

MENTAL HEALTH LAWS: WHERE TO FROM HERE?

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Most developed countries have laws that permit the detention and treatment of persons with severe mental impairments without their consent. In Australia, a number of governments have recently undergone or are currently undertaking reviews of mental health legislation in the light of the principles set out in the United Nations Convention on the Rights of Persons with Disabilities. This Convention has generated debates about (a) — whether mental health laws that enable involuntary detention and treatment should be abolished on the basis that they unjustifiably breach human rights; as well as (b) — whether such laws can be reformed in the light of human rights principles to ensure respect for individual choices in relation to treatment. This article explores what these debates may mean for the provision of involuntary treatment in the future.

I INTRODUCTION

In the early evening of 26 August 2007, a pedestrian walking near the Merri Creek in North Fitzroy in Melbourne found the body of a middle-aged man. The man was later identified as 55-year-old Peter Raven Fisher and a Coroner's Inquest found that he had drowned in the creek sometime between 9 August and 26 August 2007.¹

The circumstances leading up to Mr Fisher's death may seem distressingly familiar to those who have experienced severe mental impairments and those who support them.² Mr Fisher was first diagnosed as having paranoid schizophrenia at the age of 15. He moved out of home when he was 19 and subsequently refused to engage with his family. The last time he had seen his parents and brother was some 13 years before he died.

Mr Fisher was on a disability pension and had lived for some years in supported accommodation run by the Mental Illness Fellowship Victoria. He was treated for a time by his general practitioner and a private psychiatrist, but between

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1 Jane Hendtlass, Coroner, 'Inquest into the Death of: Peter Fisher' (Coroners Court of Victoria, 14 February 2013) 14 [11]–[13].

2 I will use the term 'persons with mental impairments' throughout this article as this is the term agreed upon and used in art 1 of the *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) ('CRPD'). The World Network of Users and Survivors of Psychiatry agreed to the use of this term, while noting that it prefers to use the term 'psychosocial disability': World Network of Users and Survivors of Psychiatry, 'Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities' (February 2008) 9 <http://www.wnusp.net/documents/WNUSP_CRPD_Manual.pdf>.

14 November 2005 and 12 October 2006, he was treated as an involuntary patient on a community treatment order under the *Mental Health Act 1986* (Vic). On 13 July 2006, while on the community treatment order, he attempted to commit suicide by walking in front of a car. His injuries required admission into intensive care for a month.

The Mental Health Review Board of Victoria, which conducts reviews of involuntary treatment decisions, discharged Mr Fisher from the community treatment order on 12 October 2006 and he was subsequently given injections of antipsychotic drugs by his general practitioner. He continued to keep appointments for three months, but on 11 January 2007, he was taken by ambulance to hospital after being hit by a car a second time.

Mr Fisher was once more made an involuntary patient on 16 January 2007. He was discharged from the inpatient unit as a voluntary patient a month later after his condition had stabilised and he agreed to return to supported accommodation. He had made it clear to his treating team at the inpatient unit that he particularly disliked being treated as an involuntary patient and wanted to be given his medication by his general practitioner.

There were ongoing disputes about Mr Fisher smoking in his room at the supported accommodation that had been arranged for him. He eventually left these premises and stayed for a month in a guest house before handing in his key on 1 June 2007. His movements between June and when his body was found on 26 August are unknown. It appears that he had not been given any medication after his discharge from the inpatient unit in February.

The Coroner found that Mr Fisher died ‘in circumstances consistent with submersion’ but was ‘unable to say whether he intended to die’.³ In commenting about the management of voluntary patients in the community, she stated:

Mr Fisher’s voluntary legal status left him vulnerable to self-imposed isolation and making inappropriate decisions when his mental state was florid. In the absence of appropriate accommodation and regular antipsychotic injections with associated monitoring of his mental state, he was always going to be at high risk of early death.⁴

The life and death of Peter Fisher raise important questions as to how persons with mental impairments should be treated. Should persons with mental impairments be detained and treated despite their objections? If so, on what basis? Or should someone like Mr Fisher be left alone to cope as best he or she can, even if that may mean an early death?

3 Hendtlass, above n 1, 14 [13].

4 Ibid 18 [41].

In the past, a person in Mr Fisher's situation might have been detained indefinitely in an institution.⁵ Deinstitutionalisation has meant more emphasis on community mental health programs and services, but many people, particularly those living with severe types of mental impairments such as schizophrenia and bipolar disorder, experience various forms of social exclusion and discrimination.⁶ They may refuse treatment because of past adverse experiences in mental health facilities, the side-effects of drug treatment, a belief that they are not ill, or because they want to be left alone.

This article outlines current Australian laws that enable persons with mental impairments to be detained and treated without their consent and examines the effect of the *Convention on the Rights of Persons with Disabilities* ('CRPD') on mental health law reform processes. In particular, it focuses on calls for the abolition of mental health (and guardianship) laws in the light of the CRPD.

When Australia ratified the CRPD, it included a declaration interpreting this Convention as allowing for the 'compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability'.⁷ However, as will be explored below, this declaration is inconsistent with recent pronouncements by the United Nations Committee on the Rights of Persons with Disabilities, such that it does not preclude the exploration of law reform options that provide an alternative framework to involuntary detention and treatment.

This article argues that in light of the ethos of the CRPD, the focus for mental health laws into the future should be on positive rights such as 'the right to the enjoyment of the highest attainable standard of health' as set out in art 25, rather than continuing the current focus on involuntary detention and treatment. By placing obligations on governments to provide and fund services adapted to individual needs, the CRPD shows the way towards finding a midway point between treating people without their consent on the one hand, and leaving them without any care at all on the other.

II CURRENT AUSTRALIAN MENTAL HEALTH LAWS

At present, when it comes to treatment for severe mental impairments, the law in certain circumstances enables the imposition of both detention in mental health facilities and compulsory treatment regardless of a person's wishes and preferences. As Mary Donnelly has pointed out, this constitutes 'an anomaly

5 See, eg, Stephen Garton, 'Asylum Histories: Reconsidering Australia's Lunatic Past' in Catharine Coleborne and Dolly MacKinnon (eds), *'Madness' in Australia: Histories, Heritage and the Asylum* (University of Queensland Press, 2003) 11, 21; Mark Finnane, 'From Dangerous Lunatic to Human Rights?: The Law and Mental Illness in Australian History' in Catharine Coleborne and Dolly MacKinnon (eds), *'Madness' in Australia: Histories, Heritage and the Asylum* (University of Queensland Press, 2003) 23, 24–5.

6 See, eg, Graham Thornicroft, *Shunned: Discrimination Against People with Mental Illness* (Oxford University Press, 2006).

7 *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Australia)* <<https://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-15.en.pdf>>.

within legal systems which privilege and protect the individual's right of autonomy'.⁸

Currently, each Australian state and territory has mental health legislation that enables the involuntary detention and treatment of persons with mental impairments.⁹ Provisions in the various Australian mental health Acts enabling involuntary treatment require there to be some form of 'mental illness' which is largely based on the existence of certain symptoms. For example, s 4 of the *Mental Health Act 2007* (NSW) defines 'mental illness' as:

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:

- (a) delusions,
- (b) hallucinations,
- (c) serious disorder of thought form,
- (d) a severe disturbance of mood,
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

There is generally also a 'need for treatment' criterion such that the treatment must be linked to the mental illness plus a criterion relating to risk, dangerousness or harm to self or others. For example, s 14(1) of the *Mental Health Act 2007* (NSW) states:

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:

- (a) for the person's own protection from serious harm, or
- (b) for the protection of others from serious harm.

Terry Carney and colleagues have pointed out that traditionally, the criteria for involuntary commitment 'have been ... categorised according to whether they are based on dangerousness (invoking the so-called "police power") or need for

8 Mary Donnelly, 'From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights' in Bernadette McSherry (ed), *International Trends in Mental Health Laws* (Federation Press, 2008) 37, 37.

9 *Mental Health (Care and Treatment) Act 1994* (ACT); *Mental Health Act 2007* (NSW); *Mental Health and Related Services Act 2004* (NT); *Mental Health Act 2000* (Qld); *Mental Health Act 2009* (SA); *Mental Health Act 2013* (Tas); *Mental Health Act 2014* (Vic); *Mental Health Act 1996* (WA). At the time of writing, the Australian Capital Territory and Western Australia are drafting entirely new mental health legislation, while the legislation in New South Wales and Queensland is being subjected to limited reviews. For further analysis of the differences between involuntary treatment criteria in Australian mental health legislation, see Bernadette McSherry, 'Australian Mental Health Laws and Human Rights' in Paula Gerber and Melissa Castan (eds), *Contemporary Perspectives on Human Rights Law in Australia* (Thomson Reuters, 2013) 371.

treatment (invoking the protective *parens patriae* jurisdiction of the courts).¹⁰ In Australian laws, as exemplified by s 14(1) of the *Mental Health Act 2007* (NSW) set out above, the relevant provisions combine both the need for treatment and dangerousness criteria. The *Mental Health Act 2013* (Tas) also includes a criterion that ‘the person does not have decision-making capacity’.¹¹ Notions of capacity are explored later in this article.

Some statutes make it clear that involuntary treatment should be a last resort. For example, s 7(1)(b) of the *Mental Health Act 2009* (SA) states:

[Mental health] services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carers or supporters, reside ...

Mental health laws are undergoing reviews in a number of Australian states and territories. International human rights law and, in particular, the principles set out in the *CRPD*, are guiding mental health law reform endeavours in Australia and abroad.¹² The *CRPD* came into force on 3 May 2008. It places obligations on those countries that have become parties to the *CRPD* to promote and ensure the rights of person with disabilities, and sets out the steps that should be taken to ensure equality of treatment. Australia ratified the *CRPD* on 17 July 2008. It is therefore bound to comply with its provisions.¹³ However, the Articles set out in the *CRPD* do not form part of Australian law unless they are specifically incorporated by Parliament into domestic law.¹⁴

Neither ‘disability’ nor ‘persons with disabilities’ is defined in the *CRPD*, but art 1 states that the latter term includes ‘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’ (emphasis added). The Preamble recognises that disability is ‘an evolving concept’ and that it results from the interaction between individuals with impairments and societal barriers.¹⁵

While some individuals with mental impairments may not want to be labelled as disabled and there is an argument that the episodic nature of some mental disorders means they should not be viewed as ‘long-term’, it is important to note that art 1 is an inclusive rather than an exclusive definition. While it refers to ‘long-term’ impairments, the provision is not exhaustive and other impairments may

10 Terry Carney et al, *Australian Mental Health Tribunals — Space for Fairness, Freedom, Protection & Treatment?* (Federation Press, 2011) 51–2 (citation omitted).

11 *Mental Health Act 2013* (Tas) ss 25(c), 40(e).

12 For example, Ireland and Northern Ireland are currently reviewing their mental health laws in the light of the *CRPD*.

13 Article 26 of the *Vienna Convention on the Law of Treaties* sets out that a convention is ‘binding upon the parties to it and must be performed by them in good faith’: *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980).

14 See, eg, *Kioa v West* (1985) 159 CLR 550, 570.

15 *CRPD* preamble (e).

be included.¹⁶ In any case, there is some evidence indicating that those who are subject to involuntary treatment are more likely than not to have been diagnosed with conditions generally thought of as long term. For example, in hearings conducted by the Victorian Mental Health Review Board between July 2012 and June 2013, 59.6 per cent of the diagnoses listed by the treating doctor related to schizophrenia, 18.4 per cent to schizoaffective disorder and 8.8 per cent to bipolar affective disorder.¹⁷ Such conditions may include auditory hallucinations and/or delusions as well as disorganised thinking which, in conjunction with various barriers can hinder ‘full and effective participation in society’. Article 1 would therefore encompass such mental impairments.

The rights outlined in the *CRPD* include the right to life (art 10), the right to equal recognition before the law (art 12), the right to liberty and security of the person (art 14), the right to respect for physical and mental integrity (art 17), the right to live in the community (art 19), the right to education (art 24), and the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability (art 25). The *CRPD* establishes two implementation bodies: the Committee on the Rights of Persons with Disabilities which monitors implementation, and the Conference of State Parties which considers matters regarding implementation.

When Australia ratified the *CRPD*, it included a declaration which is a form of ‘interpretative declaration’.¹⁸ This differs from a reservation which may serve to limit the legal effect of certain provisions in a Treaty.¹⁹ Australia’s declaration attempts to clarify its understanding of certain provisions. It states:

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;

16 Tina Minkowitz, ‘The United Nations *Convention on the Rights of Persons with Disabilities* and the Right to be Free from Nonconsensual Psychiatric Interventions’ (2007) 34 *Syracuse Journal of International Law and Commerce* 405, 407.

17 Mental Health Review Board of Victoria and Psychosurgery Review Board of Victoria, *2012/2013 Annual Report* (2013) 11.

18 United Nations Enable, *Chapter Four: Becoming a Party to the Convention and the Optional Protocol — Declarations to the Convention and Optional Protocol*, United Nations <<http://www.un.org/disabilities/default.asp?id=233>>.

19 See, eg, Alina Kaczorowska, *Public International Law* (4th ed, Routledge, 2010) 105–6.

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.²⁰

This declaration signals that laws enabling 'fully supported or substituted decision-making arrangements' for persons with mental impairments will remain in place in Australia, at least in the short term. However, Annegret Kämpf has argued that this declaration 'contravenes the spirit of the *CRPD*' and that, '[u]nlike a reservation, it cannot exclude or alter the legal effect of the *CRPD*'.²¹ The *CRPD* does not refer to the status of interpretative declarations, but art 46(1) states that '[r]eservations incompatible with the object and purpose of the present Convention shall not be permitted'.²² This implies that if interpretative declarations by States Parties are incompatible with interpretations set out in General Comments and the like, such declarations should not inform law reform endeavours.

As explored below, the United Nations Committee on the Rights of Persons with Disabilities states in its *General Comment on Article 12*,²³ that 'mental health laws that permit forced treatment ... must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others'.²⁴ This Committee has accordingly recommended that Australian review its declaration 'with a view to withdrawing' its interpretations of the relevant Articles.²⁵ On that basis, Australia's declaration should not be viewed as a barrier

20 *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Australia)* <<https://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-15.en.pdf>> (emphasis added).

21 Annegret Kämpf, 'Involuntary Treatment Decisions: Using Negotiated Silence to Facilitate Change?' in Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 129, 148–9.

22 Interestingly, Canada in ratifying the *CRPD*, included both a declaration and a reservation. In a similar fashion to Australia, Canada declared 'its understanding that Article 12 permits supported and substitute decision-making arrangements', but went one step further in stating '[t]o the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate circumstances and subject to appropriate and effective safeguards'. The status of this reservation is unclear — although it was permitted at the time of ratification, the recent pronouncements by the United Nations Committee indicate that the reliance on substituted decision-making regimes is incompatible with the object and purpose of the *CRPD*: *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Canada)* (ratified by Canada on 11 March 2010) <<https://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-15.en.pdf>>.

23 Committee on the Rights of Persons with Disabilities, *General Comment No 1 (2014) — Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014).

24 *Ibid* [7].

25 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia Adopted by the Committee at Its Tenth Session (2–13 September 2013)*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 2 [9].

to law reform endeavours that go beyond the status quo of involuntary detention and treatment.

This next section sets out some of the arguments concerning the potential effect of the *CRPD* upon mental health legislation in the light of specific rights, and examines whether or not the *CRPD* requires mental health legislation to be abolished or reformed to comply with its provisions. It is argued that from a principled theoretical perspective, the *CRPD* does require the abolition of mental health laws. The challenge is to provide realistic alternatives for the care and treatment of persons with mental impairments, which would benefit someone like Mr Fisher who had refused to engage with his family, and who had limited social supports in place.

III SPECIFIC RIGHTS UNDER THE *CRPD* AND MENTAL HEALTH LAWS

This Part focuses on three rights that have particular relevance for persons with mental impairments: the right to liberty and security of the person, the right to equal recognition before the law, and the right to enjoy the highest attainable standard of health.²⁶ Each is analysed in respect to what they may mean for legal frameworks within Australia relating to the detention and treatment of persons with mental impairments.

A *The Right to Liberty and Security of the Person*

Article 14(1) of the *CRPD* sets out that:

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*.²⁷

Article 14 reflects to some extent the wording of art 9(1) of the *International Covenant on Civil and Political Rights*, which Australia ratified on 13 August

26 These rights are discussed because recent interpretations of arts 12 and 14 call for the abolition of mental health laws and art 25 places obligations on State Parties to provide health services targeted towards individual needs. This is not to say that other *CRPD* Articles are not relevant to mental health laws. For example, for a discussion of what art 17 may mean in relation to mental health laws, see Bernadette McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' in Bernadette McSherry (ed), *International Trends in Mental Health Laws* (Federation Press, 2008) 111.

27 Emphasis added.

1980.²⁸ However, as outlined below, the main debate has been about the meaning of the words ‘the existence of a disability shall in no case justify a deprivation of liberty’. These words could be interpreted to mean that that laws enabling the involuntary detention of individuals with disabilities should be abolished, or alternatively, it could be read down to mean that the existence of a disability *alone* does not justify such laws.

During the drafting of art 14, some States, including Australia, advocated that it should set out that any deprivation of liberty should not be ‘solely’ based on disability.²⁹ This approach would leave it open for detention to be allowed where other criteria such as the need for treatment or dangerousness coexisted with a criterion of disability.

In contrast to this submission, the World Network of Users and Survivors of Psychiatry argued that the introduction of the word ‘solely’

would 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. ... [Those with disabilities] should not be subject to a different standard.³⁰

On this point, however, it should be noted that there are laws in place that do enable the ‘civil’ detention of certain individuals such as those who have infectious diseases or are addicted to drugs, those who are classified as dangerous sex offenders, and those seeking asylum.³¹

Ultimately, the word ‘solely’ was not included in art 14 and there are now a number of statements which indicate that mental health legislation that enables the involuntary detention of those with mental impairments breaches this Article. For example, the Office of the High Commissioner of Human Rights has stated that ‘[I]n legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished’.³² It has stated 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

28 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) (‘ICCPR’).

29 United Nations Enable, *Daily Summary of Discussions Related to Article 10: Liberty and Security of the Person* (26 May 2004) United Nations <<http://www.un.org/esa/socdev/enable/rights/ahc3sum10.htm>>.

30 *Ibid.*

31 See generally Bernadette McSherry, ‘Sex, Drugs and “Evil” Souls: The Growing Reliance on Preventive Detention Regimes’ (2006) 32 *Monash University Law Review* 237; Bernadette McSherry, *Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment* (Routledge, 2014).

32 Human Rights Council, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General — Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities*, 10th sess, UN Doc A/HRC/10/48 (26 January 2009) 16 [49].

persons on an equal basis'.³³ Any such statements from the Office of the High Commissioner of Human Rights, however, are not legally binding.

Perhaps of more significance are specific statements by the United Nations Committee on the Rights of Persons with Disabilities which monitors the implementation of the *CRPD*. In response to Tunisia's report to the Committee, the Committee recommended that Tunisia 'repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability'.³⁴ The Committee reiterated this position in response to a report by Spain, calling for the repeal of 'provisions that authorize involuntary internment linked to an apparent or diagnosed disability'.³⁵ The Committee has not resiled from this position in subsequent responses to reporting countries.

Interestingly, Australia's declaration refers only to 'compulsory assistance or treatment' and is silent as to involuntary *detention* for the purposes of treatment. In its initial report under the *CRPD*, Australia stated:

Australia is committed to ensuring that the right of all persons with mental health concerns to liberty and security of person is respected. Persons with mental illnesses will only be detained in a health context where there is a risk of harm to themselves and others. These detention measures are subject to a number of safeguards.³⁶

In response, the United Nations Committee, in line with its previous directions, recommended that Australia

repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.³⁷

This leaves no room for argument that mental health laws as they currently exist are compatible with art 14. One alternative would be to enact laws that allow for the deprivation of liberty in certain circumstances without referring to disabilities. The reference to risk of harm in Australia's report raises the spectre

33 Ibid.

34 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*, UN Doc CRPD/C/TUN/CO/1, 5th sess (13 May 2011) [25].

35 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*, UN Doc CRPD/C/ESP/CO/1, 6th sess (19 October 2011) [36].

36 Attorney-General's Department (Cth), 'Australia's Initial Report under the *Convention on the Rights of Persons with Disabilities*', Report to the Committee on the Rights of Persons with Disabilities, 3 December 2010, 22 [76] (citation omitted).

37 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia Adopted by the Committee at Its Tenth Session (2–13 September 2013)*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [34].

of preventive detention which has long existed for certain groups across place and time.³⁸ Peter Bartlett states in this regard:

If it is dangerousness that is of concern, for example, a disability-neutral law could be introduced to detain people who are perceived as dangerous, irrespective of disability. While this might satisfy the problems of interpretation of Article 14, it is difficult to see that it is a good idea. It is difficult to see that it would be wise in human rights terms to encourage autocratic regimes to introduce laws allowing detention of people perceived as dangerous (whether mentally disabled or not), as such a law invites political abuse.³⁹

Returning to the facts of the coronial enquiry referred to at the start of this article, should a person in Mr Fisher's circumstances be detained in hospital against his or her will? There appears to be no evidence to suggest that Mr Fisher was a danger to others. It was apparent that he particularly disliked being treated as an involuntary patient in hospital and had for some time been treated in the community by his general practitioner and a private psychiatrist. Obviously this option is preferable to preventive detention and art 14 signals that policymakers need to explore ways of treating people with dignity in the community, rather than detaining them against their will in psychiatric facilities.

It appears unlikely in the short term that mental health legislation as it currently exists will be repealed, given the focus of policymakers on law reform rather than abolition, but the Committee's statements interpreting art 14 indicate that mental health laws that enable the involuntary detention of those with mental impairments are incompatible with this Article.

B The Right to Equal Recognition before the Law

Article 12 of the *CRPD* sets out the right to equal recognition before the law and refers to the right to 'enjoy legal capacity on an equal basis with others in all aspects of life'. Of particular relevance to those with mental impairments are the following paragraphs:

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*

38 McSherry, *Managing Fear: The Law and Ethics of Preventive Detention and Risk Assessment*, above n 31.

39 Peter Bartlett, 'The United Nations *Convention on the Rights of Persons with Disabilities* and Mental Health Law' (2012) 75 *Modern Law Review* 752, 773.

*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.*⁴⁰

Article 12 begins with the presumption that those with disabilities possess legal capacity on an equal basis with others. However, it then goes on to require support to be given to individuals, should they need help with exercising their legal capacity. This has been taken to mean that art 12 permits *supported* decision-making processes.

1 The concept of 'legal capacity'

The Council of Europe's Commissioner for Human Rights defines 'legal capacity' as 'a person's power or possibility to act within the framework of the legal system'.⁴¹ There are two constituent elements to legal capacity. The first refers to 'legal standing' in the sense of being viewed as a person before the law; the second to 'legal agency', or what is sometimes referred to as 'active legal capacity'.⁴²

At various times in different societies, certain groups have been viewed as not having legal 'personhood' or standing. The extinction or suspension of legal standing, sometimes referred to as 'civil death', was once seen as a necessary consequence of conviction.⁴³ Similarly, women, children under the age of majority and persons with mental and intellectual impairments have been and continue to be viewed in some societies as not having legal standing.⁴⁴ Paragraph (1) of art 12 states 'that persons with disabilities have the right to recognition everywhere as

40 Emphasis added.

41 Commissioner for Human Rights, 'Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities' (Issue Paper No 2, Council of Europe, 20 February 2012) 7 [1.1].

42 See generally István Hoffman and György Könczei, 'Legal Regulations Relating to the Passive and Active Legal Capacity of Persons with Intellectual and Psychosocial Disabilities in Light of the *Convention on the Rights of Persons with Disabilities* and the Impending Reform of the Hungarian Civil Code' (2010) 33 *Loyola of Los Angeles International and Comparative Law Review* 143; Gerard Quinn and Anna Arstein-Kerslake, 'Restoring the "Human" in "Human Rights": Personhood and Doctrinal Innovation in the UN Disability Convention' in Conor Gearty and Costas Douzinas (eds), *Cambridge Companion to Human Rights Law* (Cambridge University Press, 2012) 36; Bernadette McSherry, 'Legal Capacity under the *Convention on the Rights of Persons with Disabilities*' (2012) 20 *Journal of Law and Medicine* 22; Fiona Morrissey, 'The *United Nations Convention on the Rights of Persons with Disabilities*: A New Approach to Decision-Making in Mental Health Law' (2012) 19 *European Journal of Health Law* 423; Nicholas Caivano, 'Conceptualizing Capacity: Interpreting Canada's Qualified Ratification of Article 12 of the UN Disability Rights Convention' (2014) 4(1) *Western Journal of Legal Studies* <<http://ir.lib.uwo.ca/uwojls/vol4/iss1/>>; Eilionóir Flynn and Anna Arstein-Kerslake, 'The Support Model of Legal Capacity: Fact, Fiction or Fantasy?' (2014) 32 *Berkeley Journal of International Law* 124.

43 See generally Alec Ewald, "'Civil Death": The Ideological Paradox of Criminal Disenfranchisement Law in the United States' [2002] *Wisconsin Law Review* 1045.

44 Flynn and Arstein-Kerslake, above n 42, 125.

persons before the law', thereby requiring States Parties to ensure that those with disabilities are not treated differently when it comes to legal standing.

'Legal agency' refers to the ability 'to act within the framework of the legal system'.⁴⁵ The reference to exercising legal capacity in art 12(3) together with art 12(2) ensures that legal agency is also encompassed by the concept of legal capacity within the *CRPD*.⁴⁶ It is this aspect of legal capacity that has been the focus of recent writing in relation to those with mental and intellectual impairments.

Gerard Quinn and Anna Arstein-Kerslake have conceptualised the exercise of legal capacity in terms of it being both a sword and a shield.⁴⁷ Used as a sword, the exercise of legal capacity reflects an individual's right to make decisions for him or herself and to have those decisions respected by others. Such decisions include the right to marry and to have a family, the right to enter into contracts such as to buy a house or to be employed, the right to make a will and so on. Used as a shield, the exercise of legal capacity refers to the power of the individual to stop others from purporting to make decisions on his or her behalf.

Article 12 sets up a presumption of legal capacity by making it clear that those with disabilities have legal capacity on an equal basis with others. The main issue therefore becomes whether and in what circumstances such a presumption can be displaced.

2 Traditional Approaches to Displacing Legal Capacity

Traditionally, there have been two main approaches to determining whether or not a person lacks legal capacity:⁴⁸

- (1) The *status approach* focuses on a certain characteristic of the person in order to find that the person lacks capacity. Hence, having a particular disability — in particular having a severe mental or intellectual impairment — has led to an automatic loss of legal capacity in both terms of legal standing and legal agency.
- (2) The *cognitive approach* focuses on assessing the decision-making abilities of the individual concerned. The cognitive approach encompasses the notion of 'mental capacity' or 'mental competence', the latter term being used most often in North America.

Certain statutes such as the *Mental Capacity Act 2005* (UK) ('*MCA*'), which applies in England and Wales, take a cognitive approach to displacing legal capacity,

45 Commissioner for Human Rights, 'Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities' (Issue Paper No 2, Council of Europe, 20 February 2012) 7 [1.1].

46 Article 12(2) of the *CRPD* sets out that 'States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'.

47 Quinn and Arstein-Kerslake, above n 42, 42.

48 See generally Gareth S Owen et al, 'Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge' (2009) 52 *Inquiry* 79; McSherry, 'Legal Capacity under the *Convention on the Rights of Persons with Disabilities*', above n 42.

and there are moves towards following this approach in Australian mental health laws.⁴⁹ Section 2(1) of the MCA states that ‘a person lacks capacity in relation to a matter if at the material time he [or she] is unable to make a decision for himself [or herself] in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain’. Section 3(1) then sets out that ‘a person is unable to make a decision’ if that person is unable —

- (a) to understand the information relevant to the decision,
- (b) to retain that information,
- (c) to use or weigh that information as part of the process of making the decision, or
- (d) to communicate his [or her] decision (whether by talking, using sign language or any other means).

This test is sometimes referred to as a ‘functional’ test in that it assesses decision-making abilities on an issue-specific or ‘domain’-specific basis, recognising that mental capacity may fluctuate, and that it needs to be assessed at a particular time in relation to a particular decision. Genevra Richardson writes in relation to this concept of mental capacity:

For the law, mental capacity is an essential ingredient of individual autonomy and is employed to define the line between legally effective and legally ineffective decisions. Those with mental capacity will have the legal capacity to act: their decisions or choices will be respected. In contrast, those who lack mental capacity will also lack legal capacity: their decisions and choices will not be respected and decisions will be made by others on their behalf.⁵⁰

Mental capacity is therefore, at present, closely linked to legal capacity in certain jurisdictions. Some commentators on art 12 of the CRPD have questioned the cognitive approach to legal capacity on the basis that it promotes a medical model of decision-making based purely on cognition at the expense of other factors, and because it assesses decision-making in isolation from the influence of third party support.⁵¹ For example, John Brayley has called for a re-casting of ‘legal capacity’

49 As stated above, the *Mental Health Act 2013* (Tas) now includes a capacity criterion for assessment and involuntary treatment. Section 7(1) of that Act states:

For the purposes of this Act, an adult is taken to have the capacity to make a decision about his or her own assessment or treatment (*decision-making capacity*) unless a person or body considering that capacity under this Act is satisfied that —

- (a) he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain; and
- (b) he or she is unable to —
 - (i) understand information relevant to the decision; or
 - (ii) retain information relevant to the decision; or
 - (iii) use or weigh information relevant to the decision; or
 - (iv) communicate the decision (whether by speech, gesture or other means).

50 Genevra Richardson, ‘Mental Capacity in the Shadow of Suicide: What Can the Law Do?’ (2013) 9 *International Journal of Law in Context* 87, 89 (emphasis in original).

51 *Ibid* 91; Michael Bach and Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (October 2010) Law Commission of Ontario, 67 <<http://www.leo-cdo.org/disabilities/bach-kerzner.pdf>>.

to see it as a universal entitlement rather than a concept linked primarily to mental capacity.⁵² This idea is explored further below.

Significantly, there is no mention in art 12 of mental capacity, nor is there any reference to substituted decision-making which is the basis for involuntary treatment. That is, it is the treating psychiatrist who, under Australian mental health laws, substitutes his or her decision to provide treatment in place of the decision of a person with a mental impairment. This means that the psychiatrist's substituted decision can apply even when the person with a mental impairment does not want treatment. Substituted decision-making also underpins Australia's guardianship and administration laws. In its *Initial Report* to the Committee on the Rights of Persons with Disabilities, the Australian Government stated in relation to art 12:

Australia strongly supports the right of persons with disabilities to legal capacity. In some cases, persons with cognitive or decision-making disabilities may require support in exercising that capacity. In Australia, substituted decision-making will only be used as a measure of last resort where such arrangements are considered necessary, and are subject to safeguards in accordance with article 12(4). For example, substituted decisionmaking may be necessary as a last resort to ensure that persons with disabilities are not denied access to proper medical treatment because of an inability to assess or communicate their needs and preferences. Australia's interpretive declaration in relation to article 12 of the Convention sets out the Government's understanding of our obligations under this article. Australia's guardianship laws and the safeguards contained in them aim to ensure abuse, exploitation and neglect does not occur, consistent with article 16 of the Convention.⁵³

The notion that others should be able to make decisions on behalf of those with mental or intellectual impairments under mental health or guardianship laws rests on interpreting art 12(4) as including substituted decision-making within the phrase 'all measures that relate to the exercise of legal capacity'. The focus then becomes: what does 'respect' mean in relation to the 'will and preferences of the person' in making a substituted decision? Many law reform endeavours are focused on this point.⁵⁴ However, this view is now being challenged, as will be explored in the next section.

52 John Brayley, 'Supported Decision Making in Australia: Presentation Notes' (Notes of speech delivered at the Office of the Public Advocate, Victoria, Melbourne, 14 December 2009) <http://www.opa.sa.gov.au/documents/08_News_%26_Articles/Supported%20Decision%20Making.pdf>. See also International Disability Alliance, *Legal Opinion on Article 12 of CRPD* (2008) International Disability Alliance <<http://www.internationaldisabilityalliance.org/en/ida-position-papers-and-statements>>.

53 Attorney-General's Department (Cth), 'Australia's Initial Report under the *Convention on the Rights of Persons with Disabilities*', Report to the Committee on the Rights of Persons with Disabilities, 3 December 2010, 16 [55] ('*Initial Report*').

54 See, eg, the Victorian Law Reform Commission's interpretation of art 12 for the purposes of reforming guardianship laws: Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) chs 7–9.

3 Current Interpretations of Article 12 — No Exceptions to Legal Capacity

The response by the Committee on the Rights of Persons with Disabilities to Australia's *Initial Report* makes it clear that laws that enable substituted decision-making should be replaced. The Committee notes that the Australian Law Reform Commission is inquiring into the barriers to equal recognition before the law,⁵⁵ and states: 'The Committee recommends that ... [Australia] effectively use the current inquiry to *take immediate steps* to replace substitute decision-making with supported decision-making'.⁵⁶

In its *General Comment on Article 12*, the Committee clarifies that

substitute decision-making regimes such as guardianship, conservatorship, mental health laws that permit forced treatment ... must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.⁵⁷

There have been recent calls in Australia for involuntary treatment criteria to be based on decision-making capacity rather than notions of dangerousness.⁵⁸ Others have argued for generic mental capacity legislation that would enable the involuntary treatment of those with mental and intellectual impairments regardless of the cause.⁵⁹ However, the *General Comment on Article 12* points out that

the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. ... a person's disability and/or decision-making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity ...⁶⁰

55 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia Adopted by the Committee at Its Tenth Session (2–13 September 2013)*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [24].

56 *Ibid* [25] (emphasis added).

57 Committee on the Rights of Persons with Disabilities, *General Comment No 1 (2014) — Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) [7].

58 M M Large et al, 'The Danger of Dangerousness: Why We Must Remove the Dangerousness Criterion from Our Mental Health Acts' (2008) 34 *Journal of Medical Ethics* 877; Christopher James Ryan, 'Capacity as a Determinant of Non-Consensual Treatment of the Mentally Ill in Australia' (2011) 18 *Psychiatry, Psychology and Law* 248; Christopher Ryan, Sascha Callaghan and Matthew Large, 'Better Laws for Coercive Psychiatric Treatment: Lessons from the Waterlow Case' (2012) 20 *Australasian Psychiatry* 283.

59 See, eg, John Dawson and George Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *British Journal of Psychiatry* 504; George Szmukler, Rowena Daw and John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' [2010] (Special issue) *Journal of Mental Health Law* 11; Rowena Daw, 'The Case for a Fusion Law: Challenges and Issues' in Bernadette McSherry and Ian Freckelton (eds), *Coercive Care: Rights, Law and Policy* (Routledge, 2013) 93.

60 Committee on the Rights of Persons with Disabilities, *General Comment No 1 (2014) — Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) [15].

Laws that enable involuntary treatment on the basis of a loss of decision-making capacity on this view are discriminatory. Mental capacity should no longer be intrinsically linked to legal capacity. In Genevra Richardson's words, '[in] its purest form there is no point beyond which legal capacity is lost. There is no binary divide'.⁶¹ This 'purist' approach to legal capacity means that there can be no displacement and no exceptions to it. Gerard Quinn warns against trying to work out exceptions to legal capacity by invoking the maxim of political philosopher Karl Schmitt: 'he who controls the exceptions controls the rules'.⁶²

If substituted decision-making breaches art 12, what is the alternative? Peter Bartlett points out that '[t]he big issue that is largely unexamined in the *CRPD* itself is how the shift to a pure supported decision-making structure will work in practice'.⁶³ In 2007, a handbook for parliamentarians on the *CRPD* stated:

Establishing comprehensive support networks requires effort and financial commitment, although existing models of guardianship can be equally costly. Supported decision-making should thus be seen as a redistribution of existing resources, not an additional expense.⁶⁴

The handbook, however, does not go into details about what sort of support networks should be established. Research is now being undertaken as to how best to implement supported decision-making regimes. Tina Minkowitz has outlined a number of such regimes — from informal networks of family and friends, to formal registration of support persons and peer support schemes.⁶⁵ Michael Bach and Lana Kerzner have outlined a range of supports under the headings 'life planning supports', 'independent advocacy', 'communicational and interpretive supports', 'representational relationship-building supports' and 'administrative supports'.⁶⁶ They however also allow for a form of substitute decision-making in exceptional circumstances.⁶⁷ Piers Gooding has referred to the core concepts of supported decision-making as involving an emphasis on '[a]utonomy with [s]upport', autonomy as 'interdependent' in nature, and attributing a 'positive value to risk taking' (sometimes referred to as 'the dignity of risk').⁶⁸ He sets out a number of examples of how these concepts can be found in practice.⁶⁹

61 Richardson, above n 50, 92.

62 Gerard Quinn, 'Rethinking Personhood: New Directions in Legal Capacity Law and Policy,' (Speech delivered at the New Foundations for Personhood & Legal Capacity in the 21st Century Conference, University of British Columbia, 29 April 2011) 6 <http://cic.arts.ubc.ca/files/2014/07/Gerard_Quinn_s_Keynote_-_April_29__2011.pdf>.

63 Bartlett, above n 39, 766.

64 United Nations Department of Economic and Social Affairs, Office of the United Nations High Commissioner for Human Rights and the Inter-Parliamentary Union, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities* (United Nations, 2007) 91 <<http://www.ipu.org/PDF/publications/disabilities-e.pdf>>.

65 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, 2010) 151, 163–6.

66 Bach and Kerzner, above n 51, 72–82.

67 *Ibid* 91–4.

68 Piers Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law' (2013) 20 *Psychiatry, Psychology and Law* 431, 434–6.

69 *Ibid* 442–5.

Supported decision-making schemes are generally being introduced alongside substituted decision-making schemes. The *General Comment on Article 12* cautions that the ‘development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12’.⁷⁰

Returning to the facts of the coronial enquiry, it is unclear what Mr Fisher thought about the medical treatment he was receiving, apart from the fact that he did not want to be treated against his will. There was evidence, however, about ongoing disputes with those in charge of the supported accommodation where he was staying in relation to his smoking. Would the existence of supported decision-making schemes help assist someone in Mr Fisher’s position in this regard? Soumitra Pathare and Laura Shields refer to a range of informal supports such as peer support networks (where those who have experienced mental health issues work with others) and independent advocates as helping to ‘alleviate the barrier of social exclusion that limits support’ for those who have lost touch with their families and friends.⁷¹ Perhaps an informal network of supports could have assisted Mr Fisher in reaching a compromise about the issue of his smoking, but it is unclear whether such a scheme, or indeed a more formal legislative scheme would have assisted Mr Fisher in making decisions about his medical treatment and care.

Peter Bartlett outlines some of the practical difficulties with putting supports into practice:

For some individuals, the intensity of support that will be necessary is likely to be such as to raise fundamental questions, such as whether the decision is the will of the person with disabilities or the supporter, whether the person with disabilities is empowered any more than under a well-developed capacity-based system, how one is theoretically to understand the roles of supporter and supported in this system, and how to practically provide appropriate protections in the event that the supporter is taking advantage.⁷²

Fiona Morrissey has also pointed out that ‘[o]ne of the challenges for national legislatures is to ensure that the new model [of supported decision-making] constitutes genuine support and not substituted decision-making under a new guise’.⁷³

On a ‘purist’ level, therefore, mental health and guardianship laws breach art 12. Those with mental impairments should not be treated without their consent. On a practical level, however, it seems unlikely that any Australian government will immediately take up the *CRPD* Committee’s recommendation to abolish substituted decision-making in favour of supported decision-making. Instead, it

70 Committee on the Rights of Persons with Disabilities, *General Comment No 1 (2014) — Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) [28].

71 Soumitra Pathare and Laura S Shields, ‘Supported Decision-Making for Persons with Mental Illness: A Review’ (2012) 34(2) *Public Health Reviews* 1, 29.

72 Bartlett, above n 39, 766–7.

73 Morrissey, above n 42, 432.

appears more likely that ongoing reforms to mental health laws will explore how supported decision-making can be introduced into existing legislative regimes.⁷⁴

C The Right to Health

Article 25 of the *CRPD* reiterates art 12(1) of the *International Covenant on Economic, Social and Cultural Rights*,⁷⁵ in requiring States to recognise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. However, art 25 goes further than art 12(1) by adding certain obligations on States including obligations to:

(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; ...

(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 ...⁷⁶

Article 25 can be viewed as helping to develop the interpretation of the right to the highest attainable standard of health set out in *General Comment No 14* of the United Nations Committee on Economic, Social and Cultural Rights.⁷⁷ That *General Comment* states that ‘the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health’.⁷⁸ Article 25 of the *CRPD* sets out the steps that should be taken to ensure that these facilities and services are provided.

The human rights debates concerning mental health have traditionally focused on the rights to liberty and autonomy in relation to the involuntary commitment of persons with very severe mental impairments.⁷⁹ It has only been during the past

74 In the guardianship arena, for example, the Victorian Law Reform Commission has made extensive recommendations in relation to the introduction of ‘supporters’ and ‘co-decision makers’ in addition to substitute decision makers: Victorian Law Reform Commission, above n 54.

75 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976; entered into force for Australia 10 March 1976).

76 Emphasis added.

77 Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000): The Right to the Highest Attainable Standard of Health (Art 12 of the International Covenant on Economic, Social and Cultural Rights)*, 22nd Sess, UN Doc E/C.12/2000/4 (11 August 2000).

78 *Ibid* [9].

79 On this point, see generally, Donnelly, above n 8.

decade that any discussion of the right to health and the associated right to access health services has carried over to the mental health arena.⁸⁰

The focus in mental health laws on involuntary detention and treatment may affect the allocation of mental health resources in general. For example, Mary Durham and Glenn Pierce have pointed out that broadening the scope of civil commitment criteria in Washington mental health laws meant that '[c]ivil commitment became focused almost exclusively on involuntary patients, and the number of voluntary admissions to the state mental hospital system was reduced drastically'.⁸¹ Certainly, there is evidence in Australia that far fewer individuals with mental impairments access health services when compared to those with physical disorders.⁸² In 2010, Sarah Olesen, Peter Butterworth and Liana Leach stated that 'only 39% of Australian adults who met the criteria for a common mental disorder in the last 12 months had used formal mental health services'.⁸³ While some mental health laws contain separate provisions for those who are being treated on a voluntary basis,⁸⁴ most laws focus on involuntary detention and treatment. This skews the system such that those who want treatment may be refused access because they are not 'ill enough', while those who do not want treatment are detained and/or treated without their consent.

In interviews conducted as part of an Australian Research Council Federation Fellowship,⁸⁵ half of the interviewees (37 out of 65) were concerned about resource constraints preventing persons with mental impairments obtaining access to treatment, at times with tragic consequences. Kay Wilson points out in this regard:

There was a general concern about the lack of services for voluntary patients. The problem was perceived to be that people seeking treatment for themselves or their children are turned away because they are not sick enough. This means that they are left to deteriorate in the community without treatment until they either commit a crime (and so enter the

80 See, eg, Lawrence O Gostin and Lance Gable, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (2004) 63 *Maryland Law Review* 20.

81 Mary L Durham and Glenn L Pierce, 'Legal Intervention in Civil Commitment: The Impact of Broadened Commitment Criteria' (1986) 484 *Annals of the American Academy of Political and Social Science* 42, 55.

82 Department of Health and Ageing, *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services Under the National Mental Health Strategy 1993–2008* (Report No 11, 2010) 17.

83 Sarah C Olesen, Peter Butterworth and Liana Leach, 'Prevalence of Self-Management Versus Formal Service Use for Common Mental Disorders in Australia: Findings from the 2007 National Survey of Mental Health and Wellbeing' (2010) 44 *Australian and New Zealand Journal of Psychiatry* 823, 829.

84 For an overview of Australian laws in this regard, see Bernadette McSherry, 'The Right of Access to Mental Health Care: Voluntary Treatment and the Role of the Law' in Bernadette McSherry and Penny Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 379.

85 Australian Research Council Federation Fellowship Project ID FF0776072, *Rethinking Mental Health Laws: An Integrated Approach*, awarded to Professor Bernadette McSherry 2007–12.

forensic system) or satisfy the criteria for involuntary treatment (and are civilly committed).⁸⁶

This right to the enjoyment of services marks a significant challenge for mental health laws, given that it is difficult for tribunals and courts to ‘force’ governments to resource mental health services. Nancy Rhoden has pointed out in relation to mental health care in the United States that:

Since judicial decrees can grant rights against government infringement of liberty far more easily than they can establish positive entitlements to care and services, the result was that mental patients obtained their liberty, but at the expense of the community care they so desperately needed.⁸⁷

Some laws in fact make it clear that there is no obligation on clinicians to admit those with mental impairments into hospital. For example, s 6(1) of New Brunswick’s *Mental Health Act*⁸⁸ states that ‘admission to a psychiatric facility may be refused by the authorities at the facility if the immediate needs in the case of the proposed patient are such that hospitalization is not urgent or necessary’.

One existing example that reflects the right to the enjoyment of services relates to powers to review a decision by a clinician not to admit an individual to a mental health facility. Section 25(9) of the *Mental Health and Related Services Act* (NT) states:

On refusing to admit a person or to confirm the admission of a person under this section, the medical practitioner or authorised psychiatric practitioner:

- (a) must inform the person of the grounds of the decision and that the person has a right to apply to the Tribunal for a review of the decision; and
- (b) must explain the review procedure to the person.

The Mental Health Review Tribunal under s 127(5) has the following powers in relation to reviewing a decision to refuse admission:

Following a review in relation to an application made under subsection (1), the Tribunal may:

- (a) affirm, vary or set aside the decision or order;
- (b) make any decision or order that the medical practitioner or authorised psychiatric practitioner may have made;
- (c) refer the matter back to the medical practitioner or authorised psychiatric practitioner for further consideration; or
- (d) make any other order it thinks fit.

86 Kay Wilson, ‘Law Reform or Systemic Reform? Stakeholder Perceptions of Resource Constraints in Mental Health in Australia, New Zealand and Canada’ (2013) 20 *Psychiatry, Psychology and Law* 553, 567.

87 Nancy K Rhoden, ‘The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory’ (1982) 31 *Emory Law Journal* 375, 377.

88 *Mental Health Act*, RSNB 1973, c M-10.

This last power means that, in theory at least, the Mental Health Review Tribunal may order that the person concerned be admitted to the facility. In New South Wales, an individual can apply to the ‘medical superintendent’ (the psychiatrist in charge of the mental health facility) for a review of a decision not to be admitted to the facility.⁸⁹ The former New South Wales Minister for Mental Health, Kevin Humphries, has signalled that this may be reformed to enable a right of appeal to the Mental Health Review Tribunal for ‘those who are refused access to ensure that mental health services remain open and accessible to consumers’.⁹⁰ There has, as yet, been no study carried out as to how often the Northern Territory and New South Wales provisions are used. Applying to another psychiatrist for a review of a decision not to admit may not be a popular option for those with mental impairments because of the reviewer’s connection to the mental health facility. Review by a Tribunal has the benefit of being seen to be independent from the mental health facility.

While the situation remains skewed towards involuntary treatment, these provisions indicate that there can be avenues of review available for those who seek admission to mental health facilities but who are refused. While this may appear to be discriminatory given that those refused admission to health services in general have no right of review, the situation needs to be placed in the context of the differential implementation of resources for mental health services. The Australian Institute of Health and Welfare has estimated that during 2011–12, Australia spent \$140.2 billion or 9.5 per cent of the Gross Domestic Product on health.⁹¹ Around 8 per cent of that total figure is spent on ‘mental disorders’,⁹² indicating that 92 per cent of health spending goes elsewhere. A 2013 report by health insurer Medibank Private claims that the amount of mental health funding is higher than previously indicated, but that the main problem is poor system design.⁹³ As well as identifying fragmentation and insufficient coordination of services, this report found that ‘[s]atisfaction levels with mental health services are low relative to other health services’.⁹⁴

Shifting the focus from involuntary treatment towards resourcing high quality mental health services, particularly in the community, will not only serve

89 *Mental Health Act 2007* (NSW) s 11.

90 Kevin Humphries MP, ‘NSW Government Response to the Release of the Report into the Evaluation of Efficacy and Cost of the Mental Health Inquiry System, NSW’ (Media Release, 15 March 2012) <http://www.health.nsw.gov.au/news/Documents/20120315_00.pdf>. For a discussion of a refusal of access, see also New South Wales Ministry of Health, *Review of the NSW Mental Health Act 2007 — Summary of Consultation Feedback and Advice* (Report for NSW Parliament, May 2013) 23–7 <<http://www.health.nsw.gov.au/mhdao/Documents/Review-of-the-Mental-Health-Act-2007.pdf>>.

91 Australian Institute of Health and Welfare, *Health Expenditure Australia 2011–12* (Report No 50, 25 September 2013) viii <<http://www.aihw.gov.au/publication-detail/?id=60129544658>>.

92 It is difficult to find precise figures for spending on mental health, but the Australian Institute of Health and Welfare reports that \$6.1 billion or 8 per cent of the health budget was spent on ‘mental disorders’ between 2008–09: Australian Institute of Health and Welfare, *How Much Do We Spend on Health?* (2012) <<http://www.aihw.gov.au/australias-health/2012/spending-on-health/>>. Between 2010–11, \$6.9 billion was spent on mental health related services: Australian Institute of Health and Welfare, *Mental Health Services In Brief* (2013) 28 <<http://www.aihw.gov.au/publication-detail/?id=60129544726>>.

93 Medibank Private Limited and Nous Group, *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design* (Report, May 2013) 2 <https://www.medibankhealth.com.au/Mental_Health_Reform>.

94 *Ibid* 13, 75.

to implement art 25 of the *CRPD*, but ensure that individuals with mental impairments are able to access the care they need.

IV CONCLUSION

The circumstances leading to the death of Peter Raven Fisher outlined at the start of this article raise issues about how far the State should go in detaining and treating persons with mental impairments without their consent. The coroner referred to Mr Fisher's vulnerability to 'self-imposed isolation and making inappropriate decisions when his mental state was florid'.⁹⁵

The United Nations Committee on the Rights of Persons with Disabilities has clearly signalled that a person in Mr Fisher's situation should not be detained and treated without consent. Instead, supports should be put in place to help people access mental health services designed for their needs. The *CRPD* thus moves beyond a focus on negative rights in the sense of freedom from involuntary detention and treatment, to one that emphasises positive rights in requiring States Parties to provide the services and supports that are needed to enable persons with mental impairments to become fully functioning members of society.⁹⁶

But what if persons with mental impairments do not want any support, but would prefer 'self-imposed isolation'? The abolition of mental health laws raises the spectre that there will be more lives lost to suicide and/or more persons with mental impairments brought within the criminal justice system via laws of preventive detention. In reality, it is difficult to imagine Australian governments abolishing mental health laws in the near future, given that current reviews are focused on reforming the criteria for detention and treatment, rather than abandoning them entirely.

While treating people without consent is generally seen as a matter of last resort, existing mental health laws support a mental health system geared towards emergency treatment. The rights set out in the *CRPD* challenge this system. Ultimately, the situation should not be seen as a binary one; a stark choice between detaining and treating persons with mental impairments without consent or, in Darold Treffert's oft-quoted phrase, leaving them '[d]ying with [t]heir [r]ights [o]n'.⁹⁷ By shifting the focus away from involuntary detention and treatment, to providing and funding high quality services and support systems adapted to individual needs, the *CRPD* highlights that there may just be a midway point between these two extremes.

95 Hendtlass, above n 1, 18 [41].

96 Heather Stuart, 'United Nations *Convention on the Rights of Persons with Disabilities: A Roadmap for Change*' (2012) 25 *Current Opinion in Psychiatry* 365.

97 Darold A Treffert, Letter to the Editor, 'Dying with Their Rights on' (1973) 130 *American Journal of Psychiatry* 1041, 1041.