vic) requires the protection of members of the public, see Mental Health Act 1986 (Vic), s 8.

\textsuperscript{154} Mental Health Act 2009 (SA), ss 21, 25; Mental Health Act 1996 (Tas), s 32; Mental Health Act 1996 (WA), s 26. The Victorian legislation requires the “protection of members of the public”, see Mental Health Act 1986 (Vic), s 8.

\textsuperscript{155} See Tables 11 to 18 (Appendix).

\textsuperscript{156} See section 5.1.3 above.
\end{footnotesize}
failed to result in reliable predictions of risk. However, James Ogloff and Michael Davis argue that in the criminal law, modern risk assessment techniques may be used to define the risk of reoffending in reliable, narrow and precise terms. In 2008, John Monahan stated that:

After three decades of largely depressing research on the abilities of mental health professionals at predicting violence among people with mental disorder, the journals have become replete with guardedly optimistic studies indicating that actuarial instruments may succeed where unstructured clinical judgment has failed. For the first time, relatively accurate assessments of the risk of violence that a patient poses may be within the realm of science rather than science fiction.

However, several other commentators maintain that current risk assessment tools are not sufficiently reliable to be used as a criterion for differentiation in mental health laws, even though they have improved in recent times. In particular, Nicholas Scurich and Richard John point out that there is insufficient research into

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the effect of evidence of actuarial assessment on legal decision-makers.\textsuperscript{162} Scurich and John are concerned with civil commitment in the United States context which differs significantly from the Australian system.\textsuperscript{163} However, their research is interesting in relation to the potential bias that may be displayed by decision-makers in assessing risk. While having pointed out that "dispositional decisions made by judges tend to be influenced most by risk factor/management information",\textsuperscript{164} Scurich and John argue that "it appears judges prefer categorical estimates of risk … even though categorical estimates of risk have little consensual meaning amongst forensic clinicians".\textsuperscript{165} They argue that "it is important to know whether the way the risk estimate is framed inherently biases the task".\textsuperscript{166} They explain that current clinical risk assessments emphasise the costs of false negatives (the risk of violence occurring), rather than the consequences of a false positive (the risk of erroneously confining a person).\textsuperscript{167} Their findings indicate that the communication of false negatives tends to influence the decision-maker towards civil commitment.\textsuperscript{168} They argue that their study "demonstrates that even a subtle manipulation in the framing of risk estimates is powerful enough to affect commitment decisions".\textsuperscript{169} They acknowledge that this effect may add to already well-known biases in decision-making, to which judges are not immune.\textsuperscript{170} They state that

\begin{itemize}
  \item \textsuperscript{162} Nicholas Scurich and Richard S John, 'The Effect of Framing Actuarial Risk Probabilities on Involuntary Civil Commitment Decisions' (2011) 35 Law and Human Behavior 83, 84.
  \item \textsuperscript{163} For an overview of the United States civil commitment laws, see John Petrila, 'Rights-Based Legalism and the Limits of Mental Health Law: The United States of America's Experience' in Bernadette McSherry and Penelope Weller (eds), Rethinking Rights-Based Mental Health Laws (Hart Publishing, Oxford & Portland, 2010) 357.
  \item \textsuperscript{164} Nicholas Scurich and Richard S John, 'The Effect of Framing Actuarial Risk Probabilities on Involuntary Civil Commitment Decisions' (2011) 35 Law and Human Behavior 83, 84 with further references.
  \item \textsuperscript{165} Ibid, 84.
  \item \textsuperscript{166} Ibid, 85.
  \item \textsuperscript{167} Ibid, 85. See also George Szmukler and Frank Holloway, 'Reform of the Mental Health Act: Health or Safety?' (1998) 177 British Journal of Psychiatry 196. Szmukler and Holloway argued that risk-assessments enable worst-cases prognosis (or a large number of ‘false positives’ (at 199 with further references); Christopher J Ryan et al, 'Clinical Decisions in Psychiatry Should Not Be Based on Risk Assessment' (2010) 18(5) Australasian Psychiatry 398, 401.
  \item \textsuperscript{168} Nicholas Scurich and Richard S John, 'The Effect of Framing Actuarial Risk Probabilities on Involuntary Civil Commitment Decisions' (2011) 35 Law and Human Behavior 83, 85.
  \item \textsuperscript{169} Ibid, 88.
  \item \textsuperscript{170} Ibid, 90. See also Leslie Salzman, 'Guardianship for Persons with Mental Illness - A Legal and Appropriate Alternative?' (2011) 4 Saint Louis Journal of Health Law & Policy 279, 300.
\end{itemize}
the risk assessment literature continues to be preoccupied with enumerating risk factors [ref], while the communication and effects of actuarial risk assessment on legal decision-makers remain largely understudied.  

In the Australian context, risk assessment tools are used in the criminal law field, but are not used in the civil arena in mental health review board hearings. The assessment of risk is largely dependent upon the treating doctor’s clinical ‘experience’ rather than the use of actuarial tools. This means that there is not only an inherent vagueness in what this criterion means, but the potential for mental health review boards to overly rely on the treating clinician’s views.

The development of the CRPD can be viewed as a response to the fact that persons with disabilities, and persons with psychosocial disabilities alike, have been viewed through the ideas of medicine, despite the fact that medicine alone cannot sufficiently explain the effect of disability on the life of the individual with disability. Traditionally, persons with psychosocial disabilities experienced interventions on the premise that such interventions were necessary. The CRPD aims to respond to biases in decision-making and attitudinal barriers that have resulted in shortcomings to the human rights realisation of persons with psychosocial disabilities. The vagueness associated with assessing the criterion of risk of harm to others and the emphasis placed in Australia on clinical ‘experience’ in this regard conflicts with the social model of the CRPD.

8.4.2.2 The Threshold of the Harm Criterion and the Likelihood of Harm to Others

Second, when the Australian mental health acts differentiate persons with mental illness on the basis of posing a harm to others, concerns arise because some acts define harm broadly and only the Mental Health Act 2000 (Qld) emphasises the

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172 See sections 4.2 and 4.41 above.

173 See section 5.1.2 above.
immediacy or imminence of harm.\textsuperscript{174}

The \textit{Mental Health (Treatment and Care) Act 1994 (ACT)} and the \textit{Mental Health and Related Services Act 2009 (NT)} state in their requirements on involuntary treatment that persons with mental illness need to pose a \textit{serious} harm to others.\textsuperscript{175} A lower threshold of harm further emphasises the costs of false negatives (the risk of harm occurring) and may result in increased bias in decision-making.\textsuperscript{176} Thus, the mental health acts which aim to \textit{prevent harm to others}\textsuperscript{177} will tend to have higher rates of false negatives than those acts which cover \textit{serious harm to others}.

Scurich and John have argued that a low level in the likelihood of harm occurring may further increase the emphasis on false negatives.\textsuperscript{179} Most of the Australian mental health acts require that the risk of harm to others be based on a belief on “reasonable grounds”\textsuperscript{180} or on “the assessment of the medical expert”.\textsuperscript{181} However, the acts do not define whether the likelihood is based on ‘clear and convincing evidence’,\textsuperscript{182} ‘beyond reasonable doubt’\textsuperscript{183} or similarly worded standards of probability. In the criminal law, such standards apply for deprivations in liberty. Similarly, the international human rights framework considers that, following the principle of in \textit{dubio pro libertate},\textsuperscript{184} the interpretations of human

\textsuperscript{174} Ian Freckelton argues that most Australian mental health acts are applied to that effect. Ian Freckelton, ‘Mental Health Law’ in Ben White, Fiona McDonald and Lindy Willmott (eds), \textit{Health Law in Australia} (Lawbook Co, Sydney, 2010) 537, 558.

\textsuperscript{175} \textit{Mental Health (Treatment and Care) Act 1994 (ACT)}, ss 11, 38; \textit{Mental Health and Related Services Act 2009 (NT)}, s 14. Most other mental health acts state that in their Preliminary or their definition of mental illness.


\textsuperscript{177} \textit{Mental Health Act 2009 (SA)}, ss 21, 25; \textit{Mental Health Act 1996 (Tas)}, s 32; \textit{Mental Health Act 1996 (WA)}, s 26. The \textit{Mental Health Act 1986 (Vic)} requires the protection of members of the public, see \textit{Mental Health Act 1986 (Vic)}, s 8.

\textsuperscript{178} \textit{Mental Health (Treatment and Care) Act 1994 (ACT)}, ss 11, 38; \textit{Mental Health and Related Services Act 2009 (NT)}, s 14; \textit{Mental Health Act 2007 (NSW)}, ss 14, 29.


\textsuperscript{180} \textit{Mental Health (Treatment and Care) Act 1994 (ACT)}, ss 10 f, 38; \textit{Mental Health Act 2007 (NSW)}, s 29.

\textsuperscript{181} \textit{Mental Health Act 2009 (SA)}, ss 21, 25; \textit{Mental Health Act 2000 (Qld)}, s 13; \textit{Mental Health Act 1996 (WA)}, 26; \textit{Mental Health Act 1986 (Vic)}, s 8.


\textsuperscript{183} Ibid, 430.

\textsuperscript{184} If in doubt, favour liberty.
rights restrictions must be as narrow as possible.\textsuperscript{185} Considering that the imposition of involuntary treatment affects a person’s bodily integrity, which the international human rights debate subjects to higher standard than other rights,\textsuperscript{186} such an imposition should be carefully circumscribed. In contrast to this, most mental health acts are imprecise when they address the likelihood of harm to others.\textsuperscript{187}

The Burdekin Report recommended that mental health acts should provide clear and comprehensive guidance on the requirements for involuntary treatment,\textsuperscript{188} at least as a matter of accountability.\textsuperscript{189} The Burdekin Report and the CRPD considered that imprecise formulations in mental health legislation and the law’s dependency on clinical discretion have resulted in ongoing shortcomings to the human rights realisation of persons with psychosocial disabilities.\textsuperscript{190}

The mental health acts’ broad understanding of harm also runs the risk of re-emphasising misconceptions and stigmatisation. Olav Nielssen and colleagues have stated that “[p]ublicity arising from homicides of complete strangers have been a catalyst for changes in mental health policy and for laws governing compulsory psychiatric treatment.”\textsuperscript{191} Nancy Wolf has criticised “policy making in the face of risk”\textsuperscript{192} because the risk perceptions of policy-makers is different to the risk perceptions of clinicians.\textsuperscript{193} She argues that policy-makers respond to risks as perceived by public opinion, rather than clinical risk assessment.\textsuperscript{194}

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\begin{itemize}
\item Manfred Nowak, \textit{U.N. Covenant on Civil and Political Rights: CCPR Commentary} (N.P. Engel, 2\textsuperscript{nd} revised ed, 2005), XXVII. \textit{In dubio pro vita} (if in doubt, favour life) may prevail in cases of emergencies. See also Sarah Joseph, Melissa Castan and Jenny Schultz, \textit{The International Covenant on Civil and Political Rights: Cases, Materials, and Commentary} (Oxford University Press, 2\textsuperscript{nd} ed, Oxford, 2004), 30.
\item See section 2.1.2.3 above.
\item The \textit{Mental Health Act 2000} (Qld) incorporates the highest threshold and likelihood of the risk of harm to others.
\item See section 6.3 above.
\item See section 6.3 above.
\item Olav Nielssen et al, ‘Homicide of Strangers by People with a Psychotic Illness’ (2011) 37(3) \textit{Schizophrenia Bulletin} 572, 573 with further references.
\item Ibid, 802.
\item Ibid, 804 ff.
\end{itemize}
The growing preoccupation with risk assessment has reinforced a
defensive climate for clinical practice and promoted a risk aversive
culture to protect and safeguard patients, but also staff and the
institution.\textsuperscript{195}

Several commentators have argued that the association between mental
illness and dangerous behaviour is misleading. Christopher Ryan, for example,
has argued that persons with mental illness “are, by and large, no more dangerous
than people in other identifiable groups”.\textsuperscript{196} Peter Bartlett and Ralph Sandland
state that:

The reality in the overwhelming number of cases [of persons with
mental illness] is likely to be characterised by banality rather than extremes.\textsuperscript{197}

They comment on the high prevalence of mental illness within society and point
out that:

This would suggest it is not appropriate to think in terms
condescendingly of ‘them’ but rather, somewhat more humbly, of ‘us’.
The frequency suggested by the statistic would suggest that any
generalisation may well mislead as much as it informs.\textsuperscript{198}

The \textit{CRPD} combats attitudinal barriers to the human rights realisation of persons
with psychosocial disabilities\textsuperscript{199} and in extending its full protection to persons with
psychosocial disabilities, it aims to apply the same high standards for interventions
that apply to persons other than those with psychosocial disabilities.\textsuperscript{200} However,
the provisions in Australian mental health acts dealing with harm to others lack
precision. This means that those who determine the need for intervention are

\begin{flushleft}
\textsuperscript{195} M Cleary et al, ‘Locked Inpatient Units in Modern Mental Health Care: Values and Practice
\textsuperscript{196} Christopher J Ryan, ‘Capacity as a Determinant of Non-consensual Treatment of the
Mentally Ill in Australia’ (2011) 18(2) \textit{Psychiatry, Psychology and Law} 248, 248 with further
references.
\textsuperscript{197} Peter Bartlett and Ralph Sandland, \textit{Mental Health Law: Policy and Practice} (Oxford
\textsuperscript{198} Ibid, 4. See also Jill Peay, ‘Mental Illness, Dangerousness and Protecting Society’ (2009)
8(12) \textit{Psychiatry} 490.
\textsuperscript{199} See section 4.4.2 above.
\textsuperscript{200} See sections 5.1.1 and 5.1.3 above.
\end{flushleft}
legally guided to take a precautious stance towards risk-prevention.\textsuperscript{201}

8.4.2.3 The Consequences of Differentiation

Third, when the mental health acts address the criterion of harm to others concerns with the CRPD arise because the Australian mental health acts address harm to others interchangeably with self-harm, implying that both kinds of harm require the same level of likelihood. However, there are differences between these two categories of harm.

The risk assessment tools which are used in the criminal law arena aim to predict a person’s potential for re-offending.\textsuperscript{202} Some studies indicate that suicide risk assessment tools have become more effective in acute care settings, but are not as reliable and as manageable as risk assessment tools which aim to predict a person’s likelihood of harming others.\textsuperscript{203} The Victorian Department of Health carried out an assessment of suicide risk assessment tools and found that they tend to be difficult to apply in practice and can result in a high number of false positives.\textsuperscript{204} When mental health acts define self-harm beyond diagnostic criteria, an assessment as to whether a person is at risk of harming him- or herself becomes increasingly subjective. Because mental health acts address these two categories of harm interchangeably, they leave the impression that both can be assessed with the same level of accuracy.

The responses to a person who poses a risk of harming others tend to follow a different rationale than the responses to a person who poses a risk of harming him- or herself. The justifications for interfering with the rights of those who pose a threat to others are based on the rationale of applying interventions restrictively. Thus, they apply as a matter of last resort with a limited scope for discretion. The mental health acts follow this rationale and set out the due process

\textsuperscript{201} See section 8.3.2.2 above.
\textsuperscript{202} See section 8.4.2.1 above.
\textsuperscript{204} Victorian Department of Health, ‘Suicide Risk Assessment and Management: A Systematic Evidence Review for the Clinical Practice Guidelines for Emergency Departments and Mental Health Services Project’ (Department of Health, 2010), 16 with further references.
of applying interventions to persons with mental illness. If they are similar to the formal safeguards that apply in criminal law settings, the discriminatory effect is reduced.

Public health legislation also allow for the detention of persons with infectious diseases in hospitals, permanently, if necessary.\textsuperscript{205} Thus, significant restrictions on an individual’s liberty can apply on public interest grounds. The screening for infectious diseases may identify a specific group of persons, such as persons who originate from a certain country that has high incidents of infectious diseases. Even though the international human rights treaties include a person’s national origin into the criteria for non-discrimination, laws can identify groups of people without subjecting them to a substantially different standard. But the links between identifying certain groups of people and applying restrictions need to apply restrictively in order to ensure that they do not apply on discriminatory, but on objective, reasonable and proportionate grounds. Mental health acts may apply on similar grounds to laws which restrict human rights for reasons other than mental illness and thus, they may not have a discriminatory effect.\textsuperscript{206}

However, when the mental health acts use the criterion of harm to others interchangeably with self-harm, they use terminology in the requirements for involuntary treatment that aims to apply restrictively,\textsuperscript{207} but remains responsive to allow for interventions which ensure necessary medical treatment.\textsuperscript{208} This discrepancy in applying interventions compromises the transparency and consistency of interventions: while the requirements for involuntary treatment appear to apply restrictively, their closer examination reveals that they allow for a broad scope of interpretation and application because the mental health acts aim to be restrictive and responsive at the same time.\textsuperscript{209}

The CRPD aims to ensure the substantial equality of persons with psychosocial disabilities and protects persons with disabilities from indirect

\textsuperscript{205} See, for example, Health Act 1958 (Vic), s 58.

\textsuperscript{206} See section 2.1.2.2 above.


\textsuperscript{208} See section 8.5 below.

\textsuperscript{209} See Tables 11 to 18 (Appendix) on the requirements for involuntary treatment in the domestic mental health acts.
discrimination\textsuperscript{210} and de-facto discrimination.\textsuperscript{211} Thus, the CRPD scrutinises provisions that appear to apply on non-discriminatory grounds, but have a discriminatory effect on persons with psychosocial disabilities.\textsuperscript{212}

The later sections of this Chapter\textsuperscript{213} explore the degree to which the Australian mental health acts extend their application in order to ensure medical treatment for persons with mental illness. However, before this Chapter addresses the concerns about the mental health acts’ understanding of self-harm, this Chapter discusses Articles 14 of the CRPD.

\textbf{8.4.3 Discussion in Light of Article 14}

The Australian mental health acts enable the involuntary detention of persons with mental illness who pose a serious risk of harm to others.\textsuperscript{214} Thus, Article 14 of the CRPD which protects the liberty and security of persons with disabilities becomes relevant.

\textbf{8.4.3.1 The ‘Solely’ Discussion}

Article 14(1)(b) of the CRPD states that “the existence of a disability shall in no case justify a deprivation of liberty”. Article 14(2) implies that deprivations of liberty can be justified. It states that any deprivation of liberty requires following a process that applies on an equal basis with others, complies with international human rights and provides reasonable accommodation.

During the drafting process of the CRPD,\textsuperscript{215} several States Parties suggested that Article 14(1)(b) should state that any deprivation of liberty cannot be ‘solely’ based on disability. If Article 14 stated that any deprivation of liberty cannot be ‘solely’ based on disability, Article 14 would allow for the interpretation that persons with psychosocial disabilities can be detained if they have a

\textsuperscript{210} See section 4.4.6.2 above.
\textsuperscript{211} See section 4.4.6.1 above.
\textsuperscript{212} See section 4.4.6.2 above.
\textsuperscript{213} See section 8.5 below.
\textsuperscript{214} Mental Health (Treatment and Care) Act 1994 (ACT), s 16; Mental Health Act 2007 (NSW), s 35; Mental Health and Related Services Act 2009 (NT), s 14; Mental Health Act 2009 (SA), s 12; Mental Health Act 1996 (Tas), s 24; Mental Health Act 2000 (Qld), s 13; Mental Health Act 1996 (Vic), s 8; Mental Health Act 1996 (WA), s 26.
\textsuperscript{215} See section 5.3 above.
psychosocial disability and at least one additional criterion for differentiation.\textsuperscript{216} If the additional criterion for differentiation does not subject persons with psychosocial disabilities to unequal treatment, then psychosocial disability is not the cause for differentiation, but it can be used legitimately to target a specific group of persons. Thus, the detention of persons with psychosocial disabilities would be justifiable, if psychosocial disability as such is not causal to the deprivation of liberty.

Now that Article 14 states that disability cannot justify any deprivation of liberty, the \textit{CRPD} changed the rationale for detention. Article 14 with the word ‘solely’ would have allowed for links between the disability and additional criteria. Now, the wording of Article 14 aims to de-link disability from additional criteria that could justify detention. The difference sounds subtle, but it is significant. The \textit{CRPD} requires decision-makers to scrutinise not only whether disability makes a difference to the decision-making process on detention. Rather, the justification must rest on other considerations.\textsuperscript{217}

Oliver Lewis states that the “global disability movement fought hard for the \textit{CRPD} to include an explicit prohibition against forced psychiatric interventions, and the text is quite clear on the prohibition of detention [in Article 14].”\textsuperscript{218} The Human Rights Council considers that Article 14 poses a ”radical departure from the pre-existing human rights position”.\textsuperscript{219} In 2011, the Committee on the Rights of Persons with Disabilities indicated that it aims to enact the ‘radical departure’ in the human rights standard. In response to Tunisia’s first report to the Committee on the Rights of Persons with Disabilities, the Committee recommended that Tunisia has to

\textsuperscript{216} The subsequent discussion focuses on one additional criterion only because this is the minimum requirement.
\textsuperscript{217} The fact that risk assessment tools consider medical findings does not result in discriminatory differentiation because medical findings may also justify interventions to persons without disabilities.
repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability.\textsuperscript{220}

Later in 2011, the Committee confirmed this position in response to Spain’s report and stated that Spain must

repeal provisions that authorize involuntary internment \textit{linked} to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned.\textsuperscript{221}

Thus, the Committee confirmed the view that Article 14 changes the pre-existing justifications for the detention of persons with psychosocial disabilities and it measures state compliance accordingly.

The Committee implies that separate mental health legislation, such as the Australian mental health acts which are based on the “twin criteria”\textsuperscript{222} of mental illness and harm to self or others, reflect the pre-existing view that a deprivation in liberty cannot be ‘solely’ based on disability. The discussions on the \textit{CRPD} considered that the pre-existing human rights standard runs the risk of perpetuating current practice which has shown to presume links between disability and the need for detention. Thus, Article 14 requires States Parties to abolish mental health legislation which are based on the ‘twin criteria’ and it calls for a new human rights standard which reflects the paradigm shift of the \textit{CRPD}.

\section*{8.4.3.2 Reasonable Accommodation}

Article 14 also requires that the detention of persons with disabilities is subject to

\textsuperscript{220} Committee on the Rights of Persons with Disabilities, Consideration of Reports Submitted by States Parties under Article 35 of the Convention: Concluding Observations of the Committee on the Rights of Persons with Disabilities (Tunisia), CRPD/C/TUN/CO/1, 5\textsuperscript{th} sess, (13 May 2011) para 24.

\textsuperscript{221} Committee on the Rights of Persons with Disabilities, Consideration of Reports Submitted by States Parties under Article 35 of the Convention: Concluding Observations of the Committee on the Rights of Persons with Disabilities (Spain), CRPD/C/ESP/CO/1, 6\textsuperscript{th} sess, (19 October 2011) para 36. The Committee stressed the requirement of informed consent in light of Article 14 which addresses involuntary detention and Article 17 which addresses involuntary treatment.

reasonable accommodation. Thus, States Parties need to establish and continuously improve services to persons who are detained. When this amendment stresses that detention is subject to reasonable accommodation, Article 14 raises awareness of the fact that States Parties can provide services to avoid detention.

Thus, Article 14 implies that States Parties can provide alternatives to detention. The CRPD considers that mental health specific detention applies not purely on punitive grounds and can be avoided, or shortened, if persons with disabilities have early access to mental health services which may help them avoid a deterioration in their mental health to a point that would justify interventions. Thus, Article 14 implies that States Parties need to establish equal access to mental health services and continuously work towards improving them.

The human rights debate on mental health care in Australia showed that the absence of mental health services increased the potential of using, and extending, involuntary detention as the primary form of care. The Mental Health and Related Services Act 2009 (NT) stands out from the other mental health acts because its Preamble requires that a person should only be admitted after every effort has been taken to avoid detention. Most other mental health acts can be used to ensure access to treatment, but they respond only when the person’s health has deteriorated to a point that interventions are justified.

8.4.4 Conclusions

The Australian mental health acts conflict with the CRPD when they allow for the involuntary treatment and detention of persons with mental illness to ensure the protection of others. This applies in particular in respect to Article 14. In 2011, the Committee on the Rights of Persons with Disabilities indicated that Article 14 calls for the abolition of mental health legislation which allows for the detention of persons with mental illness. The Committee aims to delink the justification for detention from mental illness to ensure that presumptions into the effect of mental

223 See section 6.6.6 above and in particular The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, Interim Report (Commonwealth of Australia, Canberra, 2006), 55.

224 Mental Health and Related Services Act 2009 (NT), s 10(a).
illness do not influence the finding that a person with mental illness is potentially dangerous to others.

Irrespective of the interpretation of Article 14, the Australian mental health acts conflict with the CRPD because they do not ensure a person’s potential harm to others is assessed in the restrictive and accountable way that is required for interventions into the rights of other people. Most acts run the risk of identifying false negatives (the risk of violence occurring) and allow for an unstructured clinical judgment of risks. This applies in particular when the mental health acts do not define the threshold and the likelihood of harm occurring in meaningful ways to ensure that interventions apply restrictively.

8.5 Therapeutic Need as a Criterion for Differentiation

The following sections discuss whether differential treatment may be justified when mental health acts serve to protect the therapeutic interests of persons with mental illness. They outline the Australian mental health acts’ understanding of self-harm and discuss these findings in light of the CRPD’s provisions on the equality and non-discrimination of persons with disabilities and the protection of their bodily integrity (Article 17).

8.5.1 Mental Health Acts: The Need for Treatment

All mental health acts respond to a person’s need for treatment and serve to ensure the care and treatment of persons with mental illness. They allow for the involuntary treatment of persons with mental illness who are at risk of posing harm to themselves. Most acts also allow for interventions when medical treatment is necessary to prevent the person’s deterioration in health. John Gray and colleagues point out that the Australian mental health acts have “broad harm and

225 See section 8.3.2.2 above. See also Fleur Beaupert, 'Mental Health Tribunals - From Crisis to Quality Care?' (2007) 32(4) Journal of Law and Medicine 219, 219.
226 See section 8.2 above.
227 See Tables 11 to 18 (Appendix) on the requirements of involuntary treatment.
228 Mental Health (Treatment and Care) Act 1994 (ACT), s 38; Mental Health Act 2007 (NSW), s 14; Mental Health and Related Services Act 2009 (NT), s 55; Mental Health Act 2009 (SA), ss 21, 25; Mental Health Act 2000 (Qld), s 14; Mental Health Act 1996 (Tas), s 3; Mental Health Act 1986 (Vic), s 8.
deterioration criteria\textsuperscript{229} which cover a spectrum of self-harm that is not “limited to physical or bodily harm”.\textsuperscript{230} In particular, the \textit{Mental Health Act} 1996 (WA) and the \textit{Mental Health Act} 2007 (NSW) cover financial harm as well as harm to a person’s reputation.\textsuperscript{231} Thus, the Australian mental health acts allow for the broad interpretation and application of the concept of self-harm in order to ensure the therapeutic needs of the person with mental illness. The tables in the appendix outline the criterion of self-harm in the context of the respective mental health acts’ requirements for involuntary treatment.\textsuperscript{232}

The broad interpretation of the concept of self-harm applies in particular when the Australian mental health acts allow for considering the person’s refusal to treatment as potentially self-harming behaviour. The acts adopt different approaches to considering a person’s refusal of treatment. The \textit{Mental Health Act} 1996 (WA) allows for the involuntary treatment of a person with mental illness if he or she refuses treatment.\textsuperscript{233} In Victoria, the mental health act allows for involuntary treatment if the mentally ill person refuses necessary treatment.\textsuperscript{234} The \textit{Mental Health Act} 2000 (Qld)\textsuperscript{235} and the \textit{Mental Health and Related Services Act} 2009 (NT)\textsuperscript{236} consider the mentally ill person’s unreasonable refusal to treatment. The previous discussion on the MI Principles indicates that a person who unreasonably refuses treatment runs the risk of being in a position in which he or she will be prevented from deciding to take any risks. This concern increases when most of the mental health acts consider any refusal to treatment as justifying the authorisation of treatment.\textsuperscript{237}

\begin{itemize}
\item \textsuperscript{230} Ibid, 1127.
\item \textsuperscript{232} See Tables 11-19 (Appendix).
\item \textsuperscript{233} \textit{Mental Health Act} 1996 (WA), s 26(1)(c).
\item \textsuperscript{234} \textit{Mental Health Act} 1986 (Vic), s 8(1)(d).
\item \textsuperscript{235} \textit{Mental Health Act} 2000 (Qld), s 14(1)(f).
\item \textsuperscript{236} \textit{Mental Health and Related Services Act} 2009 (NT), s 14(b)(iii).
\item \textsuperscript{237} See section 3.4.2 above. See also Grant H Morris, Legal Studies Research Paper Series: Refusing the Right to Refuse - Coerced Treatment of Mentally Disordered Persons (Vandeplas Publishing, Lake Mary, 2006), 179 f.
\end{itemize}
8.5.2 Discussion in Light of the Preamble and Articles 1 and 5

While the Australian mental health acts address harm to others and self-harm interchangeably, the international human rights framework considers them to be separate issues. The UDHR, the Human Rights Committee and the Siracusa Principles allow for restrictions on human rights and fundamental freedoms in exceptional cases. The Siracusa Principles and the Human Rights Committee allow for human rights interventions that serve to protect public health and public interests, including the health of others, but they have not stated the same about interventions which serve to protect the individual from self-harm.

With the adoption of the CRPD, persons with disabilities are protected from treatment which serves to ensure their medical interests because the CRPD has departed from the medical model of disability. The development of the CRPD can be viewed as responding to the view that the medical model of disability resulted in systematic human rights violations. When the mental health acts include a criterion relating to a person’s risk of self-harm, it is argued that they run the risk of perpetuating the substantial inequality of persons with mental illness and the lack of service reform. This is explained in the next sections.

8.5.2.1 Early Intervention as a Means of Ensuring Access to Services

First, when the Australian mental health acts enable involuntary treatment as a response to potential self-harm, they run the risk of continuing the use of coercive care as the primary response to mental illness. The Australian debate on mental health care has been influenced by the idea that the human rights protection of persons with mental illness is detrimental to their interests because the restrictive application of mental health acts prevents early treatment interventions which

238 See section 8.4.2.3 above.
240 See section 2.1.2 above.
242 See section 2.3.4 above.
would be less intrusive.\textsuperscript{243} Thus, law reform eased restrictions on the requirements of involuntary treatment and responded to a person’s \textit{deterioration} in health which allows for earlier intervention.\textsuperscript{244} This movement has aimed at ensuring that persons with mental illness can receive treatment prior to deterioration to a degree that would justify involuntary orders.

After the adoption of the \textit{CRPD}, several commentators on Australian mental health care stated that persons with mental illness need improved access to mental health care and called for extending early \textit{interventions} without sufficiently considering that persons with mental illness might choose to enter services without the use of force, if they were available.\textsuperscript{245} This indicates that the idea of coercive care is deeply entrenched in mental health service delivery. Considering that Chapter Seven pointed out that Australian human rights law focuses on traditional civil and political rights, this view is not surprising because the human rights debate focuses on the justifications for interventions.

However, one of the new features of the \textit{CRPD} is found in Article 8, a separate provision on awareness-raising which requires States Parties to combat stereotypes, prejudice and harmful practices. Article 8 implies that Australia has to become proactive towards ensuring that mental health service reform does not solely revolve around interventions. The domestic mental health debate pointed out that restrictive access to services and their focus on involuntary treatment have had a deterring effect.\textsuperscript{246} The development of the \textit{CRPD} was based on the notion that the use of force has resulted in attitudinal barriers to the human rights realisation of persons with mental illness. Thus, the continued focus of the Australian mental health acts on the use of coercion conflicts with the \textit{CRPD}.

\textsuperscript{243} See section 6.5.2 above. See also Mental Health Council of Australia, \textit{Time for Service: Solving Australia’s Mental Health Crisis} (Mental Health Council of Australia, Canberra, 2006), 7.
\textsuperscript{246} See section 6.6.2 above.
8.5.2.2 Treatment Bias and Clinical Decision-Making

Second, when the Australian mental health acts enable involuntary treatment in response to potential self-harm, they give preference to interventions, delegate this difficult decision to the discretion of mental health professionals or mental health tribunals and run the risk of not reflecting the paradigm shift of the CRPD.

When the mental health acts guide decision-makers in relation to ensuring “necessary” treatment, they focus the decision-making process on the medical interests of the person with mental illness. This applies in particular when clinicians drive the decision-making process because medical professionals are ethically obliged to protect the welfare of their patients or clients. Thus, in choosing what is best for the patient or client, they are bound to take a medical point of view. However, the mental health acts provide insufficient guidance to decision-makers concerning how to take into account the individual’s point of view and how to balance it in light of medical recommendations. Several commentators have raised the spectre of bias towards clinical decision-making and have argued that decision-makers do not sufficiently challenge medical opinion, but tend to follow the views of the medical expert.

The Mental Health Act 2000 (Qld) and the Mental Health and Related Services Act 2009 (NT) are most explicit about ensuring that mental health services revolve around the participation of the individual with mental illness.

247 In all State and Territories the decision-making on involuntary treatment and detention is subject to independent review. The review body is either a magistrate or tribunal (sometimes referred to as mental health board).
248 The Australian Psychological Society, Code of Ethics (The Australian Psychological Society Ltd, Melbourne, 2007), General Principles B and C, Explanatory Statement; The Royal Australian & New Zealand College of Psychiatrists, Code of Ethics (The Royal Australian & New Zealand College of Psychiatrists, 4th ed, Melbourne, 2010), Preamble, Principles 1 and 3. The Code of Ethics for psychiatrists emphasises the patient’s human dignity and provides psychiatrists with principles on how to balance the respect for the patient’s autonomy and his or her welfare interests. However, this thesis argues that the law emphasises the patient’s welfare.
However, the provisions of the CRPD require more than patient participation only and these acts run short in facilitating genuine engagement with the patient. Also, these Acts’ statements of principle are subject to the discretion of decision-makers who are guided to respect the patient’s wishes as one amongst a number of other considerations. Thus, the purposes and objectives of the Mental Health and Related Services Act 2009 (NT) and the Mental Health Act 2000 (Qld) guide the decision-maker to interpret the best interests of a person with mental illness in light of that person’s point of view as well as the need for treatment. The requirements for involuntary treatment and detention can thus override the person’s view251 and the interpretative guidance of the mental health acts’ purposes and objectives have limited potential to change the fact that the provisions on the requirements of involuntary treatment and detention are decisive. Chapter Seven argued that human rights-based arguments have limited influence on changing the literal interpretation and application of the substantive provisions of domestic mental health legislation.

Some mental health acts protect the individual with mental illness from harm to a substantial degree, with their definitions of self-harm covering certain kinds of harm that society tolerates in respect to other persons, such as the risk of harming finances or personal relationships.252 In addition to the concern that the mental health acts’ definitions of harm run the risk of resulting in an increased rate of false negatives (the risk of harm occurring), the mental health acts also emphasise a precautionary approach towards potential errors in decision-making. The aim of protecting persons with mental illness from a wide range of harm, in particular harm beyond physical and mental harm, guides the decision-maker to take a precautionous stance towards risk prevention and protecting an individual from behaviour that the individual might regret later. David Bell has posited that a person’s aim of avoiding regret may significantly influence that person’s

251 See Tables 11-18 (Appendix).
decisions.253 For those making a decision about involuntary treatment, there is the possibility that they will assume a person with mental illness will regret refusing treatment. A person’s need for treatment drives decision-making on treatment to a degree that the person with mental illness has little room to argue why he or she would not want treatment. Thus, regardless of the assessment of whether or not the person with mental illness is impaired in making treatment decisions, the need for treatment can override the person’s choice and preference.

Thus, the Australian mental health acts confirm the view of the Australian Senate Select Committee on Mental Health that the medical model of decision-making is “hampering improvement in mental health care”254 because the mental health acts have the effect of excluding persons with mental illness from decision-making to a degree that their personhood is called into question. Thus, they conflict with the CRPD.

8.5.2.3 The Lack of Access to Health Services

Third, the CRPD can be viewed as a response to the fact that broadening the scope of mental health legislation has not resulted in better access to mental health services. Bernadette McSherry has stated that persons with mental illness still experience significant shortcomings in accessing mental health services.255 She argues that mental health law has a legitimate role to play in reducing the use of coercion and facilitating a culture change in service delivery, but she also stresses that the role of the law is limited in an environment of limited resources.256 Penelope Weller has stated that in the absence of alternative access to mental health services

254 The Senate - Select Committee on Mental Health, A National Approach to Mental Health - From Crisis to Community, First Report (Commonwealth of Australia, Canberra, 2006), 19. See section 6.5.3 above.
256 Ibid, 392 f.
the understanding of treatment in the least restrictive environment has not necessarily resulted in restrictions of involuntary treatment. She comments that:

Civil commitment laws that rely on the notion of dangerousness in under-resourced systems therefore work to impose involuntary detention in an arbitrary way.

Thus, ensuring access to services through legislation has had limited success. Rather, the broad scope of applying interventions to ensure the therapeutic needs of the person with mental illness comes at the costs of a deterrent and counter-therapeutic effect.

In 2008, the Victorian Government Department of Human Services found that the "current arrangements and service cultures mean that individuals with mental health problems receive inadequate services when compared to those with physical health conditions". Chapter Six argued that the Australian debate on mental health law reform has long recognised that the lack of equal access to mental health services has contributed to the mental health acts' focus on

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258 Ibid, 58. She also argued that "[i]n a stressed system, refusal of treatment is more likely to operate as an indicator of the potential risk of violence or dangerousness and to be interpreted as a proxy indicator of the two other elements that are usually required to justify civil commitment – the need for treatment and a lack of capacity. The observation that stressed systems produce cyclical escalations of crisis, refusal and aggressive intervention has been made in New Zealand, Canada and the United States." Penelope Weller, 'Lost in Translation: Human Rights and Mental Health Law' in Bernadette McSherry and Penelope Weller (eds), Rethinking Rights-Based Mental Health Laws (Hart Publishing, Oxford & Portland, 2010) 51, 57 f.


interventions. Yet, mental health service reform is still lacking.

Now, the CRPD is unprecedented in its call for States Parties to become proactive towards ensuring that persons with psychosocial disabilities have equal access to services. The CRPD has merged civil and political and social, cultural and economic rights under one framework and stresses that respect for human rights does not result in protections from interventions only, but also requires States Parties to become proactive in ensuring rights, such as the right to health. The Australian human rights debate has not yet adopted this understanding of human rights realisation, but the CRPD might bring about the cultural change that is necessary to ensure the understanding that freedoms from interventions in mental health care are interrelated to, and interdependent on, service provision.

8.5.3 Discussion in Light of Article 17

Beyond these concerns, conflicts with Article 17 arise when the Australian mental health acts allow for the involuntary treatment of persons with mental illness to ensure their therapeutic needs. During its drafting process, the CRPD included a reference to the MI Principles and Article 17 had extra paragraphs which implied that the CRPD allows for the involuntary treatment of persons with psychosocial disabilities in exceptional circumstances. These paragraphs were discussed and taken out. Oliver Lewis comments:

That the CRPD is silent on forced treatment may be viewed as simply naïve, offering domestic policy-makers little guidance on the content of domestic mental health legislation, or indeed offering them plenty of room to be creative and progressive, or it may have been simply a political compromise to finalise the treaty. Whichever of these truths emerges, the CRPD is less open to be criticised for hypocrisy, unlike the United Nations Mental Illness Principles which contain a lofty principle on non-discrimination of persons with mental illness [ref], and

261 See sections 6.2.2 and 6.6.2 above.
262 See section 6.6 above.
263 See section 4.4.5 above.
264 See section 5.1.1 above.
265 See sections 5.3, 5.4, 7.1.3 and 8.4.3.1 above.
then goes on to list five principles to the right to consent to treatment without offering any legal or moral justifications for the exceptions [ref]. 266

However, the Committee on the Rights of Persons with Disability has started to use the ‘negotiated silence’ of Article 17 to call for radical change. In response to the early reports to the Committee on the Rights of Persons with Disability, the Committee stressed in light of Article 17 that States Parties must abolish laws which authorise medical treatment “without the full and informed consent of the patient’. 267

This position is consistent with the findings above that Article 14 calls for a 'radical departure' in mental health legislation. 268 The CRPD has acknowledged that psychosocial disability has posed specific challenges to the question of whether or not human rights can be limited. 269 The drafting process of Article 17 implies that the drafters of the CRPD were aware of the fact that there are legitimate reasons for limiting the rights of persons with psychosocial disabilities in cases of emergencies and the risk to public health, 270 just like there are legitimate reasons for limiting the rights of other persons. Unlike Article 14, Article 17 of the CRPD does not state that the justifications for the involuntary treatment of persons with psychosocial disabilities must be delinked from mental illness. However, by dropping the extra paragraphs in Article 17, the CRPD implies that it challenges the pre-existing justifications for involuntary treatment. In light of the other provisions of the CRPD, the interpretation and application of Article 17 allows for the following conclusions.

First, the ‘silence’ of Article 17 requires States Parties to justify interventions

268 See section 8.4.3 above.
269 See section 5.1.4 above.
270 See section 5.4 above on the suggestion to amend Article 17 with sentence (2).
without referring back to the pre-existing human rights standard because the drafters of the CRPD considered that the pre-existing human rights standard was no longer ‘fair and correct’. The CRPD follows this approach to an unprecedented degree because the CRPD departed from using any terminology in its provisions that could uphold interventions on grounds that have been accepted in the pre-existing human rights discourse. In particular, the decision-making process on treatment must revolve around the social model of disability and respect the existing abilities of the individual with mental illness. This substantiates the claim that States Parties have to depart from using coercive care as the primary response to mental illness and provide alternative services.

Second, Article 17 requires States Parties to combat presumptions into the effect of disability on the individual’s ability to exercise his or her rights and depart from the medical model of disability. The use and design of the Australian mental health acts show why this move is important to realising the paradigm shift of the CRPD. Anita Smith has stated that current mental health law balances “three potentially conflicting principles – the right to prompt and effective treatment, the right to minimal loss of freedom, and the community’s right to adequate protection.” As addressed above, all mental health acts revolve around the conflict of applying interventions restrictively, while ensuring that the justifications for interventions remain sufficiently flexible to respond to those who need treatment. The current mental health acts exemplify how difficult it is to set up laws which serve conflicting interests. The MI Principles provided a compromise solution in balancing conflicting interests and the Burdekin Report found that the Australian mental health acts failed in translating these conflicting interests into a framework of balanced and enforceable rights.

The Burdekin Report revealed the widespread discrimination of persons with mental illness and the lack of service responses to mental health aside

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271 See section 5.4 above.
272 See section 5.1.4 above.
275 See section 6.3 above.
276 See section 6.2.1 above.
from interventions as a matter of last resort.\textsuperscript{277} Subsequent mental health reforms aimed to improve the human rights situation of persons with mental illnesses, but mental health law reform revolved around the need for intervention and defining under what circumstances interventions are necessary.\textsuperscript{278} This reform progress was accompanied by the continued observation of widespread discrimination and misunderstanding of mental illness, a lack of genuine service reform and a lack of facilitating the equal standing of persons with mental illnesses in society in respect to many areas of life.\textsuperscript{279}

The \textit{CRPD} challenges the legitimacy of interventions, rather than simply focusing on the grounds by which involuntary treatment may be justified in exceptional circumstances. The drafting sessions of Article 17 imply that there is disagreement on defining the line between intervention and non-intervention. However, the drafters of the \textit{CRPD} considered that the debate about possible exceptions to the right to respect for bodily and mental integrity distracted from the fact that mental health services can be improved in order to avoid the extensive application of interventions as a matter of ensuring treatment. It departed from naming exceptional grounds for differentiation and takes a precautious stance towards interventions, in particular if the interventions serve welfare-based considerations which could resort back to the medical model of disability.\textsuperscript{280} Thus, the \textit{CRPD} combats the connotation that the primary response to mental health illness revolves around justifying interventions. It departs from leaving the decision-making process on intervention to the responsibility of medical professionals or tribunals because the \textit{CRPD} recognises that the decision-making process is shaped by the availability of alternatives to involuntary treatment as well as an environment of support. Article 17 is not sufficiently precise to render individuals with enforceable rights,\textsuperscript{281} but Article 17 sends a message to politicians who can change access to mental health services. The \textit{CRPD} takes the view that States Parties have to develop new practices which need to be trialled and presented to the Committee on Rights of Persons with Disability to work out a new

\begin{itemize}
\item \textsuperscript{277} See sections 6.2.2 and 6.2.4 above.
\item \textsuperscript{278} See section 6.6.6 above.
\item \textsuperscript{279} See sections 6.6.1, 6.6.2, 6.6.4 and 6.6.7 above.
\item \textsuperscript{280} See sections 3.6.1.1, 3.7.4, 5.1.1 and 5.1.7 above.
\item \textsuperscript{281} The development of the Article 17 may have the effect that Article 17 becomes enforceable.
\end{itemize}
framework for human rights compliant mental health care.

Third, the Australian mental health acts have a history of not translating international human rights standards into the substantive provisions of their mental health acts. For example, most of the acts use a person’s refusal of treatment as a criterion which indicates the need for treatment and thus authorises involuntary treatment, while the MI Principles aimed to limit involuntary treatment to those who unreasonably refused treatment.282 This Chapter has argued that the Australian mental health acts also do not comply with the pre-existing international human rights framework when they define mental illness and the requirements of interventions. This Chapter did not assess the details of the review procedures on involuntary treatment, but Samantha Battams and Julie Henderson state that “the review process of domestic mental health legislation falls short of WHO recommendations for independent legal review of detention on a monthly basis.”283

Many of these shortcomings result from resource constraints and a lack of alternative access to mental health services.284 They are also marked by ‘good intentions’ for interventions. Phillip Fennell has been critical of the fact that policy makers continue arguing that the primary purpose of mental health legislation is “to improve mental health services, safeguard patients and reduce stigma”285 — criteria that seem at face value to support the ideas of the CRPD,286 but substantially conflict with the CRPD because mental health legislation is about “bringing persons under compulsion”.287

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282 See sections 3.4.2 and 3.4.3 above.
284 See section 6.6.2 above.
286 Ibid, 70.
287 Ibid, 70 in reference to the Government’s response to the Bill (with further references).
In departing from the medical model of disability, the CRPD has acknowledged that ‘good intentions’ can result in detrimental effects. The development of the CRPD has revealed how much persons with disabilities were subjected to differentiation which appeared to be ethically and legally sound because the differentiation was driven by ‘good intentions’. The Special Rapporteur on Torture has also stated that ‘good intentions’ may mask serious violations of human rights.\(^{288}\) The CRPD implies that it allows for links between psychosocial disabilities and interventions, but it also protects persons with disabilities against the ‘good intentions’ of interventions when they reflect the medical model of disability. This substantiates the claim that States Parties have to depart from using coercive care to ensure the therapeutic needs of persons with mental illness.

8.6 Concluding Thoughts

This thesis argues that the justifications for separate mental health legislation, as incorporated in the Australian mental health acts, conflicts with the CRPD. The strongest argument for this conclusion derives from Article 14 because Article 14 requires States Parties to delink the justifications for detention from mental illness. This poses a significant departure from the pre-existing human rights discourse on mental health legislation because the pre-existing human rights guidance allowed for the detention of persons with mental illness, if the detention was not solely based on the existence of mental illness. However, the mental health acts which use the twin criteria of mental illness and harm to self or others are based on the pre-existing human rights standard.

Now, the CRPD requires that other considerations must justify why detention is necessary. It is premature to conclude how the CRPD will respond to structured, reliable and individualised risk assessments which are based on the features of specific diagnoses because they may not result in categorical differentiation.

However, this thesis argues that the Australian mental health acts conflict

\(^{288}\) Manfred Nowak, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment, 63\(^{rd}\) sess, UN Doc A/63/175 (28 July 2008), 49.
with the *CRPD* regardless of the new standard of Article 14. It argues that the mental health acts conflict with the *CRPD* when they set out to whom they apply because they define mental illness as a criterion for categorical differentiation beyond objective, reasonable and proportionate considerations. In particular, most of them do not require that finding a person to be mentally ill must rest on a clinical recognised set of symptoms and behaviour. Neither do they ensure that interventions apply only to those who have a serious mental illness which results in the individual’s serious impairment of judgment or behaviour. Rather, the mental health acts do not subject the definition of mental illness to substantial restrictions and accountability because they aim to ensure the therapeutic needs of individuals and allow for their involuntary treatment as a matter of primary service response.

Beyond the mental health acts’ definitions of mental illness, conflict with the *CRPD* arises when the mental health acts justify intervention for the protection of others or the therapeutic needs of the person with mental illness. This Chapter argues that the acts allow for unstructured clinical judgment and do not define the threshold and the likelihood of the harm to others criterion in precise terms to the effect that they favour interventions. This Chapter also argues that it conflicts with the *CRPD* to justify interventions to ensure the therapeutic needs of the person with mental illness because the *CRPD* has departed from the medical model of disability and opposes using force as a primary method of ensuring that persons with psychosocial disabilities receive access to mental health services. The *CRPD* remains silent on the difficult question whether or not exceptions apply to Article 17 because it considers that a focus on the exceptions hinders genuine service reform.

The following Chapter assesses whether capacity-based mental health legislation as an alternative legislative regime also conflicts with the *CRPD*. 
Chapter Nine assesses whether the CRPD requires Australia to use a person’s capacity to make decisions as an alternative criterion to the current regime for differentiation. An individual’s incapacity to make decisions can be delinked from psychosocial disability and assessed in respect to persons with mental illness, disability, physical illness or other persons alike. Thus, this Chapter discusses the proposal of “fusing” mental health and guardianship legislation into uniform incapacity legislation, as promoted in particular by George Szmukler, John Dawson and Rowena Daw.

This Chapter first outlines the fusion proposal and analyses its advantages and disadvantages in light of the relevant provisions of the Australian mental health acts and the CRPD. It argues that most of the Australian mental health acts currently conflict with the CRPD because they either presume that a person with mental illness is incapable of making decisions on his or her mental health care or they allow for overriding the decisions of a capable person with mental illness on broadly applicable criteria. This Chapter argues that uniform incapacity legislation which revolves around a person’s capacity to make decisions has a number of advantages in contrast to current mental health legislation. These advantages boost the potential of incapacity legislation to realise the human rights standards of the CRPD.

Despite certain advantages, this Chapter also argues that there is a disadvantage in having uniform incapacity legislation in that it poses risks to the human rights realisation of persons with psychosocial disabilities because treating them equally under one legislative scheme may not sufficiently respond to pre-existing

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shortcomings in their human rights realisation. However, it argues that the \textit{CRPD} provides insight into solutions as to how to respond to most of the disadvantages of uniform incapacity legislation.

\subsection{9.1 Capacity as a Criterion for Differentiation}

Prior to the development of the \textit{CRPD}, some authors were already critical of separate mental health legislation because it can override the requirement of informed consent to treatment. The question whether or not psychiatric treatment should require the individual's consent to treatment if that person is capable of making treatment decisions has been discussed in the United States and the United Kingdom since at least the early 1980s.\textsuperscript{2} In particular, George Szmukler and Frank Holloway\textsuperscript{3} have argued that mental health laws are discriminatory when they allow for the involuntary treatment of a person with mental illness despite his or her capacity to make treatment decisions. In 1998, Szmukler and Holloway described mental health laws as “a harmful anachronism”.\textsuperscript{4} They have argued that swings of policy remind us that the prescription of involuntary treatment is primarily a social matter and only weakly related to the epidemiology or clinical features of mental disorder.\textsuperscript{5}

They have argued that mental health legislation “reinforces discriminatory stereotypes”\textsuperscript{6} and should be replaced with legislation that responds to persons who lack capacity to make treatment decisions, rather than persons with mental

\begin{footnotesize}
\begin{enumerate}
\item George Szmukler and Frank Holloway, 'Mental Health Legislation is Now a Harmful Anachronism' (1998) 22 \textit{Psychiatric Bulletin} 662, 662.
\item George Szmukler and Frank Holloway, 'Reform of the Mental Health Act: Health or Safety?' (1998) 177 \textit{British Journal of Psychiatry} 196, 196.
\item George Szmukler and Frank Holloway, 'Mental Health Legislation is Now a Harmful Anachronism' (1998) 22 \textit{Psychiatric Bulletin} 662, 664.
\end{enumerate}
\end{footnotesize}
illness. In 2006, John Dawson and George Szmukler suggested that mental health and guardianship laws should be fused into one piece of legislation that delinks interventions from a diagnosis of mental illness. In 2010, Szmukler, Dawson and Rowena Daw drafted a model statute for their fusion proposal.

This suggestion of enacting uniform incapacity legislation will be further explored because Szmukler, Daw and Dawson respond to some of the concerns about using mental illness as a criterion for differentiation. Their fusion proposal suggests that ‘incapacity’ can serve as an alternative criterion for differentiation and they illustrate how to use it in law and practice.

9.2 The Fusion Proposal

Dawson and Szmukler argue that mental health and guardianship legislation both respond to persons with impairments and regulate the decision-making processes on their care or treatment. They argue that mental health legislation discriminates against persons with mental illness because the law sets up a significantly different response to persons with mental impairment when compared to persons with physical impairments. They point out that mental health legislation allows for the treatment without consent of a person who is mentally ill and poses an imminent threat to harm, while guardianship legislation allows for the

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7 Ibid, 662 ff.
8 Dawson and Szmukler predominantly have referred to ‘incapacity laws’ when they discuss legislation which covers persons with physical impairments. John Dawson and George Szmukler, ‘Fusion of Mental Health and Incapacity Legislation’ (2006) 188(6) British Journal of Psychiatry 504, 504. They discuss their proposal predominantly under consideration of the laws of the United Kingdom and use the terminology of the local debate. They also refer to adult guardianship laws. George Szmukler, Rowena Daw and John Dawson, ‘A Model Fusing Incapacity and Mental Health Legislation’ (2010) Journal of Mental Health Law - Special Issue 11, 12. The author decided to use the terminology of guardianship legislation because the Australian law predominantly responds to persons with physical impairment under the heading of guardianship or disability legislation.
11 They responded to mental health legislation which differentiates persons with mental illness on “twin criteria”: their mental illness (or mental disorder) and a risk of harm. John Dawson and George Szmukler, ‘Fusion of Mental Health and Incapacity Legislation’ (2006) 188(6) British Journal of Psychiatry 504, 504.
12 Ibid, 505.
13 Ibid, 504.
treatment without consent of a person who is incapable of making treatment decisions.\textsuperscript{14} They argue that capacity assessments should be applied to both groups of people.\textsuperscript{15}

Thus, they suggest that both schemes should be fused into uniform incapacity legislation. They recommend that the assessment of an individual’s capacity to make decisions on his or her care and treatment should be at the heart of the fused legislation.\textsuperscript{16} The incapacity test that they suggest is not linked to any specific diagnosis. Rather, it assesses the individual’s “inability to understand, recall, process, use or weigh relevant information; inability to communicate a decision; or inability to reach a decision that is sufficiently stable for it to be followed”.\textsuperscript{17} They allow for some “modification of pure capacity principles … in the forensic field”,\textsuperscript{18} but consider that “the number of persons likely to fall into this category who retain capacity is extremely small”.\textsuperscript{19}

They do not suggest that involuntary treatment and detention be subjected to different legal criteria because they do not promote the position that a person can be detained in a psychiatric facility without being treated there. They suggest that involuntary \textit{treatment} and \textit{detention} should be applied only to persons without capacity.\textsuperscript{20}

Several commentators have responded to the fusion proposal and have discussed the advantages and disadvantages of using legislation which revolves around an individual’s capacity to make decisions. This Chapter discusses these advantages and disadvantages in light of the \textit{CRPD} and the Australian mental health acts.\textsuperscript{21} Thus, the following section first outlines the relevant provisions of the

\begin{thebibliography}{9}
\bibitem{15} Ibid, 12.
\bibitem{18} Ibid, 14.
\bibitem{19} Ibid, 14.
\bibitem{20} Ibid, 13. With the exceptions named above.
\bibitem{21} The author does not address forensic matters in detail.
\end{thebibliography}
Australian mental health acts concerning an individual’s capacity to make decisions and informed consent to treatment.

9.3 Mental Health Acts: Capacity and Informed Consent

All Australian mental health acts address the requirement of informed consent. The Mental Health and Related Services Act 2009 (NT) requires the patient’s informed consent to treatment, unless the Act provides otherwise.\(^{22}\) The Act states that it aims to “establish provisions for obtaining informed consent and the authorisation of treatment”.\(^{23}\) In its Preliminary sections, the Act elaborates on how to obtain informed consent.\(^{24}\) It requires that the person is capable of understanding the effects of giving consent.\(^{25}\)

The Mental Health Act 1996 (Tas) also addresses consent to treatment within its Preliminary sections. The Act requires the person’s informed consent to medical treatment\(^{26}\) which must ensure, inter alia, that the person is capable of understanding the general nature and effect of the proposed treatment.\(^{27}\) The Act also provides for the relevant procedures for obtaining consent.\(^{28}\)

The general principles of the Mental Health Act 2000 (Qld) address the person’s role in making treatment decisions.\(^{29}\) They stress that persons with mental illness have equal human rights and dignity.\(^{30}\) They state that, inter alia, persons with mental illness should be encouraged to take part in treatment decisions.\(^{31}\) Also, their views\(^{32}\) and values\(^{33}\) should be taken into account and they should have support to exercise their rights, including help to represent their point of view.\(^{34}\) The Mental Health Act 2000 (Qld) also states that the person with

\(^{22}\) Mental Health and Related Services Act 2009 (NT), s 9(j).
\(^{23}\) Mental Health and Related Services Act 2009 (NT), s 3(d).
\(^{24}\) Mental Health and Related Services Act 2009 (NT), s 7.
\(^{25}\) Mental Health and Related Services Act 2009 (NT), s 7(2)(b).
\(^{26}\) Mental Health Act 1996 (Tas), ss 5AA. If the person is in an approved hospital, medical treatment requires the person’s informed consent or the consent of an authorised guardian (Section 31).
\(^{27}\) Mental Health Act 1996 (Tas), s 5AA(1)(a).
\(^{28}\) Mental Health Act 1996 (Tas), s 5AA(2).
\(^{29}\) Mental Health Act 2000 (Qld), s 8.
\(^{30}\) Mental Health Act 2000 (Qld), s 8(1)(a).
\(^{31}\) Mental Health Act 2000 (Qld), s 8(1)(b).
\(^{32}\) Mental Health Act 2000 (Qld), s 8(1)(b).
\(^{33}\) Mental Health Act 2000 (Qld), s 8(1)(g).
\(^{34}\) Mental Health Act 2000 (Qld), s 8(1)(c).
mental illness “is presumed to have the capacity to make decisions about the person’s assessment, treatment and choosing of an allied person”. The Act further regulates the person’s consent to treatment within its Part 3 which predominantly addresses the administration of electroconvulsive therapy and psychosurgery. It requires that the person must have capacity to give informed consent and provides for the relevant procedures for obtaining consent.

Thus, these Acts allow for the treatment of persons with mental illness who retain capacity, but when they address informed consent in their Preliminary sections, they stress that obtaining informed consent is important to the interpretation and application of the Acts.

The other mental health acts address informed consent predominantly in respect to specific kinds of mental health treatment, such as electroconvulsive therapy and psychosurgery. Most of these Acts provide for the relevant procedures for obtaining consent. When the mental health acts of Victoria and Western Australia require informed consent to specific kinds of mental health treatment, they state this at the beginning of these provisions. Their subsequent provisions allow for exceptions and regulate, for example, the administration of

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35 Mental Health Act 2000 (Qld), s 8(1)(b).
36 Mental Health Act 2000 (Qld), s 133.
37 Mental Health Act 2000 (Qld), s 134.
38 Mental Health Act 2000 (Qld), ss 135-137.
39 See Tables 11-18 below. The mental health acts of the Northern Territory and Queensland also regulate consent to specific kinds of mental health treatment (see Mental Health and Related Services Act 2009 (NT), Part 9, Mental Health Act 2000 (Qld), Chapter 4, Mental Health Act 2000 (Qld), Part 3.
40 Mental Health (Treatment and Care) Act 1994 (ACT), Part 7; Mental Health Act 2007 (NSW), Parts 2 and 3; Mental Health Act 2009 (SA), Part 7; Mental Health Act 1986 (Vic), Part 5; Mental Health Act 1996 (WA) ss 95 f. The MI Principles require additional safeguards to specific kinds of mental health treatment, see Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, GA Res 46/119, UN GAOR, 46th sess, 75th plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), Principle 11.
41 Mental Health (Treatment and Care) Act 1994 (ACT), s 54; Mental Health Act 2007 (NSW), s 91; Mental Health Act 1986 (Vic), s 53B; Mental Health Act 1996 (WA), ss 97 f. The Mental Health Act 1986 (Vic) regulates the requirement for obtaining informed consent predominantly in respect to psychosurgery and electroconvulsive therapy (Sections 53B, 73) as well as non-psychiatric treatment (Sections 83 ff).
42 The Mental Health Act 1996 (WA) regulates the patient’s informed consent to treatment decisions within Part 5 of the Act which predominantly addresses electroconvulsive therapy and psychosurgery.
43 Mental Health Act 1986 (Vic), s 53B; Mental Health Act 1996 (WA) ss 95 f. The Mental Health Act 2000 (Qld) takes a similar approach (Section 133).
non-consensual electroconvulsive therapy in emergencies. However, they first emphasise that informed consent is important for the interpretation and application of the subsequent provisions.

The mental health acts of the Australian Capital Territory, New South Wales and South Australia refer to informed consent in the details of their provisions. This difference in approach does not necessarily change the application of the mental health acts in practice because all acts follow a common rationale. However, the reading of the Mental Health (Treatment and Care) Act 1994 (ACT) and the Mental Health Act 2007 (NSW) contrasts with the reading of those Acts which address the requirement of informed consent in their principles. The provisions of the Mental Health (Treatment and Care) Act 1994 (ACT) and the Mental Health Act 2007 (NSW) are convoluted and difficult to understand. They emphasise procedures for ensuring that the correct authority consents to treatment and this requires a sophisticated understanding of the Acts. They require that other decision-makers who have the authority to consent to treatment must take into account whether the person who receives treatment has the capacity to consent to treatment. This is not a decisive consideration because it sits amongst other matters that must be taken into account.

In contrast to this, the Acts which address the informed consent of the person with mental illness in an overarching manner emphasise the value of consensual treatment. They also promote engaging with the persons with mental illness. In particular, the Mental Health Act 2000 (Qld) aims to engage with the patient when it states that the person should be encouraged to participate in making decisions, that the person is presumed to have capacity to make decisions

45 Mental Health Act 1986 (Vic), s 73(3); Mental Health Act 1996 (WA), ss 73(4), 113 ff.
46 Mental Health (Treatment and Care) Act 1994 (ACT), Part 7.
47 Mental Health Act 2007 (NSW), Parts 2 and 3. The Act addresses informed consent requirements in respect to electroconvulsive therapy (Section 91) and presumes a person to be incapable of giving consent to electroconvulsive therapy when the person is affected by medication which impairs the person’s ability to give consent (Section 92).
48 Mental Health Act 2009 (SA) addresses consent to treatment in respect to electroconvulsive therapy and neurosurgery (Part 7).
49 This does not mean that those who apply the Act consider it an unimportant consideration. For example, the Mental Health and Related Services Act 2009 (NT) states that persons with mental illness must be provided with appropriate and comprehensive information about their mental illness, the proposed and alternative treatment and services (Section 9(d)).
about his or her treatment and have his or her wishes taken into account.\textsuperscript{51}

However, the Australian mental health acts do not generally require the person’s incapacity to make decisions for the making of involuntary treatment orders.\textsuperscript{52} The \textit{Mental Health Act} 2009 (SA) does not require a capacity assessment. When the mental health acts of the Australian Capital Territory, New South Wales and the Northern Territory define mental illness they require an “impairment of mental functioning”,\textsuperscript{53} but they refer to the presence of symptoms which characterise the impairment of mental functioning. Thus, they do not require an impairment of capacity.\textsuperscript{54}

The \textit{Mental Health Act} 1996 (Tas) requires that a person has a “serious impairment or disturbance of capacity for rational thought”.\textsuperscript{55} Christopher Ryan comments that this phrasing is “the closest to decisional incapacity; however it cannot be regarded as congruent with it.”\textsuperscript{56} Also, the Tasmanian legislation defines mental illness broadly and the individual’s capacity for thought is not decisive.

When the \textit{Mental Health Act} 1996 (WA) requires that a person is impaired in “judgment or behaviour to a significant extent”,\textsuperscript{57} that person with mental illness can also be treated if he or she refuses treatment.\textsuperscript{58} Similarly, the \textit{Mental Health Act} 1986 (Vic) allows for the involuntary treatment of a mentally ill person if he or she is unable to consent or refuses necessary treatment.\textsuperscript{59} In Queensland\textsuperscript{60} and the Northern Territory\textsuperscript{61} a mentally ill person can be treated if he or she is unable to consent or \textit{unreasonably} refuses treatment.

\textsuperscript{51} \textit{Mental Health Act} 2000 (Qld), s 8(b). The \textit{Mental Health Act} 2000 (Qld) allows for exceptions to the requirement of informed consent under similar considerations as other Acts. For example \textit{Mental Health Act} 2000 (Qld), s 139 and \textit{Mental Health Act} 1986 (Vic), s 73(3); \textit{Mental Health Act} 1996 (WA), ss 73(4), 113 ff.
\textsuperscript{52} Most Acts require the consent of a mentally ill person who is capable of making treatment decisions in respect to specific kinds of mental health treatment which are particularly intrusive or irreversible.
\textsuperscript{53} \textit{Mental Health (Treatment and Care) Act} 1994 (ACT), s 3; \textit{Mental Health Act} 2007 (NSW), s 4; \textit{Mental Health and Related Services Act} 2009 (NT), s 4. See Tables 1-2 below.
\textsuperscript{54} See also, Christopher J Ryan, ‘Capacity as a Determinant of Non-consensual Treatment of the Mentally Ill in Australia’ (2011) 18(2) \textit{Psychiatry, Psychology and Law} 248, 250.
\textsuperscript{55} \textit{Mental Health Act} 1996 (Tas), s 4.
\textsuperscript{56} Christopher J Ryan, ‘Capacity as a Determinant of Non-consensual Treatment of the Mentally Ill in Australia’ (2011) 18(2) \textit{Psychiatry, Psychology and Law} 248, 250.
\textsuperscript{57} \textit{Mental Health Act} 1996 (WA), s 4.
\textsuperscript{58} \textit{Mental Health Act} 1996 (WA), s 26(1)(c).
\textsuperscript{59} \textit{Mental Health Act} 1986 (Vic), s 8(1)(d).
\textsuperscript{60} \textit{Mental Health Act} 2000 (Qld), s 14(1)(f).
\textsuperscript{61} \textit{Mental Health and Related Services Act} 2009 (NT), s 14(b)(iii).
Thus, the Australian mental health acts do not require an assessment of capacity for the making of involuntary treatment orders. Neil Rees has commented in this regard:

A person’s capacity, or lack of it, to consent to any interference with their liberty or freedom to choose medical treatment is not a primary consideration.

The following sections assess what conflicts arise with the CRPD when the mental health legislation is not capacity-based. They discuss the strengths of using capacity-based legislation in light of the fusion proposal and the CRPD.

9.4 The Advantages of the Fusion Proposal in Light of the Preamble and Articles 1 and 5

9.4.1 The Respect for Autonomy and Self-determination

First, the proposed uniform incapacity legislation has the advantage of paying “considerable respect” to the autonomy of persons with mental illness who retain their capacity. The principle of informed consent is closely linked to the respect for personal autonomy and a person’s self-determination, and the respect for

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autonomy is one of the most fundamental principles in bioethics.\textsuperscript{68}

The international human rights framework protects a person’s freedom from bodily intrusion in the sense that there is the fundamental principle that no-one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.\textsuperscript{69} Article 7 of the ICCPR and Article 15 of the CRPD expand this provision and require that “no one shall be subjected without his or her free consent to medical or scientific experimentation”. The Committee on Economic, Social and Cultural Rights considers that the right to health is interrelated to other human rights,\textsuperscript{70} in particular the freedom from torture or to cruel, inhuman or degrading treatment or punishment. The Committee has emphasised that an individual’s freedom from torture and cruel, inhuman or degrading treatment or punishment includes the individual’s right to control his or her health and body and the right to freedom from non-consensual medical treatment and experimentation.\textsuperscript{71} In 2008, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment emphasised that medical treatment “may constitute torture and ill-treatment if enforced or administered without the free and informed consent of the person concerned”.\textsuperscript{72} These comments indicate that the United Nations has increasingly recognised the need for increased protection from non-consensual treatment in such environments,\textsuperscript{73} which has led some to argue that psychiatric treatment without consent constitutes

\textsuperscript{68} Tom L Beauchamp and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 5th ed, New York, 2001).
\textsuperscript{69} See sections 2.1.2.3 and 8.5.3 above.
\textsuperscript{71} Ibid para 8. Emphasis added.
\textsuperscript{72} Manfred Nowak, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment, 63\textsuperscript{rd} sess, UN Doc A/63/175 (28 July 2008) para 47. See also paragraphs 38 and 63. The European human rights scheme recognises the risk of using or withholding medical treatment as a means of torture and inhuman or degrading treatment when individuals live in an environment of compulsion or seclusion. See Elizabeth Wicks, 'The Right to Refuse Medical Treatment under the European Convention on Human Rights' (2001) 9 Medical Law Review 17; Peter Bartlett, "The Necessity Must Be Convincingly Shown to Exist": Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983’ (2011) 19(4) Medical Law Review 1.
torture.\textsuperscript{74}

The Australian mental health acts conflict with the aims of the CRPD in respect to the right to freedom from non-consensual treatment. The Mental Health and Related Services Act 2009 (NT) and the Mental Health Act 2000 (Qld) stand out as the most capacity-based mental health acts. They aim to respect persons with mental illness in viewing them as drivers of their own treatment.\textsuperscript{75} However, both Acts allow for the overriding of the person’s decision if the individual \textit{unreasonably} refuses treatment. Chapter Three pointed out that the question whether or not mentally ill persons who are capable of making treatment decisions should be treated against their will if they \textit{unreasonably} refuse treatment has been subject to international debate.\textsuperscript{76} However, a discussion of this debate is obsolete because Chapter Five pointed out that the CRPD protects the equality of persons with disabilities, their abilities and preferences to an unprecedented degree.\textsuperscript{77} The CRPD responds to the idea that persons with psychosocial disabilities should be subject to a different legal regime which allows for overriding their competent refusal because of their disabilities. This idea conflicts with the paradigm shift of the CRPD, regardless of the question whether the refusal was \textit{unreasonable}.

In general health care settings, contemporary medicine values autonomy to the effect that informed consent to treatment is central to health care provision,\textsuperscript{78} despite the various difficulties of obtaining informed consent in practice.\textsuperscript{79} Health care professionals who fail to obtain informed consent can be held accountable in


\textsuperscript{75}As expressed in their purposes and objectives, see section 8.2 above.

\textsuperscript{76}See the discussion on the Principle 11 of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, GA Res 46/119, UN GAOR, 46\textsuperscript{th} sess, 75\textsuperscript{th} plen mtg, Supp No 49, UN Doc A/Res/46/119 (17 December 1991), section 3.4.2 above.

\textsuperscript{77}See sections 5.2 and 5.2.2.4 above.


civil and criminal proceedings or face disciplinary actions.\textsuperscript{80} Bernadette Richards states that if a patient has the requisite understanding of the nature and effect of the treatment (or withholding or withdrawing treatment), then the principle of autonomy will prevail. The law in this area is in fact clear; all competent adults can choose what is or is not to be done, to their bodies.\textsuperscript{81}

She concludes that a refusal of treatment is the “corollary of the expectation that patients must consent to all medical treatment”\textsuperscript{82} and stresses that the process of refusing treatment is decisive, rather than the outcome of that refusal.\textsuperscript{83} Thus, when persons with psychosocial disabilities refuse treatment, respect for their decisions should be subject to the question whether or not they are capable of refusing treatment.

All Australian mental health acts allow for the treatment of persons with mental illness despite a competent refusal of treatment.\textsuperscript{84} They use the fact that a person refused treatment as an alternative to the person’s incapacity to give consent. Thus, by law, the person’s refusal of treatment is decisive, regardless as to whether the person is capable of making treatment decisions. This applies in particular to those Australian mental health acts which do not require that a person unreasonably refuses treatment, but apply to any refusal of treatment. These Acts conflict with both the MI Principles and the CRPD, while the fusion proposal could achieve compliance with the CRPD.

Also, respect for a person’s autonomy is lowered when the mental health acts do not leave a real choice, but operate under the threat of compulsion. Philip Fennell points out that “[a] person may consent to treatment or to remain in

\textsuperscript{80} See Andrew Hockton, \textit{The Law of Consent to Medical Treatment} (Sweet & Maxwell Ltd, London, 2002), 17 ff.

\textsuperscript{81} Bernadette Richards, ‘General Principles of Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), \textit{Health Law in Australia} (Lawbook Co, Sydney, 2010) 93, 104.

\textsuperscript{82} Ibid, 104.

\textsuperscript{83} Ibid, 104.

\textsuperscript{84} \textit{Mental Health Act} 1996 (WA), s 26(1)(c); \textit{Mental Health Act} 1986 (Vic), s 8(1)(d).
hospital if they know that they will be compelled in the event of refusal.”

He argues that “[c]ompliance in the shadow of compulsion is an important feature of the psychiatric system.”

The _CRPD_ was a response to the fact that wide-ranging prejudice into an individual’s need for treatment has allowed for substantial interferences with the rights of persons with disabilities. The _CRPD_ respects persons with psychosocial disabilities as agents of their rights. Thus, it requires States Parties to ensure that persons with psychosocial disabilities are the drivers behind the decisions relating to their treatment. This requires that they have options and equal respect for their choices, in particular when they are capable of making treatment decisions. The development of the _CRPD_ was also a response to the fact that persons with disabilities who are capable of making decisions concerning their treatment have been treated for their own welfare to overcome their disability.

The _CRPD_ has taken into account that this happened systematically because laws allowed for others to decide on behalf of persons with disabilities. Most mental health acts do not revolve around the consent of the person with mental illness. Those Acts which call for respect to be given to a person’s consent do not sufficiently translate that aim into the substantive provisions concerning involuntary orders. Thus, they conflict with the _CRPD_, while uniform incapacity legislation would comply with the _CRPD_ when it respects persons with psychosocial disabilities as equal agents of their rights when they are capable of making treatment decisions.

### 9.4.2 Equally Applicable and Objective Standards of Assessment

Second, uniform incapacity legislation has the advantage of bringing "mental health law in line with the principles followed in other branches of health care.

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87 See sections 4.4.1 and 5.1.2 above.
88 See sections 3.3 and 5.1.5 above.
89 See sections 4.4.1, 5.1.2 and 5.1.5 above.
90 See section 3.6.1.1 above.
Szmukler, Daw and Dawson argue that their fusion proposal ensures that involuntary orders apply on equally applicable criteria, rather than categorical differentiation. Capacity assessments can apply regardless as to whether the person is affected by physical illness, mental illness, shock, age, confusion or the like. Thus, uniform incapacity legislation “would be respectful of the principle of non-discrimination” because persons with psychosocial disabilities would be subjected to equal standards of assessment.

Dawson and Szmukler also argue that capacity assessments are objective and involve clinically reliable considerations. They have based their fusion proposal on the *Mental Capacity Act 2005* for England and Wales. Genevra Richardson has pointed out that the clinical assessment of capacity in the *Mental Capacity Act 2005* for England and Wales “closely resembles the tests for capacity refined from US case law”. She has stated that these tests are based on the MacArthur Competency Assessment Tool for Treatment (MacCAT-T).

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Richardson has analysed the use of capacity-assessment tools and has concluded that “research has indicated that the use of established assessment tools can achieve high levels of inter-rater consistency in the clinical assessment of capacity.” Similarly, Scott Kim confirms this view when he states that “[c]apacity is a reasonably objectively defined threshold, likely to achieve high reliability and durability.”

Thus, the difficulty of defining mental illness, its effect on the person’s judgment or behaviour and assessing risks would be replaced with a criterion that is well defined, reliable and applicable on an equal basis to all people.

Uniform incapacity legislation would address the contrast between autonomous decision-making in general health care and beneficial decision-making in mental health care. This approach could ensure that decision-making in mental health care places more emphasis on autonomy. It would also ensure that persons with mental illness who have capacity to make treatment decisions have the same “right to refuse any form of medical intervention, however grave the personal consequences of doing so” as other persons who are capable of refusing consent.

At the same time, this approach could also ensure that decision-making in general health care places more emphasis on beneficence. Anthony Holland

100 Tom Burns, ‘Mental Illness is Different and Ignoring its Differences Profits Nobody’ (2010) 34 Journal of Mental Health Law - Special Issue 34, 39.
101 However, Mary Donnelly addresses concerns about using clinical tools for assessing as a legal standard for capacity in Mary Donnelly, Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism (Cambridge University Press, Cambridge, 2010), 171 ff. She considers that the MacCAT-T are “not intended to provide hard and fast answers”, while the law requires such answers (at 173). She argues that “while recognising the possible contribution of a legally sensitive capacity testing mechanism, it must also be remembered that such a mechanism can only be effective as part of a larger effort to address the difficulties to which capacity assessments give rise.” (at 173). The fusion model could amend the use of the MacCAT-T as differentiator in law.
states that:

The need for an option of non-consensual treatment for a physical illness is also apparent, such as in the case of unconsciousness where, for example, treatments without consent for diabetic coma or cerebral haemorrhage are likely to be life-saving.\(^{103}\)

Thus, uniform incapacity legislation could ensure the comprehensive re-evaluation of non-consensual treatment and could foster equal consequences of choice.

The Australian mental health acts allow for applying involuntary orders to persons with mental illness on grounds that can be applied subjectively.\(^{104}\) Only the *Mental Health Act 2000* (Qld)\(^{105}\) complies with the recommendations of the pre-existing human rights standard to ensure that interventions apply restrictively. But all Acts rely on subjective grounds to determine whether or not a person needs treatment and allow for coercive responses to ensure appropriate medical treatment.\(^{106}\) They exemplify the contrast between the respect for autonomous decision-making in general health care settings and beneficial decision-making in mental health care settings which the *CRPD* aims to alleviate.

### 9.4.3 Measures against Prejudice

Third, uniform incapacity legislation has the advantage that it can delink psychosocial disability from stigmatising connotations and thus reduce “sanism”.\(^{107}\) When Michael Perlin identified sanism\(^{108}\) in mental disability law, he stressed that the irrational prejudice against persons with mental disabilities can affect all participants in the mental disability service sector, including “litigants, fact finders, ...

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\(^{103}\) Anthony Holland, 'The Model Law of Szmukler, Dawson and Daw - The Next Stage of a Long Campaign?' (2010) 34 *Journal of Mental Health Law - Special Issue* 63, 63

\(^{104}\) See section 8.4.2.3 above.

\(^{105}\) *Mental Health Act 2000* (Qld), s 12(4).

\(^{106}\) See section 8.4.2.3 above.


\(^{108}\) Michael Perlin uses the term 'sanism' to express “an irrational prejudice of the same quality and character of other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia or ethnic bigotry”. Michael L Perlin, "'You Have Discussed Lepers and Crooks': Sanism in Clinical Teaching' (2003) 9(2) *Clinical Law Review* 683, 684.
counsel, expert and lay witnesses”. He considers that irrational prejudice results in pretextual decision-making which accepts prejudice based on mental disability. He argues that sanism and pretextuality also affect the questions of the perceived competency and incompetency of persons with mental disabilities. Uniform incapacity legislation could reduce the risk of sanist and pretextual decision-making when it gives “greater legal weight to the frequently expressed notion that mental illness and loss of capacity are not synonymous”. The World Health Organisation has pointed out that separate mental health legislation emphasises segregation which has the potential of reinforcing stigmatisation and prejudice against persons with mental illness.

The Mental Health (Treatment and Care) Act 1994 (ACT) exemplifies that Australian mental health care reflects a different mindset to that of the World Health Organisation. The recent review of the Act has extended the powers of mental health legislation to those who cannot be treated. During the Act’s review process, consumer advocates and provider representatives argued that the inclusion of mental dysfunction has “no place in contemporary mental health law”. However, the review considered that the term mental dysfunction is “useful and very clear” and that it is necessary to include it in mental health legislation because current disability legislation does not allow for the coerced treatment of persons with intellectual disabilities. This view reinforces the connotation that mental health legislation revolves around the use of compulsion that other laws cannot justify.

The CRPD protects persons with psychosocial disabilities from attitudinal barriers to their human rights realisation. The CRPD protects them from presumptions which assume that they have inherent deficiencies when they live

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110 Ibid, 161.
113 Ibid, 7.
115 Ibid, 14.
116 Ibid, 14.
117 See section 5.1.2 above.
with mental illness and that they need to be protected from detrimental behaviour. The CRPD combats such attitudinal barriers to an unprecedented degree because it requires States Parties not only to change laws and practices which have a detrimental effect on the human rights realisation of persons with disabilities. Rather, the CRPD requires States Parties to become proactive towards promoting attitudinal changes in society. The uniform incapacity legislation would send a strong political message to society and combat presumptions concerning the abilities of persons with psychosocial disabilities.

9.4.4 No Best Interest Considerations as Defined by Others

Fourth, the uniform incapacity legislation can guide the decision-making processes on persons who lack capacity to ensure their best interests from their point of view. Mary Donnelly argues that:

Best interests is inherently an elusive, and, in some ways, unsatisfactory concept. She has argued that a more sophisticated understanding of best interests considerations can ensure patient participation which recognises the contributions of the person who lacks capacity. Thus, best interest considerations can be applied to include the person’s past wishes, beliefs and values. Such a sophisticated understanding of the best interests standard could be incorporated into uniform incapacity legislation to guide decision-making concerning persons who lack capacity.

The CRPD has refrained from referring to best interests considerations for persons with psychosocial disabilities. Similar to Mary Donnelly’s concern about

118 See section 5.1.2 above.
119 See section 4.4.2 above which addressed Article 8 (awareness-raising) of the CRPD.
121 Ibid, 11.
122 Ibid, 21.
124 See section 5.4 above which addressed the suggested amendments to Article 17 of the CRPD that were dropped.
the potential vagueness of best interest considerations, the CRPD seems to take a precautionous approach towards best interests considerations. The CRPD has responded to the experience of persons with disabilities who claimed that persons without disabilities valued their lives through ideas of medicine and aimed to correct their disabilities towards achieving a 'normal' and integrated life.\textsuperscript{125} The CRPD considers that welfare considerations have had a disabling effect on the lives of persons with disabilities when they were not interpreted subjectively from their point of view.\textsuperscript{126} Thus, the CRPD has refrained from adopting terminology that could revive such an interpretation.\textsuperscript{127}

Chapter Eight argued that the Australian mental health acts tend to guide treatment decisions to focus on the necessity for treatment.\textsuperscript{128} Some Acts stress the need to work with the mentally ill person in order to ensure his or her wishes.\textsuperscript{129} In particular the Mental Health Act 2000 (Qld) stands out for ensuring the participation, wishes and values of persons with mental illness.\textsuperscript{130} These considerations guide the decision-maker on treatment to ensure that the decision-making process revolves around what the person would have wanted if he or she was competent to make treatment decisions. However these are considerations which may or may not be taken into account, while the provisions on involuntary treatment require the decision-maker to assess whether treatment is necessary.\textsuperscript{131} Len Doyal argues that best interests considerations in mental health legislation focus on rationalising whether or not interventions are necessary. He states that:

The argument that the psychiatrist wishes to act in the best interests of such patients has little relevance; so does the accident and emergency consultant. It is also of no use to argue that the psychiatrist is uniquely concerned to protect the interests of others; similar arguments apply to the doctor presented with a patient who has just

\textsuperscript{125} See sections 3.2 and 4.4.1 above.
\textsuperscript{126} This would include medical considerations, but extend to other considerations.
\textsuperscript{128} See section 8.2.2.2 above.
\textsuperscript{129} See section 8.3.2 above.
\textsuperscript{130} See section 9.1.2 above.
\textsuperscript{131} See section 8.4 below.
converted to the Jehovah's Witnesses and whose dependent family begs him to ignore the patient's wishes.\textsuperscript{132}

Chapter Eight posited that it is not difficult to argue that interventions are justified when mental health legislation guides those who apply the legislation to ensure necessary treatment.\textsuperscript{133} It argued that the \textit{Mental Health Act} 1996 (WA) exemplifies the concern that mental health acts can be applied broadly in order to avoid a wide range of harm, while they initially appear to apply restrictively. The \textit{Mental Health Act} 1996 (WA) adopts a high threshold of impairment and a low threshold of harm. It is difficult to justify why a decision-maker would not authorise an intervention, if the Act guides the decision-maker to prevent persons from self-inflicted harm. Thus, the decision-maker does not need to take a precautious approach towards intervention. This applies in particular when the mental health act allows for interpreting mental illness broadly, if necessary. Thus, the \textit{Mental Health Act} 1996 (WA) shows that mental health acts need to be explicit in guiding the decision-maker as to how to interpret and apply best interest considerations, if they aim to achieve a balance to medical interests.

The fusion proposal does not aim to take a protective stance towards ensuring necessary treatment because it does not require the decision-maker to ensure the best interests of the individual from a medical point of view.\textsuperscript{134} Rather, when uniform incapacity legislation revolves around the individual's capacities, the legislation encourages the decision-maker to consider what that individual wants, or would have wanted, and the proposed model defines 'best interests' from the patient’s point of view.\textsuperscript{135}

\begin{thebibliography}{10}
\bibitem{132} Len Doyal and Julian Sheather, 'Mental Health Legislation Should Respect Decision Making Capacity' (2005) 331 \textit{British Medical Journal} 1467, 1468.
\bibitem{133} See section 8.3.2.2 above.
\bibitem{134} George Szmukler, Rowena Daw and John Dawson, 'A Model Fusing Incapacity and Mental Health Legislation' (2010) \textit{Journal of Mental Health Law - Special Issue} 11, 16.
\end{thebibliography}
9.5 The Advantages of the Fusion Proposal in Light of Article 12

9.5.1 The Presumption of Legal Capacity

Fifth, the fusion proposal has the advantage of ensuring compliance with Article 12 of the CRPD because uniform incapacity legislation presumes that persons with mental illness have legal capacity. Fistein and colleagues have stated that “empirical studies indicate that the majority of psychiatric in-patients are capable of making treatment decisions”.136 David Okai and colleagues have stated that “[m]ental capacity can be reliably assessed”137 and “most psychiatric in-patients are capable of making key treatment decisions”.138 They state that:

Studies that used a standardised assessment reported very higher interrater reliabilities, with a median kappa of 0.81. Despite capacity being a complex, value-laden, multidimensional construct, this finding suggests that it can be assessed with greater reliability than cardiologists interpreting exercise electrocardiograms, radiologists interpreting mammograms or haematologists reading peripheral blood films [ref].139

Mental health laws which do not adopt capacity assessments conflict with the CRPD because they run the risk of presuming that persons with psychosocial disabilities are incapable of making treatment decisions. In Australia, only the Mental Health Act 2000 (Qld) states that a person with mental illness is presumed capable of making treatment decisions.140

Mary Donnelly, Oliver Lewis and Peter Bartlett stress that legal capacity

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139 Ibid, 295.
140 Sees section 9.1.2 above.
serves as a ‘gatekeeper’ of autonomy and other rights. Scott Kim states that “a patient’s right to refuse treatment is about as close to absolute as anything ever gets in law”.

Article 12 reflects this idea when it protects the legal capacity of persons with disabilities as an aspect of the individual’s equal recognition before the law. Thus, the presumption of capacity serves to ensure that persons with psychosocial disabilities are recognised as subjects of rights and have equal opportunities to exercise their rights.

Uniform incapacity legislation complies with the CRPD when it presumes that persons with psychosocial disabilities are capable of making decisions on their treatment. Even if the person is not capable of making treatment decisions, the fusion model aims at ongoing engagement with the person who is incapable of making treatment decisions. Thus, it fosters the inclusion of persons with psychosocial disabilities in all decision-making that affects them. Anthony Holland states that uniform incapacity legislation thus promotes “choice and inclusion”. The Australian mental health acts tend not to follow the same approach. Penelope Weller argues that:

By defining people who are subject to mental health legislation as incapable of consenting to medical treatment, the legislation encourages a culture of exclusion and non-participation.

Considering that the CRPD protects the human rights of persons with disabilities under the umbrella of their social inclusion and the protection of their inherent human dignity, the suggestion to fuse mental health legislation into universally

146 See, however, Mental Health Act 2000 (Qld), s 8.
148 See sections 4.1 and 5.1 above.
applicable capacity-based legislation complies with the CRPD.

9.5.2 Task Related Capacity Assessments

Second, uniform incapacity legislation has the advantage of ensuring that persons with psychosocial disabilities have equal opportunities to exercise their rights. Scott Kim points out that “cognitive or psychiatric symptoms or diagnoses are relevant to capacity because they may impair the patient’s functional abilities to make a decision; but they do not define legal incompetence”. The fusion proposal considers that a person who is not capable of making treatment decisions may still be capable of exercising other rights. Anthony O’Brien thus argues that:

A capacity standard might also signal to mental health professionals that capacity should be considered situational, rather than an all or nothing determination.

The Mental Health Act 2000 (Qld) which stands out for presuming that a mentally ill person is capable of making treatment decisions, follows this approach. If the person is not capable of making treatment decisions, the Act still calls for an assessment as to whether or not the person is capable of choosing a support person or participating in treatment decisions. However, most other mental health acts assume that people with mental illness “not only lack the capacity to make decisions, but lack the capacity to contribute to the decision-making process”. Several commentators on the fusion proposal argue that task related

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149 Scott Y H Kim, Evaluation of Capacity to Consent to Treatment and Research (Oxford University Press, Oxford & New York, 2010), 34.
152 Mental Health Act 2000 (Qld), s (8)(1)(b).
capacity assessments are difficult and cumbersome to assess.\textsuperscript{154} Derek Chiswick states that this applies in particular when “capacity is a fluctuating commodity”\textsuperscript{155} and incurs repeated capacity assessment.\textsuperscript{156} Alec Buchanan also points out that persons who have fluctuating states of capacity run the risk of not receiving a sustained course of treatment.\textsuperscript{157} Thus, they argue that uniform incapacity legislation runs the risk of resulting in inconsistencies and delays in the treatment of persons with mental illness.

However, Szmukler, Daw and Dawson argue that uniform incapacity legislation allows for early responses because the fusion model regulates emergency treatment on the ‘reasonable belief’ that the patient lacks capacity.\textsuperscript{158} This emergency response takes the patient into a “place of safety”.\textsuperscript{159} Thus, they claim that their model legislation is responsive without delay to ensure that further evaluation can take place\textsuperscript{160} in order to assess how to respond best to the individual with mental illness. They also argue that recovery is generally progressive\textsuperscript{161} and propose that treatment responses would recognise that the individual’s capacity needs to be restored with stability.\textsuperscript{162}

Chapter Five argued that the \textit{CRPD} protects the equality and non-discrimination of persons with psychosocial disabilities to an unprecedented degree in order to ensure that persons with disabilities are respected as subjects of rights.\textsuperscript{163} Article 12 substantiates this idea when it protects the person’s equal


\textsuperscript{155} Derek Chiswick, ‘Commentary: Test of Capacity has Little Practical Benefit’ (2005) 331 \textit{British Medical Journal} 1469, 1469.

\textsuperscript{156} Ibid, 1469.


\textsuperscript{159} Ibid, 92.

\textsuperscript{160} Ibid, 92, with further references.

\textsuperscript{161} Ibid, 92.

\textsuperscript{162} See section 5.1.5 above.
recognition before the law and provides that legal capacity is vital to any realisation of rights. It guarantees that persons with disabilities have the right to possess and exercise legal capacity. Chapter Five also argued that Article 12 represents an unambiguous move away from a legal presumption of incapacity to ensure that persons with disabilities are respected as subjects of rights.

Thus, the CRPD implies that difficulties in task related capacity assessments do not justify lowering the standards for differentiation. Rather, the ‘hidden’ effect of finding a person incapable of making treatment decisions would run the risk of resorting back to the medical model of disability and excluding persons with psychosocial disabilities from exercising their rights because of assumptions concerning the debilitating effect of their mental illness.

9.6 Concluding Thoughts

This Chapter argues that the fusion proposal reflects some of the important aims of the CRPD. The uniform incapacity legislation subjects persons with psychosocial disabilities to the same standards of differentiation that apply to those who do not have disabilities. Thus, the fusion proposal delinks disability from the connotation that disability comes with inherent deficiencies or needs and ensures standards of assessment that apply with equal reliability and an equal level of scrutiny as to whether or not interventions are justified. Thus, the proposed uniform incapacity legislation applies interventions on more objective and reliable grounds than mental health legislation that is based on the twin criteria of mental illness and harm to others or self-harm. It fosters the social inclusion of persons with psychosocial disabilities, presumes them to be subjects of rights who are capable of exercising the various aspects of their rights and aims to ensure their best interests from their point of view, when they are not capable of exercising some of their rights. These aims are crucial to realising the ‘paradigm shift’ of the CRPD.

The Mental Health Act 2000 (Qld) shows that it is possible to incorporate

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164 See section 5.2 above.
165 See section 5.2 above.
166 See section 5.2.1 above.
167 See sections 1 and 4.4.1 above.
respect for an individual’s capacity to make decisions into mental health legislation. However, the Act allows for the overriding of the individual’s informed consent, if that individual unreasonably refuses treatment. This Chapter argues that ensuring the ‘paradigm’ shift of the CRPD within established models of mental health legislation poses significant challenges to legislative reform. It argues that the vision of the CRPD is so complex that it requires completely rewriting existing legislation, rather than amending it. Much of the criticism against the current provisions in the respective mental health acts has focused on identifying inconsistencies and vague formulations within the Acts. Adopting uniform incapacity legislation could present an opportunity to overhaul current legislation.

9.7 The Disadvantages of the Fusion Proposal in Light of the CRPD

Despite the advantages listed above, several commentators on the fusion proposal argue that uniform incapacity legislation poses risks to the human rights protection of persons with psychosocial disabilities. They have identified the following disadvantages of the fusion proposal.

9.7.1 Substantive Legislative Change

First, the proposed uniform incapacity legislation has the disadvantage of requiring substantial legislative change. The World Health Organisation has pointed out that amending mental health legislation is easier and less resource-intensive than setting up a new legislative regime.\(^\text{168}\) Neil Rees comments that in England and Wales, recent attempts to fuse existing legislation have been complicated and have resulted “in cumbersome processes”.\(^\text{169}\) Christopher Ryan has discussed the difficulties of setting up a legislative regime which revolves around the individual’s capacity. He states that:

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Debate is more about how capacity should become an arbiter of non-consensual treatment than it is about whether it should be.170

All Australian mental health acts have been reviewed recently or are under review. Significant changes within some jurisdictions may result in further inconsistencies within the laws of the States and Territories. In the absence of experiences with transforming legislative models, new legislation could also result in shortcomings to the protection of the human rights of persons with psychosocial disabilities. Paul Appelbaum argues that the “work that would be involved in that effort [of fusing legislation] might better be put to use improving each distinct body of law.”171 Considering that mental health services in Australia have been underfunded,172 Appelbaum presents a strong argument to upholding current mental health laws.

However, the CRPD requires States Parties to become proactive and progressively to realise the human rights of persons with psychosocial disabilities.173 The concept of progressive realisation allows for prioritising which steps towards human rights realisation need to be taken first, when the States Parties have limited resources available to bring about change. Thus, taking reform off the agenda because the States Parties are currently not ready for change conflicts with the CRPD because the CRPD requires States Parties to work continuously, expeditiously and effectively towards realising human rights.174

9.7.2 Lack of Political Will and Public Support

Second, some commentators on the fusion proposal have argued that uniform incapacity legislation would not be accepted by the general public and policymakers. Paul Appelbaum states that

170 Christopher J Ryan, ‘Capacity as a Determinant of Non-consensual Treatment of the Mentally Ill in Australia’ (2011) 18(2) Psychiatry, Psychology and Law 248, 249.
172 See section 6.2.2 above.
173 See section 1.4.1 above.
efforts to persuade the public that, as a group, people with mental disorders present only a small elevation in the risk of violence – and that often due to substance abuse – largely have been unsuccessful.\textsuperscript{175}

Neil Rees also stresses that substantial legislative change requires community acceptance.\textsuperscript{176} However, the \textit{CRPD} requires States Parties to change community perceptions about disability.\textsuperscript{177} A change in legislation could facilitate more positive views towards persons with psychosocial disabilities when the legislation delinks psychosocial disability from the connotation that mental health care revolves around dealing with dangerous people who need to be treated under the threat of compulsion. The \textit{CRPD} requires States Parties to become proactive towards changing public attitudes which assume that persons with disabilities are subjects of welfare\textsuperscript{178} who need others to decide on their medical care and treatment.\textsuperscript{179} Oliver Lewis has stressed that the \textit{CRPD} incorporates measurable targets into its text in order to ensure that the \textit{CRPD} “moves from talking to doing”.\textsuperscript{180} The Committee on the Rights of Persons with Disabilities indicates that it measures States Parties compliance rigorously\textsuperscript{181} and persons with disabilities who need to be consulted in law and policy reform are placed in a position to become vocal about substantial change and challenge current practice.\textsuperscript{182} Thus, at least in the long-term, uniform incapacity legislation should be kept on the agenda of States Parties.

\textbf{9.7.3 The Need for Risk-related Responses}

\textsuperscript{177} See in particular Article 8 of the \textit{CRPD}.
\textsuperscript{178} See section 3.6.1.1 above.
\textsuperscript{179} See sections 1, 4.3, 4.4.1 and 4.4.2 above. In particular Article 8 of the \textit{CRPD} requires States Parties to respond to existing attitudinal barriers to the human rights realisation of persons with disabilities.
\textsuperscript{181} See section 8.4.3.1 above
\textsuperscript{182} See section 4.3 and 4.4.3 above.
Third, several commentators on the fusion proposal are of the view that uniform incapacity legislation has the disadvantage of disregarding the fact that mental health treatment is different to treatment in general health care settings.\textsuperscript{183} Kris Gledhill has responded to the fusion proposal and agrees that “there are well-established bases for preventive detention based on the risk of harm to others arising from physical disorders.”\textsuperscript{184} However, he states that:

Whilst it is important to undermine any prejudiced view that mental disorder is to be equated with danger to the public, it must also be accepted that there are a number of instances where such a risk does arise.\textsuperscript{185}

He argues that

there is nothing inherently discriminatory about making mental disorder the feature on the basis of which preventive action is taken: what is needed is the existence of an appropriate level of risk, whatever the basis for the intervention, so as to avoid any intervention being disproportionate, and an equivalence of risk in different settings so as to avoid discrimination.\textsuperscript{186}

In response to this criticism, Szmukler, Daw and Dawson argue that responses to dangerous behaviour can, and thus should be, delinked from mental illness. They argue that mental health legislation perpetuates a systematically different service response because of its focus on risk assessments.\textsuperscript{187} Chapter Eight argued that there are problems with mental health acts referring to the risk of

\begin{footnotes}
\item[185] Ibid, 51.
\item[186] Ibid, 52.
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self-harm and harm to others interchangeably. Assessing the risk of self-harm is predominantly based on subjective clinical judgment which can be unreliable, whereas assessing the risk of harm to others can now be aided by the use of risk assessment tools.

Uniform incapacity legislation can be designed to differentiate between the two considerations of harm to others and self-harm and subject them to different legal standards of assessment. It can also set up an early response regime for those who show clinically recognised symptoms and behaviour which indicate that an individual needs access to treatment or a safe environment. Such provisions are able to take a more differentiated approach to risk than current mental health act provisions. The development of the CRPD can be viewed as a response to the experience of persons with disabilities that mental health laws have been unaccommodating, despite those applying interventions acting in what they perceived to be the “best interests” of the individual concerned.

9.7.4 Need for Protection and Oversight

Fourth, in response to the fusion proposal, Neil Rees raises the concern that mental health legislation serve as a special measure for protecting rights,188 in particular in relation to ensuring the control of, and accountability for, substituted decision-making. Anthony Holland states that mental health legislation revolves around the tension “between empowerment and protection”.189 Kris Gledhill discusses the role of the mental health tribunal in this conflict as a substantive and independent review body which looks into the future of the patient and which upholds the proportionality of interventions.190 Michael Perlin argues that “therapeutic jurisprudence”191 in mental health law has advanced as a means of

realising the rights of the CRPD “as a strategy for uprooting sanism and pretextuality, by illuminating the importance of voice, validation, and voluntariness”.\textsuperscript{192} Thus, there is room to argue that there have been substantial improvements to mental health legislation which serve to protect the rights of persons with mental illness which could be lost if mental health legislation is abolished.

However, uniform incapacity legislation is based on two legislative schemes which currently exist in practice. Thus, existing legal mechanisms and the ideas of therapeutic jurisprudence can be adjusted and incorporated into the proposed uniform incapacity legislation. Specialist tribunals can be retained or merged with guardianship tribunals because they would still play a role in overseeing measures of support or non-consensual interventions. However, the proposed uniform incapacity legislation could overhaul their decision-making process in light of the CRPD and the current thinking about the justifications for involuntary orders.

This approach could also alleviate the need for others protecting the rights of persons with disabilities, and instead establish measures of support. Neil Rees has observed that guardianship laws which are not driven by the connotation that service responses revolve around dealing with coerced interventions on people who are at risk of harming others or themselves do not need to apply as restrictively as current mental health laws. Rather, Rees has stated that in practice guardianship laws apply on a more informal basis because they aim to work with the person with disability.\textsuperscript{193} In a similar way, the proposed uniform incapacity legislation could allow for flexibility in responding to a person’s incapacity through targeted measures of support and the use of advocates who are not substitute decision-makers.\textsuperscript{194}

Anthony Holland suggests that (any) legislation is defensible if it provides

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“robust and efficient means of challenge.”195 He argues that uniform incapacity legislation must allow for flexibility “to enable substitute decision-making under very different circumstances.”196 He argues that:

The balance to be achieved, particularly with respect to health decisions, is to ensure action can be taken when needed and that it is in the individual’s best interests, on the one hand, and on the other, that there are safeguards and the means of challenge that are practicable, affordable, and accessible.197

However, considering that the Committee on the Rights of Persons with Disabilities has become vocal about requiring States Parties to abolish legislation which authorises the detention of persons with mental illness,198 the fusion proposal presents a suitable starting premise to consider alternative responses to persons with mental illness which delink responses from mental illness and reflect the human rights standard of the CRPD. The fusion proposal aligns mental health legislation closer to guardianship legislation which has developed models for supporting persons who experience difficulties in decision-making that could be applied in mental health settings.

9.7.5 The Increased Use of Compulsion and Formality

Fifth, Jacqueline Atkinson and Hilary Patrick argue that the proposed uniform incapacity legislation will not reduce stigma and discrimination, but will extend interventions to a larger group of persons.199 Similarly, Tom Burns argues that the fusion proposal will result in increased compulsion.200 Paul Appelbaum has stated that people in the general health sector who are often taken care of by family members would experience a complicated and extended decision-making

196 Ibid, 67.
197 Ibid, 68.
198 See section 8.4.3.1 above.
200 Tom Burns, 'Mental Illness is Different and Ignoring its Differences Profits Nobody' (2010) 34 Journal of Mental Health Law - Special Issue 34, 39.
process. He is concerned that “[t]he proposal is likely to complicate and extend the decision-making process at the most difficult period for family members, to no apparent gain.”

However, when Szmukler, Daw and Dawson focus on a person’s incapacity as the primary differentiator, they do not propose using their legislative scheme as the primary mental health services response which aims to ensure that persons with mental illness have access to mental health treatment only if they are incapable of making treatment decisions. Their model rests on the premise that alternative responses exist. Uniform incapacity legislation aims not to override a person’s choice and provides a framework for responding to the individual in light of that person’s skills. Thus, it limits the possibility of interpreting the legislation to the effect that intervention can be applied broadly. Chapter Eight argued that mental health laws which further the idea that mental health services revolve around the use of coercion perpetuate the substantial inequality of persons with mental illness. Szmukler, Daw and Dawson’s approach reflects the aims of the CRPD which requires States Parties to ensure access to services without extending involuntary orders.

The CRPD rests on the premise that persons with psychosocial disabilities traditionally did not have equal access to mental health services. Chapter Six argued that Australia’s history of mental health care confirmed this view. The Australian experiences of mental health reform have revolved around the lack of treatment alternatives to involuntary forms of treatment. Despite calls for alternatives to provide access to mental health services, mental health service reform did not provide appropriate access to mental health services. Rather, the justifications for interventions were broadened to those whose medical treatment was deemed necessary in order to ensure their treatment.

However, both, the CRPD and the proposed uniform incapacity legislation

\[\text{References:}\]


203 See section 8.3.3 above.

204 See sections 6.2.4 and 6.6.2 above.

205 See section 6.6.2 above.

206 See section 6.3 above.
aim to reduce coerced care and the argument that coercion cannot be reduced in the absence of services will be scrutinised by the Committee on the Rights of Persons with Disabilities. If it is not feasible to provide access to services now, the CRPD requires States Parties to improve service reform subject to progressive realisation. Considering that Article 12, the CRPD’s provision on the equal recognition before the law, has been traditionally perceived as a civil and political right which has been subject to immediate realisation, there is room to argue that improvements to ensure compliance with Article 12 are subject to immediate realisation or at least be placed high on the priority list of States Parties. Thus, the CRPD raises the bar for putting the onus on States Parties to justify why they cannot improve services.

9.7.6 Autonomy does not Trump other Rights

Third, several commentators argue that capacity-based legislation runs the risk of overemphasising the right to respect for personal autonomy. Nikolas Rose argues that in balancing human rights, interventions may be justified in order to improve autonomous decision-making because “mental illness implies a changed state, a distancing from the normal self.” Thus, he argues that treatment which aims to restore the individual’s health to make a reasoned choice is justified because it has the effect of improving the individual’s ability to exercise autonomy. Tom Burns also recommends that autonomy should not trump beneficence, justice and non-maleficence because in clinical decision-making “beneficence is at least as important as respect for autonomy.”

However, the CRPD is based on the premise that beneficence has been applied differently to persons with disabilities because of presumptions concerning

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207 Mary Donnelly, ‘From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights’ in Bernadette McSherry (ed), Law in Context Special Issue: International Trends in Mental Health Laws (The Federation Press, Leichhardt, 2008) 37, 44 ff;
208 Tom Burns, ‘Mental Illness is Different and Ignoring its Differences Profits Nobody’ (2010) 34 Journal of Mental Health Law - Special Issue 34, 37.
209 Ibid, 37.
211 Tom Burns, 'Mental Illness is Different and Ignoring its Differences Profits Nobody' (2010) 34 Journal of Mental Health Law - Special Issue 34, 39.
212 Ibid, 36.
the effect of disability on the lives of persons with disabilities. The CRPD responded to the experiences of persons with disabilities who claimed that they had been treated to overcome their disabilities on the presumption that this would ensure their rights. Chapter Eight argued that the silence of Article 17 in relation to involuntary detention and treatment implies that those who drafted Article 17 were aware of the fact that such interventions pose specific challenges in responding to persons with mental illness whose judgment or behaviour is impaired. However, the CRPD took a bold approach towards mental health care in that its provisions challenge current mental health laws. Its provisions have been a response to the notion that involuntary treatment has had a detrimental effect on persons with disabilities and that new models need to be trialled. Szmukler, Daw and Dawson present a more differentiated and individualised approach to subjecting people to restrictive legislation than current mental health laws and their fusion proposal presents a model that is delinked from diagnostic findings. Okai and colleagues argue that

given that as many as a third of general medical patients lack mental capacity [ref], this should remind clinicians, policy makers and the general public that patients with psychiatric disorders are not intrinsically different and this may be important in campaigns against stigma.

Similarly, Penelope Weller states:

Challenging the strict distinction between capacity and incapacity, and the consequences of that determination, is the principal contribution of contemporary human rights thinking to the mental health field.

Further, Aswini Weeraratne argues that

the model statute has an appealing simplicity which demonstrates that concepts of capacity and best interests as we know them are capable

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213 See section 3.6.1.1 above.
of founding the care and treatment of compliant incapacitated patients so that differences between mental and physical disorders are kept to a necessary minimum.\textsuperscript{216}

Thus, the fusion proposal complies with the \textit{CRPD} because it is based on the premise that persons with mental illness must be respected as equal subjects of rights and as the drivers of decision-making. The proposal provides a legislative framework which balances the principles of autonomy, beneficence, justice and non-maleficence on the basis of individualised capacity assessments. Their model does not consider that autonomy trumps all other considerations, but it aligns the balance of conflicting interests closer to the principles that guide general health care decisions.

However, there is room to argue that the silence of Article 17 of the \textit{CRPD} requires more than a balancing of these principles. Oliver Lewis states that:

The gap between the \textit{CRPD}'s values and the current reality of many mental health laws all over the world may be an example of an area where the \textit{CRPD} is trying to set out a future reality which has yet to be explained. Ambiguity is awkward for policy-makers and for black-letter lawyers, but it represents a triumph of shared norms over policy detail, whereby those negotiating the treaty agreed on the fundamental principles, but were not able – at that moment in time, on this particular issue – to find consensus on how these principles should play out in the psychiatric emergency room.\textsuperscript{217}

The \textit{CRPD} has incorporated provisions on awareness-raising and accessibility\textsuperscript{218} and it requires Australia to become proactive towards ensuring measures of support\textsuperscript{219} to persons with psychosocial disabilities. It considers that reasonable

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\item \textsuperscript{216} Aswini Weereratne, 'Safeguards for Informal Patients' (2010) 34 \textit{Journal of Mental Health Law - Special Issue} 71, 77.
\end{itemize}
accommodation and supported decision-making are necessary in order to achieve the substantive equality of persons with disabilities in regards to all human rights and fundamental freedoms.\textsuperscript{220} Thus, the \textit{CRPD} does not state that autonomy trumps all other considerations. Rather, the \textit{CRPD} reconceptualises the understanding of autonomy and acknowledges that some persons with disabilities exercise their rights in interdependence with others. The \textit{CRPD} implies that the human rights standards which have focused on autonomy failed to ensure the human rights realisation of persons with disabilities. Almost every Article in the \textit{CRPD} contains statements which stress that persons with disabilities have a right to support or services to ensure that they can exercise their rights. Thus, the \textit{CRPD} does not perceive persons with disabilities as individuals who exercise their rights in isolation or independence of others. Rather, paragraph (n) of the Preamble and the Articles throughout the \textit{CRPD} stress the individual’s human dignity and equality more than the individual’s autonomy. The following Chapter argues that the current fusion proposal falls short of complying with the \textit{CRPD} in this regard.

\textbf{9.8 Concluding Thoughts}

This Chapter has argued that the suggestion to adopt uniform incapacity legislation has a number of advantages and disadvantages. It pointed out that proponents of capacity-based legislation have addressed the difficulties in using capacity in legislation which regulates the treatment and detention of persons with mental illness.\textsuperscript{221} It argued that a number of the disadvantages of the fusion proposal which concern the difficulties in implementing substantive legislative are subject to progressive realisation. In response to some commentators’ concerns that uniform incapacity legislation would result in inconsistencies and delays in treatment, this Chapter argued that the fusion proposal provides for differentiated responses to persons with mental illness which aim to assist that individual


towards securing stable recovery.

Despite the difficulties in assessing an individual’s capacity to make task related decisions, uniform incapacity legislation aims at responding to persons through coercive treatment only if they are incapable of making treatment decisions. It aims at recognising persons with mental illness as equal subjects of rights and acknowledges that persons with mental illness have been subjected to differential treatment because of misinterpretations of the effect of mental illness on the abilities of persons with mental illness. While some commentators argue that uniform incapacity legislation could result in increased levels of compulsion and formality in general health care settings which may cause hostility or delays in treatment, a closer examination of Szmukler, Daw and Dawson’s proposal shows that their model law is not designed to be applied broadly. Rather, it provides for a flexible approach that aligns mental health legislation closer to guardianship legislation. The common concern that the right to respect for an individual’s autonomy should not trump other considerations, such as beneficence, justice and non-maleficence is alleviated because the model balances these principles and maintains existing measures for the protection of persons with mental illness to ensure the accountability and oversight of mental health treatment.222 Thus, this Chapter argues that the fusion proposal presents a solid starting premise for law reform that complies with the CRPD. However, this thesis has foreshadowed that there are shortcomings in respect to the CRPD’s call for reasonable accommodation and supported decision-making. The following Chapter will elaborate on these observations.

10 The Impact of the CRPD on Australian Mental Health Legislation

This chapter discusses the impact of the CRPD on Australian mental health acts in light of the previous Chapters. It responds to the conflict between the CRPD's call for abolishing mental health legislation and Australia having declared its understanding that upholding mental health legislation complies with the CRPD. Based on the conclusions of Chapter Eight, this Chapter considers that current mental health acts conflict with the CRPD. It argues that this applies not only in respect to some of their details, but also in respect to the CRPD's understanding of human rights realisation.

Chapter Nine presented an alternative to mental health legislation that could be incorporated into Australian law. However, this Chapter argues that the move to abolish mental health legislation poses certain risks to the human rights situation of persons with psychosocial disabilities that currently apply in the Australian context. It argues that Australian human rights law has shortcomings in providing individuals with enforceable rights. Thus, this Chapter argues that mental health law reform should consider adopting capacity-based mental health legislation as a first step towards the progressive human rights realisation of persons with psychosocial disabilities. It identifies what features need to be incorporated into capacity-based mental health legislation in order to bring the current mental health acts closer to compliance with the CRPD.

10.1 The CRPD's Understanding of Human Rights Realisation

Chapter Five argued that the CRPD's unambiguous dedication to ensuring respect for the human dignity and equality of persons with any kind of disability is one of its

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most important features. It argued that the CRPD’s understanding of human dignity and equality reflects the paradigm shift of the CRPD because the CRPD substantiates its understanding of human dignity and equality in precise and uncompromising terms in order to ensure that persons with disabilities are respected as equal subjects of rights. This requires States Parties to provide support and reasonable accommodation to persons with disabilities in order to ensure that they have equal opportunities to realise their rights.

This Chapter further explains that the CRPD uses the concept of human dignity and equality as the foundation of its human rights protection. Chapter Two argued that the protection of human dignity has been fundamental to the human rights framework of the United Nations. It has been incorporated into the Universal Declaration of Human Rights (UDHR), the Charter of the United Nations (UN Charter) and all United Nation’s core treaties on human rights. The UDHR starts with recognising the inherent human dignity of all human beings and the idea that the equal and inalienable rights of all members of the human family are the foundation of freedom, justice and peace in the world. It guarantees in Article 1 that “(a)ll human beings are born free and equal in dignity and rights”. The Preamble of the UN Charter starts with recalling the experiences of the World Wars and re-affirming faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large

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2 See section 5.1 above.
3 See section 5.1.7 above.
4 See sections 5.1.5 and 5.1.6 above.
6 United Nations, Charter of the United Nations, 24 October 1945, 1 UNTS XVI.
and small. Thus, both documents place the protection of human dignity and equality at the top of their actual formulation.

Chapter Two pointed out that the UDHR has a central standing in the human rights protection of the United Nations. Despite its originally non-binding character and initial scepticism as to its use to enforcing human rights, it is still the most recognised and most accepted human rights standard throughout the world. The UDHR has been a milestone in that it established basic rights of the individual comprehensively, internationally and inclusively not only of civil and political rights but also of economic, social and cultural rights. Philip Alston has referred to it as “the greatest ethical and normative achievement of the United Nations (...) a beacon of light in a fog of inhumanity”. He considers Article 1, which guarantees the freedom, dignity and equality of all human beings, as “probably the single most important principle which underpins the Universal Declaration”.

The UDHR and the UN Charter link the inherent dignity and worth of all human beings with equality. Both documents address human dignity and equality in terms that express more than specific human rights and fundamental freedoms that individuals can claim. Rather, they addresses an individual’s dignity and worth as the underlying rationale why all human beings need to have their basic rights respected on an equal basis. All other human rights and fundamental freedoms elaborate what it means to be respected as an equal subject of human rights.

Thus, the protection of human dignity has two important purposes: First, it reiterates that all human beings have human dignity as an inner worth and value because they are human beings, irrespective of the characteristics, abilities or behaviour of that person. Second, respecting and protecting human dignity serves as the foundation for equality. The idea that all human beings have inherent dignity

12 Ibid, 29.
as an equal inner worth or value justifies why they ought to have equal protection and not be subjected to discriminatory treatment. When discussing human dignity and its interrelation to equality, Chaskalson defines discrimination as the “differentiation based on attributes and characteristics that have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparable serious manner”.¹³ He explains the interrelationship between human dignity and equality as follows:

Dignity and equality are interdependent. Inequality is established not simply through group-based differential treatment, but through differentiation, which perpetuates disadvantage and leads to the scarring of the sense of dignity and self-worth. Conversely, an invasion of dignity is more easily established when there is an inequality of power and status between violator and victim”.¹⁴

The interrelation between human dignity and equality is two-fold. During the drafting process of the UDHR, René Cassin, a member of the Drafting Committee of the UDHR, re-emphasised the need to develop a human rights document responding to the Holocaust. He insisted that equality must be essential and fundamental to the human rights declaration and he recalled that Hitler “started by asserting the inequality of men before attacking their liberties”.¹⁵ The idea that some people are intrinsically different can facilitate and perpetuate uncritical acceptance of unequal treatment – up to the point of questioning other human beings as bearers of rights and disrespecting their inherent dignity. Conor Gearty argues that respect for equality is

the bridge that leads us to a fuller set of principles. The reason we are interested in human rights to start with, and why we are looking for

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¹⁴ Ibid, 140.

foundations in the first place, is because of our commitment to this kind of equality.\textsuperscript{16}

Many of the specific rights and freedoms of the CRPD refer back to human dignity and equality – more so than in any other international human rights treaty.\textsuperscript{17} Penny Weller argues that the CRPD “extrapolates the principle of non-discrimination throughout its text, addressing the many facets and effects of discrimination.”\textsuperscript{18} The CRPD clarifies what actions States Parties need to take in order to guarantee the equality of persons with disabilities and the CRPD utilises the concept of human dignity to underpin the realisation of human rights.\textsuperscript{19}

The CRPD recognises the importance of individual autonomy,\textsuperscript{20} but it shifts the focus of the CRPD on human dignity and equality, rather than autonomy. Frédéric Mégret pointed out that the interpretation and application of international human rights has traditionally focused on the respect for a person’s autonomy and the right to self-determination.\textsuperscript{21} The CRPD recognises that autonomy-based human rights arguments have limited use for protecting and realising the human rights of persons with disabilities because autonomy can be applied as a threshold criterion: That is, a person either is an autonomous agent of his or her rights or the person is not an autonomous agent of his or her rights; once a person is not capable of exercising his or her rights autonomously, differentiation may be justified.

The CRPD requires that persons with disabilities have the right to equal

\begin{thebibliography}{9}
\bibitem{17} \textit{Convention on the Rights of Persons with Disabilities}, opened for signature 30 March 2007, Doc.A/61/611 (entered into force 3 May 2008), Articles 2, 3b), 4b), 5, 12(2), 13(1), 14(1, 2), 15(2), 17, 18, 19, 23(1), 24(1), 25(1) and 27(1).
\end{thebibliography}
recognition before the law and the right to claim support towards exercising their legal capacity. A person who has the capacity to make decisions is an autonomous agent of his or her rights. However, the CRPD considers that improvements within society evolve rapidly and assist individuals in exercising rights, but laws – and decision-makers who apply laws – have not adopted this understanding of human rights realisation. The CRPD requires that laws have to incorporate respect for the diverse kinds and degrees of an individual's impairment. Laws need to provide persons with disabilities with the right to be supported with devices, facilities and services in order to ensure States Parties' provide the required support. Thus, the CRPD grants rights to persons with disabilities, even if they are not recognised as autonomous agents of rights.

The CRPD also articulates the provision of support as an obligation of States Parties which continues to exist if individuals with disabilities are not in a position to claim their rights. Thus, the CRPD ensures that support is not a threshold criterion. Regardless of an individual’s degree of impairment, States Parties have to support persons with disabilities towards realising their human rights to the fullest degree possible. If the individual is not in a position to claim his or her rights, peers, family members, friends, advocates or others can claim access to support mechanisms or service improvement.

### 10.2 The Australian Understanding of Human Rights Protection

In contrast to the CRPD's understanding of human rights realisation, Australian human rights law has yet to encourage processes ensuring that persons with psychosocial disabilities are viewed as equal subjects of rights. Chapters Six and Seven pointed out that Australia’s understanding of human rights realisation focuses on protections from human rights interferences. Despite the adoption of anti-discrimination and human rights legislation into Australian law, individuals cannot legally enforce positive human rights and challenge laws that conflict with human rights. The differences in understanding human rights has the following consequences.

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22. At the very least, this requires that persons with disabilities are provided with the support that is necessary to ensure that they live in conditions which respect their human dignity.

23. See sections 6.6.6 and 7.4 above.

24. See section 7.3.1 above.
10.2.1 Non-Enforceable Human Rights

First, persons with psychosocial disabilities have limited opportunities to claim their rights as expressed in the CRPD. The CRPD requires that persons with disabilities have equal opportunities to exercise their rights. Factsheet No 31 (2009) on the Right to Health\(^\text{25}\) states that enforceable rights are important to ensure that persons with disabilities can claim their human rights. Gerard Quinn and Theresia Degener have commented on the international human rights documents which addressed the rights of persons with disability prior to the CRPD and argue that the lack of enforceability is likely to result in a lack of responsiveness by Parliaments.\(^\text{26}\)

The domestic experiences concerning the human rights of persons with mental illness confirm this view. The Burdekin Report and subsequent policy documents provided guidance on improving the human rights situation of persons with mental illness which reflects many of the ideas of the CRPD.\(^\text{27}\) However, domestic human rights law reform has not incorporated the recommendations of the Burdekin Report which aimed at bestowing substantive rights on persons with mental illness and equalising their opportunities to exercise their rights.\(^\text{28}\) Rather, mental health law reform has been slow in achieving compliance with the minimum human rights standard of the MI Principles.\(^\text{29}\) After two decades only one of the Australian jurisdictions' mental health legislation complies with the MI Principles when setting out the requirements for involuntary treatment and to whom they apply.\(^\text{30}\)

Chapter Nine argued that the suggestion to incorporate uniform incapacity legislation into Australian law has the advantage of substantiating the rights of persons with psychosocial disabilities into a new legislative scheme.\(^\text{31}\) However, Chapter Nine also argued that adopting uniform incapacity legislation comes with


\(^{27}\) See section 6.2 above.

\(^{28}\) See section 6.6 above.

\(^{29}\) See sections 3.7, 6.4 and 6.6.7 above.

\(^{30}\) See section 8.3.2.1 above.

\(^{31}\) See section 9.4 above.
the disadvantage of requiring substantial costs and efforts in setting up a new legislative scheme.32

This Chapter argues that dedication is required to ensure the “paradigm shift” of the CRPD. However, Australia’s declaration to the CRPD indicates Australia’s intention of upholding current mental health legislation under similar considerations to those currently incorporated in the mental health acts.33 The declaration interprets the CRPD as upholding substituted decision-making and the involuntary treatment of persons with psychosocial disabilities. Chapter Seven argued that the second paragraph of Australia’s declaration substantially conflicts with the CRPD because it allows for the involuntary medical treatment of persons with psychosocial disabilities if their treatment is necessary.34 The declaration stresses the restrictive nature of interventions, but falls short of providing precise and measureable criteria for judging whether or not interventions can be justified.

Michelle Cleary and colleagues are concerned about mental health legislation laws which can be applied to “restrict the rights of many in order to protect the small number of persons who are vulnerable to suicide or experience dangerousness”.35 Mental health law reform has been driven by the conflicting interests of applying interventions restrictively, but providing responses on the basis of the welfare of those who benefit from such interventions.36 Some jurisdictions have incorporated principles which aim to engage with the wishes of the individual with psychosocial disability, but they are not substantiated into rights. The notion that mental health acts are about “bringing persons under compulsion”37 drives mental health service responses.

Several commentators on the use and design of mental health legislation argue that mental health acts can be reformed in order to set out more “sophisticated

32 See section 9.1.6.1 above.
33 See section 7.1.3 above.
34 See section 7.1.3 above.
35 See also M Cleary et al, ‘Locked Inpatient Units in Modern Mental Health Care: Values and Practice Issues’ (2009) 35 Journal of Medical Ethics 644, 645.
36 See section 8.4.2.3 above.
37 Philip Fennell, ‘Mental Health Law: History, Policy, and Regulation’ in Lawrence O Gostin et al (eds), Principles of Mental Health Policy (Oxford University Press, Oxford, 2010) 3, 70. See also section 8.5.3 above.
legislation that provides for scrutiny by independent statutory bodies\textsuperscript{38} to articulate interventions with “informedness, transparency, adjustments and legal vigour”\textsuperscript{39} and to reflect the safeguards of the CRPD, such as the ones incorporated in its Article 12.\textsuperscript{40} Robert Robinson argues that mental health legislation can assist with regulating the conflict between the individual and those who have the power to detain and treat that individual against his or her will. He states that:

At the heart of the conflict is an individual’s assertion of his right to make his own choices as an autonomous being, regardless of the views of professionals about his mental capacity or what they consider to be in his best interests, against those who would seek to justify taking away his liberty and subjecting him to unwanted medical treatment.\textsuperscript{41}

Thus, mental health legislation can re-assess the justifications for interventions and aim to comply with the CRPD more closely. This approach does not reflect the “paradigm shift” of the CRPD and perpetuates the discrimination of persons with psychosocial disabilities. The CRPD aims to delink the justification for restrictions on human rights from the grounds of psychosocial disability. It aims to ensure that discriminatory attitudes do not influence, or coincide with, the justification for interventions.

However, the suggestion to reform current mental health legislation takes into account the shortcomings of Australia’s commitment to international human rights. It responds to Australia giving effect to the rights of the CRPD predominantly through legislative reform.\textsuperscript{42} Legislative reform runs the risk of delaying immediately reliaisable rights and reinforcing errors in judgment or deliberate

\textsuperscript{38} Derek Chriswick, ‘Commentary: Test of Capacity has Little Practical Benefit’ (2005) 331 British Medical Journal 1469, 1470.


\textsuperscript{42} See section 7.4 above.
departure from the human rights standard of the CRPD. However, the rights of the CRPD are almost meaningless unless domestic legislation incorporates them as substantive rights, in particular because Australia’s declaration to the CRPD indicates that legislative reform is not necessary.43 Thus, unless Australian Parliaments give effect to the rights of the CRPD within their domestic jurisdictions, persons with psychosocial disabilities have limited opportunities to claim their rights in accordance with the culture change of the CRPD.

Philip Fennell has commented on the suggestion to align mental health legislation closer to general disability legislation in the following way:

To bring the rights of mentally disordered individuals under the umbrella of disability rights will not be an easy task, either in technical legal terms, or in political terms, since governments seem strongly committed to specific mental health legislation authorising detention on grounds of mental disorder plus the presence of risk to own health or safety or the safety of others”.44

This concern applies in particular to Australian mental health acts because eight governments would have to be convinced to change their laws or account for the additional efforts towards ensuring continuity of care to persons who move between different jurisdictions. The suggested fusion model is new and has left some important details unanswered. The Australian States and Territories would need to address these details and it is likely that reform efforts would need to be substantial. However, it seems that the “mindset” of the CRPD has not yet been embraced in Australian mental health care which focuses upon using force to help people and which narrows the service response to exceptional cases.

Thus, reform efforts would be best focused on incorporating the substantive rights of the CRPD into current mental health acts because the mental health acts currently conflict with the CRPD. They could set out positive as well as negative rights and bring about the culture shift that is necessary to embrace the vision of

43 See section 7.1.3 above.
the CRPD. Thus, this Chapter argues that Australia needs to focus its first reform efforts on incorporating the rights of persons with psychosocial disabilities into domestic mental health legislation in order to ensure that persons with psychosocial disabilities can enforce those rights.

10.2.2 Protections from Interventions

Second, the fact that Australian human rights law protects traditional civil and political rights\(^45\) stresses the need to incorporate the human rights of the CRPD into domestic legislation. Chapter Six pointed out that Australian mental health law focuses on the protection of persons with psychosocial disabilities from unjustified interventions.\(^46\) The CRPD clarified that positive and negative obligations which arise from the substantive provisions of the CRPD are inseparable.\(^47\) Thus, the Australian human rights protection which focuses on ensuring freedoms from interventions, runs the risk of not reflecting the human rights understanding of the CRPD. In particular, the CRPD requires States Parties to provide support and reasonable accommodation for persons with psychosocial disabilities in respect to all substantive rights of the CRPD.\(^48\)

In this respect, uniform incapacity legislation falls short in its potential to ensure compliance with the CRPD. Uniform incapacity legislation has not substantiated the CRPD’s call for support and reasonable accommodation and it does not set out a nuanced decision-making model for persons who are found to be incapable of making decisions.

10.2.2.1 Support and Reasonable Accommodation

The CRPD poses challenges to Australia’s human rights understanding when it requires Australian governments to provide persons with psychosocial disabilities

\[^{45}\] See sections 6.6.6 and 7.4 above. See also Samantha Battams and Julie Henderson, ‘The Physical Health of People with Mental Illness and ‘The Right to Health’ ’ (2010) 9(9) Advances in Mental Health 116, 121 with further references.

\[^{46}\] See sections 6.6.6 and 7.3.3 above.

\[^{47}\] See section 4.4.5 above.

\[^{48}\] See sections 4.4.6.3 and 5.1.6 above.
with access to health services and the provision of individualised support. The Australian debate on human rights and mental health has revolved around the lack of access to services, the lack of flexibility in relation to individual circumstances and the lack of genuine engagement with the individual with disability. There is still a lack of improvement in service delivery and the domestic human rights debates focus on extending the justification for interventions to those who require early access to services and reducing the use of force and formality in relation to those who are compliant. It seems that the understanding of human rights realisation of persons with psychosocial disabilities does not sufficiently challenge the rationale that interventions are necessary to ensure the human rights of persons with disabilities.

The CRPD encourages early responses to persons with psychosocial disabilities, but it requires States Parties to trial new approaches towards ensuring that persons with psychosocial disabilities receive care when they need it. The reform of current mental health acts in light of the CRPD could ensure that mental health legislation responds to the needs of persons with psychosocial disabilities by ensuring support as the primary response to persons with psychosocial disabilities. The CRPD provides detailed guidance and precise terminology as to how to ensure that persons with psychosocial disabilities can claim rights in an environment of limited resources. The CRPD considers that a person’s freedom must be understood within his or her environment and that people respond differently to various measures of support. Thus, the reform of domestic mental health legislation could serve as a means to ensure that persons with psychosocial disabilities can claim positive rights and provide them with treatment and care options.

Chapter Four argued that the CRPD also aims to measure Australia’s compliance with the CRPD and its efforts towards ensuring the progressive realisation of the rights of persons with psychosocial disabilities. In 2006, the Mental Health

49 See sections 6.2.4 and 6.6.2 above
50 See sections 6.6.4 and 6.6.7 above.
51 See sections 6.6.1 and 8.5.2.3 above.
52 See section 8.5.2.1 above.
53 See sections 6.6.4 and 8.5.2.1 above.
54 See section 8.5.2.3 above.
55 See sections 4.4.2 and 4.4.4 above.
Council of Australia stated that:

It is commonly agreed that a lack of investment and accountability following deinstitutionalisation has led to a crisis in public confidence because people cannot access the mental health services they need when they need them. The Council approved of current mental health reform and “strongly recommend[ed] that a national accountability mechanism be adopted to report on the implementation of this new approach to mental health in Australia”.  

Thus, new initiatives to improve the accountability of mental health services could be implemented via mental health legislation.

### 10.2.2.2 A Nuanced Model of Supported Decision-Making

Chapter Five argued that the CRPD requires Australia to incorporate a nuanced model of decision-making into domestic legislation which aims to ensure measures of support, rather than substituted decision-making. This model is not yet developed. Leslie Salzman argues that “supported decision-making is not a ‘new service’ but rather one that provides the decision-making assistances of guardianship in a less restrictive manner.” He also argues that:

In the movement toward reform, it will be useful to demonstrate that supported decision-making options are able to successfully meet individual needs in a manner that is less restrictive that guardianship, that they are more beneficial to the individual’s well-being than assigning a guardian, and that they do not entail significantly greater financial resources than the guardianship option.  

There may be costs attached to the expansion and development of appropriate supported decision-making options, but the benefit in

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57 Ibid, 18.
58 See section 5.2.2 above.
60 Ibid, 328.
human terms may justify them, and the language and spirit of (...) the principles enunciated in the CRPD demand their adoption.  

Thus, existing decision making models can be studied and re-designed to remove unnecessary barriers to integration and to facilitate the full participation of individuals with psychosocial disabilities in all of life’s activities.  

The reform movement towards developing models of supported decision-making could re-assess different models of support mechanisms and apply them to mental health settings.

This movement could also validate the voices of persons with psychosocial disabilities in the reform process. Michael Perlin has commented that “[t]here is little evidence that these groups are taken seriously either by lawyers or academics.” In 1999, Richard Gosden commented that:

In the public participation struggles over expanding involuntary treatment, it is evident that mental health professionals and relatives of mental patients have a distinct credibility advantage over ex-mental patients in public forums. As a consequence human rights and civil liberties arguments against involuntary treatment are steadily losing ground.

Harvey Whiteford and William Buckingham state that in Australia the “role of non-government organisations (NGOs) expanded three-fold from 1993 to 2003 in mental health expenditure.” In their evaluation of federal policy programmes on

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62 Ibid, 328.
63 Michael L Perlin, “’You Have Discussed Lepers and Crooks’: Sanism in Clinical Teaching’ (2003) 9(2) Clinical Law Review 683, 699. See also Graeme Browne and Martin Hemsley, ‘Consumer Participation in Mental Health in Australia: What Progress is Being Made?’ (2008) 16(6) Australasian Psychiatry 446. Graeme Browne and Martin Hemsley state that “consumers of mental health services have been recipients of care with little input into how services have been delivered” (at 446).
the involvement of consumers and carers in service delivery and planning between 1993 and 2003, they comment that:

While this was initially done as a token gesture in some services to secure funding, it has, over time, become more accepted, and participation rates of consumers and carers have increased considerably.66

However, Lei Ning argues that consumer and carer participation in mental health service planning, delivery and evaluation is still "tokenistic".67 He argues that:

To date, Australia’s mental health system reform has been largely focused on formulating efficient processes and procedures and trying to achieve a ‘perfect’ system for users of services rather than co-designing services with consumers and carers based on their needs and lived experiences.68

However, this Chapter argues that the CRPD’s focus on providing support to persons with psychosocial disabilities also gives mental health professionals a different ground for expressing their views. It argues that the supported decision-making model has the potential of alleviating some of the power imbalances in therapeutic relationships and the reponsibility of mental health professionals to ensure treatment. In comparison to the relevant provisions of most mental health acts,69 the Code of Ethics for psychiatrists takes a more differentiated approach towards engaging with consumers.70 For example, the Code requires collaboration with consumers and recommends partnerships with patients as an important part of treatment.71 The CRPD stresses the value of explicit provisions in legislative

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66 Ibid, 398 with further information.
67 Lei Ning, 'Building a 'User Driven' Mental Health System' (2010) 9(2) Advances in Mental Health 112, 112.
68 Lei Ning, 'Building a 'User Driven' Mental Health System' (2010) 9(2) Advances in Mental Health 112, 112.
69 See section 8.3.32 above.
frameworks which provide for relevant treatment and care options. The re-assessment of existing models of service delivery seems to be more likely to result in immediate changes in the Australian context than the abolition or wholesale reform of mental health laws.

### 10.2.3 Concluding Thoughts

This thesis has highlighted the risks of incorporating uniform incapacity legislation into Australian law when service delivery has not yet adopted the cultural change that is necessary to ensure that mental health services change their focus from interventions to measures of support. In Australia the risk of shortcomings resulting from the adoption of uniform incapacity legislation is a substantial one. Neither the Federal government nor the governments of the Australian States and Territories have incorporated enforceable human rights legislation into their jurisdictions that encompass economic, social and cultural rights.

Thus, persons with psychosocial disabilities cannot claim the rights of the *CRPD*. Law and policy reform is likely to continue its focus on freedoms from interventions given that human rights legislation encompasses only traditional civil and political rights. However, if the Australian States and Territories incorporate reasonable accommodation and support into their mental health acts, these mental health acts may be justified at least in the interim, to drive the cultural change in mental health service delivery that is necessary to ensure compliance with the *CRPD*.

### 10.3 Conclusions

Chapter Two argued that the United Nations treaty law needs to be explicit in its guidance to States Parties as to how to interpret and apply human rights to the situation of persons with psychosocial disabilities. This is because the lack of specific guidance in legally binding documents has resulted in governmental lack of concern about applying human rights standards to mental health care.\(^\text{72}\)

Chapter Three pointed out that the non-binding international human rights

\(^\text{72}\) See section 2.4.1 above.
instruments of the United Nations provided more guidance on the interpretation and application of human rights to mental health legislation, but they expressed a minimum standard of protection which had shortcomings in sending a clear message to Parliaments as to how to ensure that persons with psychosocial disabilities have equal opportunities to exercise their rights to the fullest degree possible. It argued that shortcomings arose in particular because these human rights principles aimed at setting out a human rights compliant response to the difficult question as to whether or not interventions can be justified, but failed to do so in clear and consistent terms. It argued that the justifications for overriding a person’s informed consent were meant to apply restrictively. But the restrictive application of interventions relied predominantly on the discretion of mental health professionals who have limited options of decision-making when they work in mental health systems that do not provide for responsive alternatives to involuntary treatment.

Chapter Six argued that Australian mental health legislation has a history of falling short in respecting the minimum standard of the human rights protection of persons with mental illness. The lack of access to mental health services has been central to human rights concern and the Australian mental health acts extended powers for interventions in order to ensure that persons with mental illness could receive mental health care. Chapters Eight and Nine pointed out the ways in which this criticism still applies to most mental health acts of the Australian States and Territories, despite improvement in some jurisdictions. Both of these Chapters provided examples of how the language of mental health acts contribute to ongoing human rights concern because the requirements for involuntary treatment and detention are clear, while the substantive rights of persons with mental illness are expressed in vague terminology.

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73 See sections 3.1 and 3.4 above.
74 See section 3.4.5 above.
75 See section 3.4 above.
76 See section 3.4.1 above.
77 See section 3.4.4 above.
78 In particular to those who are in disadvantages positions. See section 3.7.4 above. For example, persons who cannot afford mental health services or who also need access to a safe and stable environment
79 See section 6.6 above.
80 See sections 6.2.2, 6.2.4, 6.6.2 and 6.6.4 above.
81 See sections 8.3.3 and 8.5.2.3 above.
82 See sections 8.3.2.1 and 9.4.2 above.
Chapter Four argued that the development of the *CRPD* responded to the need to provide explicit and comprehensive guidance on the interpretation and application of human rights to the lives of persons with disabilities in consistent and unambiguous terms.\(^{83}\) In conjunction with Chapter Five, it argued that the *CRPD* reflects a “paradigm shift” in the understanding of disabilities which breaks with the idea that interventions into the human rights of persons with disabilities can be justified because of a person’s disability in order to ensure that person’s welfare interests.\(^{84}\)

Chapter Five argued that the *CRPD* has extended its full protection deliberately to persons with psychosocial disabilities.\(^{85}\) It argued that the drafting sessions of the *CRPD* discussed the difficult question of whether or not persons with mental illness can be treated because of the effect of their illness on their judgment or behaviour.\(^{86}\) It argued that the *CRPD* omitted any mention of grounds for justifying interventions because of a person’s disability and subsequent interpretations of the *CRPD* confirmed the uncompromising position that it does not allow for the differentiation of persons with psychosocial disabilities because of their disability, even if other considerations apply.\(^{87}\)

Chapter Eight argued that the mental health acts of the Australian States and Territories exemplify why the *CRPD* took such a cautious approach towards not singling out persons with psychosocial disabilities, even though their differentiation could apply on grounds that could equally apply to other persons with or without disabilities alike. In particular, a person’s dangerousness to others is a legitimate ground for restricting some human rights and fundamental freedoms.\(^{88}\) However, Chapter Eight pointed out that the main concern about the human rights protection of persons with psychosocial disabilities results from the use of vague terminology in the justifications for interventions\(^{89}\) which are meant to apply restrictively, but allow for responses to a person’s need for treatment on grounds which are open to

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83 See section 4.4.3 above.
84 See sections 4.4.1, 4.4.6.3, 5.1.2, 5.3 and 5.4 above.
85 See section 5.1.1 above.
86 See sections 5.3 and 5.4 above.
87 See sections 5.3 and 5.4 above.
88 That is any differentiation on objective, reasonable and proportionate grounds. See section 2.1.2.2 above.
89 See section 8.4 above.
90 See section 8.4.2.2 above.
broad interpretation in most jurisdictions.91

Chapter Nine argued that uniform incapacity legislation provides an alternative to mental health legislation which aims to alleviate the differentiation between persons with psychosocial disabilities and other persons who are not fully capable of decision-making because it applies capacity assessments to all persons, with or without disabilities alike. It argued that this approach reflects the CRPD’s purpose of respecting persons with psychosocial disabilities as equal subjects of rights because it aligns the justification for interventions closer to the justifications that apply to settings outside of mental health care. It pointed out that uniform incapacity legislation allows for exceptions which affect persons with psychosocial disabilities, but in contrast to Australian mental health acts, they seem to rest on well-defined criteria which reduce the risk of applying the exception broadly, while the current mental health acts run the risk of applying interventions as primary service response to persons with mental illness. Chapter Nine considered that these elements of the uniform incapacity legislation seem to conflict with the CRPD, but it argued that the CRPD acknowledged that there are mental health specific challenges to legislative reform which need to be evaluated as progressive realisation of human rights standards. Chapter Nine argued that uniform incapacity model serves as a starting point for trialling and evaluating alternative legislative responses to persons with psychosocial disabilities.

Chapter Seven pointed out that Australia predominantly gives effect to international human rights obligations through legislative reform. It explained that Australia adopted anti-discrimination legislation into national laws and that two States and Territories adopted human rights legislation, but it argued that these laws have shortcomings in providing individuals with enforceable rights. Thus, Chapter Ten argued that compliance with the CRPD relies on Australia incorporating the rights of the CRPD into domestic legislation. It argued that the CRPD calls for States Parties to abolish mental health legislation. However, in light of Australia’s declaration which implies that Australia intends to uphold mental health legislation, it argued that that Australia should reform its current mental health legislation as a first step towards the progressive human rights realisation of

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91 See section 8.5.1 above.
persons with psychosocial disabilities.

In light of these findings and given Australia’s declaration that the CRPD allows for substituted decision-making arrangements and compulsory treatment, this thesis argues that the CRPD requires Australia to adopt capacity-based mental health legislation which reflects the “paradigm shift” of the CRPD. At the heart of this shift lies the idea that persons with disabilities are respected as equal bearers of rights and they have a right to be provided with reasonable accommodation to ensure their social inclusion. Thus, this thesis argues that Australia should adopt the following features into mental health legislation (this list is not comprehensive):

- Mental health legislation must be capacity-based and presume the legal capacity of persons with mental illness.92

- If there are reasonable grounds for believing that a person is impaired (temporarily or permanently) in decision-making, the person must be provided with a safe environment and task-related support to exercise his or her rights. This takes into account that a person who is not capable of decision-making may be capable of performing other tasks, such as choosing a support person.

- In situations of self-harm, mental health legislation must provide a safe environment for persons with mental illness and aim to provide the individual with services that support him or her to exercise his or her legal capacity and to receive health care with continuity.

- In situations of risk to public health, mental health legislation must apply on the basis of structured, reliable and individualised risk-assessments and provide persons with disabilities with support to access mental health treatment.

- Mental health legislation must establish and evolve supported decision-making processes. Such legislation must:

  - respect advance directives.
  - respect the will and preferences of the individual with mental illness.

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92 The author uses the term of “mental illness” in this context because Australian debate on mental health law and policy predominantly uses this term.
- provide persons with mental illness with appropriate access to support mechanisms without financial cost to the individual receiving the treatment or to his or her family.
- be free of conflict of interest and undue influence.
- apply legal safeguards to support measures that are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. Existing legal safeguards can be used and modified.
- protect persons with mental illness from involuntary treatment and detention aimed at correcting, improving or alleviating any actual or perceived impairment.
- omit terminology which allows for interventions because a person has refused treatment.

Ultimately, legislative schemes that support involuntary treatment must be based on respecting and realising human rights and fundamental freedoms. What the CRPD aims to portray is that disability itself cannot justify differential treatment, as it contradicts respecting the dignity, worth and equality of human beings. While this thesis has argued that current Australian mental health laws are in conflict with the CRPD and on that basis should be abolished, it recognises that abolition is unlikely in the short term. The above list of suggested reforms to current mental health legislation at the very least provides a starting point for the progressive realisation of the human rights and fundamental freedoms of the CRPD.
## Appendix

### Table 1: The Purpose and Objectives of the Mental Health Legislation

<table>
<thead>
<tr>
<th>text of the legislation</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
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<tbody>
<tr>
<td>provision of care and treatment</td>
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<td>3(a)</td>
<td>3(a)</td>
<td>4</td>
</tr>
<tr>
<td>protection</td>
<td>7(a)</td>
<td>7(d) civil rights protection</td>
<td>3(a) protection of people and their civil rights</td>
<td>4</td>
</tr>
<tr>
<td>rehabilitation</td>
<td>7(a)</td>
<td>implied in 54 (a); 56 (1)(b), 105(a)*</td>
<td>implied in 51(4); 91*</td>
<td>implied in 124*</td>
</tr>
<tr>
<td>control</td>
<td>7(a), (d)</td>
<td>3(a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>right to treatment</td>
<td>7(d)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>access to services</td>
<td>7(e), 8(a)(iv)</td>
<td>3(d)</td>
<td>9(a)</td>
<td></td>
</tr>
<tr>
<td>informed consent</td>
<td>7(e)</td>
<td></td>
<td>3(d), 7, 9(j)</td>
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</tr>
<tr>
<td>presumption of capacity</td>
<td></td>
<td></td>
<td>8(b)</td>
<td></td>
</tr>
<tr>
<td>information about rights</td>
<td>8(b)</td>
<td></td>
<td>3(j), 9(d)</td>
<td>8(c)</td>
</tr>
<tr>
<td>voluntary services</td>
<td>7(b), 8(c)</td>
<td>3(c)</td>
<td>3(c), (d), 9</td>
<td></td>
</tr>
<tr>
<td>least restriction</td>
<td>7(a)</td>
<td>68(a)*</td>
<td>8(a)</td>
<td>implied in 4(b)</td>
</tr>
<tr>
<td>human rights</td>
<td>7(a) human rights</td>
<td>3(d) civil rights</td>
<td>3(a) civil rights</td>
<td>4(a) rights + freedoms</td>
</tr>
<tr>
<td></td>
<td>7(c) dignity and self-respect</td>
<td></td>
<td>8(b) liberty, rights, dignity, privacy and self-respect</td>
<td>8(a) same human rights, human worth + dignity</td>
</tr>
<tr>
<td></td>
<td>9 freedom dignity self-respect</td>
<td></td>
<td>8(c) autonomy</td>
<td>89 liberty + rights</td>
</tr>
<tr>
<td>MI Principles</td>
<td></td>
<td></td>
<td>3(b)</td>
<td>12(4)</td>
</tr>
</tbody>
</table>

* These references are outside of the provisions on the purpose and objective of the mental health legislation. For comparative purposes, they are included in the table to show that the mental health legislation included similar considerations into the text of the respective Mental Health Act.
### Table 2: The Purpose and Objectives of the Mental Health Legislation (continued)

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<th>Vic</th>
<th>WA</th>
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<td>6(a)</td>
<td>4(1)(a)</td>
<td>5(a)</td>
</tr>
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<td>6(a)(ii)</td>
<td></td>
<td>4(1)(a)</td>
<td>5(b)</td>
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<tr>
<td>rehabilitation</td>
<td>6(a)(i)</td>
<td></td>
<td>implied in Part 10 A*</td>
<td>6(a), (e), (p) implied in 172*</td>
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<td></td>
<td>2(a)</td>
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<td></td>
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<td>right to treatment</td>
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<td></td>
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</tr>
<tr>
<td>access to services</td>
<td>6(e)</td>
<td>5(a)(iv)</td>
<td></td>
<td></td>
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<tr>
<td>informed consent</td>
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<tr>
<td>presumption of capacity</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>information about rights</td>
<td>6(b), 6A(e)</td>
<td>4(e), 5(b), 6A(e)</td>
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<td></td>
</tr>
<tr>
<td>voluntary services</td>
<td>Part 3*</td>
<td>18*</td>
<td>implied in 7(d)*</td>
<td></td>
</tr>
<tr>
<td>least restriction</td>
<td>7(1)(b)</td>
<td>implied in 6(a)</td>
<td>4(2)(a)</td>
<td>5(a)</td>
</tr>
</tbody>
</table>

**human rights**
- 6(a)(ii) freedom, rights, dignity + self-respect
- 6(a) civil rights + identity
- 6(e) equal to others
- 4(1)(ac) rights
- 4(2)(b) liberty, rights, privacy, dignity + self-respect
- 5(a)(i) equal to others
- 5(a) freedom, rights + dignity

**MI Principles**
- note to 4

* These references are outside of the provisions on the purpose and objective of the mental health legislation. For comparative purposes, they are included in the table to show that the mental health legislation included similar considerations into the text of the respective Mental Health Act.
**Table 3: The Definition of Mental Illness**

<table>
<thead>
<tr>
<th>Section</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>s 3, Dictionary</td>
<td><em>Mental Health (Treatment and Care) Act 1994 (ACT)</em>&lt;br&gt;Mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:&lt;br&gt;(a) delusions;&lt;br&gt;(b) hallucinations;&lt;br&gt;(c) serious disorder of thought form;&lt;br&gt;(d) a severe disturbance of mood;&lt;br&gt;(e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).</td>
</tr>
<tr>
<td>s 4</td>
<td><em>Mental Health Act 2007 (NSW)</em>&lt;br&gt;Mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:&lt;br&gt;(a) delusions,&lt;br&gt;(b) hallucinations,&lt;br&gt;(c) serious disorder of thought form,&lt;br&gt;(d) a severe disturbance of mood,&lt;br&gt;(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).</td>
</tr>
<tr>
<td>s 14</td>
<td>(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:&lt;br&gt;(a) for the person’s own protection from serious harm, or&lt;br&gt;(b) for the protection of others from serious harm.&lt;br&gt;(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person’s condition and the likely effects of any such deterioration, are to be taken into account.</td>
</tr>
</tbody>
</table>
Table 4: The Definition of Mental Illness (continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Mental Health and Related Services Act 2009 (NT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>s 4</td>
<td>In this Act, mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:</td>
</tr>
<tr>
<td></td>
<td>(a) by the presence of at least one of the following symptoms:</td>
</tr>
<tr>
<td></td>
<td>(i) delusions;</td>
</tr>
<tr>
<td></td>
<td>(ii) hallucinations;</td>
</tr>
<tr>
<td></td>
<td>(iii) serious disorders of the stream of thought;</td>
</tr>
<tr>
<td></td>
<td>(iv) serious disorders of thought form;</td>
</tr>
<tr>
<td></td>
<td>(v) serious disturbances of mood; or</td>
</tr>
<tr>
<td></td>
<td>(b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).</td>
</tr>
<tr>
<td></td>
<td>(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Mental Health Act 2000 (Qld)</th>
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</thead>
<tbody>
<tr>
<td>s 12</td>
<td>Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.</td>
</tr>
<tr>
<td></td>
<td>(2) (Omitted – exclusion criteria, see Table 8 below)</td>
</tr>
<tr>
<td></td>
<td>(3) Subsection (2) does not prevent a person mentioned in the subsection having a mental illness.</td>
</tr>
<tr>
<td></td>
<td>(4) On an assessment, a decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.</td>
</tr>
</tbody>
</table>
### Table 5: The Definition of Mental Illness (continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Act</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Act 2009 (SA)</strong></td>
<td>s 3</td>
<td>Mental illness means any illness or disorder of the mind.</td>
</tr>
</tbody>
</table>
| **Mental Health Act 1996 (Tas)** | s 4 | (1) A mental illness is a mental condition resulting in –  
(a) serious distortion of perception or thought; or  
(b) serious impairment or disturbance of the capacity for rational thought; or  
(c) serious mood disorder; or  
(d) involuntary behaviour or serious impairment of the capacity to control behaviour.  
(2) A diagnosis of mental illness may not be based solely on –  
(a) antisocial behaviour; or  
(b) intellectual or behavioural nonconformity; or  
(c) intellectual disability; or  
(d) intoxication by reason of alcohol or a drug. |
| **Mental Health Act 1986 (Vic)** | s 8 | (1) Subject to subsection (2), a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.  
(2) (Omitted – exclusion criteria, see Table 9 below) |
| **Mental Health Act 1996 (WA)** | s 4 | (1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent.  
(2) (Omitted – exclusion criteria, see Table 9 below) |
### Table 6: The Diagnostic Criteria of Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>ACT</th>
<th>NSW</th>
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<tr>
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<td></td>
</tr>
<tr>
<td>- disturbance of</td>
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</tr>
<tr>
<td>- thought</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- mood</td>
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<td>serious</td>
<td>serious</td>
<td>significant</td>
</tr>
<tr>
<td>- volition</td>
<td></td>
<td></td>
<td>serious</td>
<td></td>
</tr>
<tr>
<td>- perception</td>
<td></td>
<td></td>
<td>serious</td>
<td></td>
</tr>
<tr>
<td>- orientation</td>
<td></td>
<td></td>
<td>serious</td>
<td></td>
</tr>
<tr>
<td>- memory</td>
<td></td>
<td></td>
<td>serious</td>
<td>significant</td>
</tr>
<tr>
<td>- delusions</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>- hallucinations</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
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<tr>
<td>- sustained or repeated irrational behaviour indicating the presence of the symptoms referred to above</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>- serious impairment or disturbance of capacity for rational thought</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- involuntary behaviour or serious impairment of the capacity to control behaviour</td>
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<tr>
<td>impairment of mental functioning</td>
<td>serious</td>
<td>serious</td>
<td>serious*</td>
<td></td>
</tr>
<tr>
<td>impairment of judgment or behaviour</td>
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<td>significant</td>
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<td>- volition</td>
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<td>- serious impairment or disturbance of capacity for rational thought</td>
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Mental Health Act, ss

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Table 8: The Exclusion Criteria

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<td>+</td>
<td>+</td>
<td>+ (+group)</td>
<td>+ (-activity)</td>
</tr>
<tr>
<td>- religious opinion, belief or activity</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+ (-activity)</td>
</tr>
<tr>
<td>- cultural opinion, belief or activity</td>
<td></td>
<td>+</td>
<td>+ (-activity)</td>
<td></td>
</tr>
<tr>
<td>- philosophy</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>- sexual preference, orientation or promiscuity</td>
<td>+</td>
<td>+ (+activity)</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>- immoral or illegal conduct</td>
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<td>+</td>
<td>+</td>
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</tr>
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<td>- alcohol or other drug abuse</td>
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<td>- intellectual disability</td>
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<td>- personality disorder or habit or impulse disorder</td>
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Table 9: The Exclusion Criteria (continued)

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<td></td>
<td>+ (- activity)</td>
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<td>- religious opinion, belief or activity</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cultural opinion, belief or activity</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+ (- activity)</td>
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<tr>
<td>- philosophy</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sexual preference, orientation or promiscuity</td>
<td>+ (+activity)</td>
<td></td>
<td>+</td>
<td>+ (- orientation)</td>
</tr>
<tr>
<td>- immoral or illegal conduct</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+ (indecent instead of illegal)</td>
</tr>
<tr>
<td>- alcohol or other drug abuse</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- economic or social status</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- cultural or racial group</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>- antisocial behaviour</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- intellectual/behavioural nonconformity</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>- sexual disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- intellectual disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- personality disorder or habit or impulse disorder</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>- developmental disability of mind</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>- family conflict</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>- professional conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- prior mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- prior involuntary status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- acquired brain damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Act, ss</td>
<td>Sched 1</td>
<td>4(2)</td>
<td>8(2)</td>
<td>4(2)</td>
</tr>
<tr>
<td></td>
<td>mental dysfunction, Dictionary</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>--------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>Mental dysfunction means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>mental disorder, s 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If the person’s behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary: (a) for the person’s own protection from serious physical harm, or (b) for the protection of others from serious physical harm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>mental disturbance, s 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The person’s behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that: (i) the person is experiencing or exhibiting a severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and (ii) the person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td>mental disorder, s 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental disorder includes mental illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11: The Requirements for Involuntary Treatment (ACT)

<table>
<thead>
<tr>
<th>ACT</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>application by oneself, s 10</td>
<td>A person has the inability - to make reasonable judgments about matters relating to the person’s own health or safety OR - to do anything necessary for the person’s own health or safety.</td>
<td>Option 1: A person’s health and safety is, or is likely to be substantially at risk.</td>
<td>belief on reasonable grounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 2: A person is likely, because of mental illness, to do serious harm to others.</td>
<td>belief on reasonable grounds</td>
</tr>
<tr>
<td>application by others, s 11</td>
<td>Option 1: Unless subject to involuntary psychiatric treatment the person is likely - to do serious harm to him- or herself OR - to suffer serious mental or physical deterioration.</td>
<td></td>
<td>belief on reasonable grounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 2: Unless subject to involuntary psychiatric treatment the person is likely to do serious harm to someone else.</td>
<td>belief on reasonable grounds</td>
</tr>
<tr>
<td>criteria for psychiatric treatment order, s 38</td>
<td>- The person has a mental illness. - The ACAT is satisfied that psychiatric treatment is likely to reduce the harm or deterioration (or the likelihood of harm or deterioration) and to result in an improvement in the person's psychiatric condition. - The treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.</td>
<td></td>
<td>belief on reasonable grounds</td>
</tr>
</tbody>
</table>
Table 12: The Requirements for Involuntary Treatment (NSW)

<table>
<thead>
<tr>
<th>NSW</th>
<th>self-harm</th>
<th>harm to others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A person is a mentally ill person.</td>
<td>A person is a mentally ill person.</td>
</tr>
</tbody>
</table>

- Mental illness is defined in sections ss 4,14.
- The initial detention is authorised by specifically authorised persons, ss 18 ff.
- Ongoing detention requires initial and second examination, and in conflict of opinions, a third examination, s 27.
- Principles for care and treatment, s 68.

belief on reasonable grounds
<table>
<thead>
<tr>
<th>NT</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>As a result of mental illness the person requires treatment and without the treatment, the person is likely to cause serious harm to him- or herself or suffer serious mental or physical deterioration.</td>
<td></td>
<td>The person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment</td>
</tr>
<tr>
<td>Option 2</td>
<td>As a result of mental illness the person requires treatment and without the treatment, the person is likely to cause serious harm to someone else.</td>
<td></td>
<td>The person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment</td>
</tr>
</tbody>
</table>

- The person has a mental illness.
- There is no less restrictive means of ensuring that the person receives the treatment.

- The treatment is authorised by the Tribunal.
- The treatment is authorised by a psychiatric practitioner and treatment is necessary:
  (a) to prevent the person causing serious harm to himself or herself or to someone else; or
  (b) to behaviour of the person likely to cause serious harm to the person or to someone else; or
  (c) to prevent further physical or mental deterioration of the person; or
  (d) to relieve acute symptomatology.
- Every practicable effort must be made to involve the person in considering the nature and effect of the treatment and any alternatives that are reasonably available.

- The treatment is in the best interest of the person;
- the anticipated benefits of the treatment outweigh any risk of harm or discomfort to the person;
- alternative treatments that would be likely to produce equivalent benefits and with less risk of harm are not reasonably available; and
- the treatment represents the least restrictive and least intrusive treatment option reasonably available.
### Table 14: The Requirements for Involuntary Treatment (SA)

<table>
<thead>
<tr>
<th>SA</th>
<th>self-harm</th>
<th>harm to others</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Because of a person’s mental illness, the person requires treatment for the person’s own protection from harm (incl. harm involved in the continuation or deterioration of the person’s condition).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2</td>
<td>Because of a person’s mental illness, the person requires treatment for the protection of others from harm.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Option 1 | - The person has a mental illness.  
- The person requires treatment.  
- There is no less restrictive means than detention and treatment order of ensuring appropriate treatment of the person’s illness.  
- The option of voluntary treatment or a community treatment order must be considered.  
- Expires after max 7 days. | | |
| Option 2 | | | |
| level 1 treatment order, s 21 | | | |
| Option 1 | Because of a person’s mental illness, the person requires treatment for the person’s own protection from harm (incl. harm involved in the continuation or deterioration of the person’s condition). | | |
| Option 2 | Because of a person’s mental illness, the person requires treatment for the protection of others from harm. | | |
| Option 1 | - The person has a mental illness.  
- The person requires treatment.  
- There is no less restrictive means than a detention and treatment order of ensuring appropriate treatment of the person’s illness.  
- The option of voluntary treatment or a community treatment order must be considered.  
- Expires after max 42 days. | | |
| level 2 treatment order, s 25 | | | |
| Option 1 | Because of a person’s mental illness, the person requires treatment for the person’s own protection from harm (incl. harm involved in the continuation or deterioration of the person’s condition). | | |
| Option 2 | Because of a person’s mental illness, the person requires treatment for the protection of others from harm. | | |
| Option 1 | - The person has a mental illness.  
- The person requires treatment.  
- There is no less restrictive means than a detention and treatment order of ensuring appropriate treatment of the person’s illness.  
- The option of voluntary treatment or a community treatment order must be considered.  
- Expires after max 42 days. | | |
| Option 2 | | | |
Table 15: The Requirements for Involuntary Treatment (Qld)

<table>
<thead>
<tr>
<th>Qld</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1</strong></td>
<td>Because of a person’s illness, there is an imminent risk that the person may cause harm to him- or herself or the person is likely to suffer serious mental or physical deterioration.</td>
<td>The person lacks the capacity to consent to be treated for the illness or has unreasonably refused proposed treatment for the illness.</td>
<td>13 assessment of an authorised mental health service, s 13</td>
</tr>
<tr>
<td><strong>Option 2</strong></td>
<td>Because of a person’s illness, there is an imminent risk that the person may cause harm to someone else.</td>
<td>The person lacks the capacity to consent to be treated for the illness or has unreasonably refused proposed treatment for the illness.</td>
<td>13 assessment of an authorised mental health service, s 13</td>
</tr>
</tbody>
</table>

- The person has a mental illness.
- The person’s illness requires immediate (and available) treatment.
- There is no less restrictive way of ensuring that the person receives appropriate treatment for the illness.
- In this context consent requires the person’s own consent only.
Table 16: The Requirements for Involuntary Treatment (Tas)

<table>
<thead>
<tr>
<th>criteria for involuntary treatment, s32</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>The person should be given the treatment in his or her own interests.</td>
<td></td>
<td>The person’s informed consent or substituted consent.</td>
</tr>
<tr>
<td>Option 2</td>
<td>The person should be given the treatment for the protection of others.</td>
<td></td>
<td>A medical practitioner has recommended medical treatment for the illness but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment.</td>
</tr>
<tr>
<td>Option 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The person has a mental illness that is amendable to medical treatment.
Table 17: The Requirements for Involuntary Treatment (WA)

<table>
<thead>
<tr>
<th>WA</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
</table>
| Option 1   | Treatment is required to protect the health or safety of the person or to protect the person from the following kinds of self-inflicted harm:  
- serious financial harm  
- lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has such relationships  
- serious damage to the reputation of the person to prevent the person doing any damage to any property |                                                                              | The person has refused or, due to the nature of the mental illness, is unable to consent to treatment. |
| Option 2   | Treatment is required to protect the health or safety of any other person. |                                                                              | The person has refused or, due to the nature of the mental illness, is unable to consent to treatment. |

- The person has a mental illness requiring treatment.  
- The treatment can be provided through detention.  

The treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.
Table 18: The Requirements for Involuntary Treatment (Vic)

<table>
<thead>
<tr>
<th>Vic</th>
<th>self-harm</th>
<th>harm to others</th>
<th>capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Option 1: Because of the person’s mental illness,</td>
<td>Because of the person’s mental illness, involuntary treatment is necessary for</td>
<td>The person has refused or is unable to consent to</td>
</tr>
<tr>
<td></td>
<td>involuntary treatment is necessary for his or her</td>
<td>the protection of members of the public.</td>
<td>the necessary treatment for the mental illness.</td>
</tr>
<tr>
<td></td>
<td>health or safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Option 2: Because of the person’s mental illness,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>involuntary treatment is necessary for the protection of members of the public.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- The person appears to be mental ill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- The person requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- The person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- In this context consent to treatment requires the person’s own consent only, s 3A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Expires after 72 hours.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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