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Clerk to the Ad Hoc Committee on the Mental Capacity Bill and  
Clerk to the Committee for Health, Social Services and Public Safety  
Northern Ireland Assembly  
Room B32  
Parliament Buildings  
Stormont Estate BT4 3XX

Dear Dr Aiken,

Thank you for the opportunity to comment in writing on the *Mental Capacity Bill*.

### **My Background**

I have a PhD in Law from York University in Canada and a Graduate Diploma in Psychology from Monash University in Australia. My undergraduate Honours degrees in Arts and Law, as well as a Masters degree in Law were obtained from the University of Melbourne, Australia.

In 2007, I was awarded an Australian Research Council Federation Fellowship to carry out a five year research project entitled *Rethinking Mental Health Laws*. That project compared reforms to mental health legislation in common law jurisdictions and resulted in a number of publications including two edited collections. Full details of my publications in this field can be obtained from

[https://www.researchgate.net/profile/Bernadette\\_Mcsherry2/contributions](https://www.researchgate.net/profile/Bernadette_Mcsherry2/contributions) I am also attaching two recent articles which summarise some of what is happening in the international field.

### **General Comments About the Mental Capacity Bill**

It is obviously timely to enact comprehensive legislation aimed at protecting the interests of persons with mental and intellectual impairments given that the Convention on the Rights of Persons with Disabilities (CRPD) has been ratified by the United Kingdom.

I note however that the lead up to the Bill occurred prior to important clarifications by the United Nations CRPD Committee about the 'exact scope of the obligations of States Parties under Article 12' (General Comment No 1 on Article 12, 2014, para [3]) . Eilionoir

Flynn in her article for the *Northern Ireland Law Quarterly* (vol 64(4)) has made the point that there may need to be reforms made to the Bill 'in light of Article 12' (page 486).

The General Comment on Article 12 states that what is required is 'both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives' (para [24]).

Further, the General Comment calls for the de-linking of mental capacity from legal capacity, pointing out (para [13]) that:

the concepts of mental and legal capacity have been conflated so that where an individual is thought to have impaired decision-making skills, often because of a cognitive or psychosocial disability, her legal capacity to make a particular decision is removed...an individual's disability and or decision-making skills are accepted as a legitimate basis for denying her legal capacity and lowering her status before the law. Article 12 does not permit this discriminatory denial of legal capacity... .

This General Comment thus casts doubt as to whether the Bill as a whole, based as it is on a lack of decision-making capacity, is compliant with the CRPD.

Looking at the situation here in Australia, it is significant that no Australian jurisdiction has introduced mental capacity legislation along the lines of the current Bill. Instead, each of the six Australian states and two territories has stand-alone mental health legislation that uses risk of harm to self or others as the key criteria for compulsory treatment and some form of guardianship legislation. Many states and territories have or undergoing reform processes to these laws.

Recent reforms to Tasmanian and Western Australian legislation (the *Mental Health Act 2014* (WA) is yet to be proclaimed) have included a lack of decision-making capacity as one of the criteria for compulsory treatment, making the criteria a hybrid risk/capacity one. However, it was decided not to include such a criterion for compulsory treatment in the Victorian *Mental Health Act 2014* and the Australian Law Reform Commission in its final report on *Equality, Capacity and Disability in Commonwealth Laws* (August 2014) has shifted away from a capacity-based approach in its National Decision-Making Principles (see attached article by myself and Kay Wilson on this).

It is therefore important to note that focusing on mental capacity in itself may not be the best way in which to comply with the push towards supported decision-making under the CRPD. Ultimately, as the Australian Law Reform Commission has pointed out (page 59):

[t]he policy impetus is clearly away from models that, in substance, form or language, appear as ones that are not reflective of the individual as decision-maker, based on their wishes and preferences to the greatest extent possible.

## **Comments on Specific Provisions**

*Clauses 1,3,4 and 5: mental capacity and its lack*

If mental capacity is going to be central to this legislation, then the emphasis on the presumption of capacity as well as providing support to make decisions in Clause 1 and in Clause 5 is to be welcomed.

Clauses 3 and 4 appear to be largely based on sections 2 and 3 of the *Mental Capacity Act 2005* for England and Wales. Given that this legislation appears to have been accepted in practice for over ten years, it may be a model worth emulating. The Tasmanian *Mental Health Act 2013* also largely follows this model, but it should be noted that the Western Australian legislation does not require there to be any impairment of disturbance in the functioning of the mind or brain. Instead, section 13(1) of that Act states:

an adult is presumed to have the capacity to make a decision about a matter relating to himself or herself unless the adult is shown not to have that capacity.

Section 15(1) then states:

For the purposes of this Act, a person has the capacity to make a decision about a matter relating to himself or herself if another person who is performing a function under this Act that requires that other person to determine that capacity is satisfied that the person has the capacity to —

- a) understand any information or advice about the decision that is required under this Act to be provided to the person; and
- (b) understand the matters involved in the decision; and
- (c) understand the effect of the decision; and
- (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the decision; and
- (e) communicate the decision in some way.

Not incorporating a provision relating to impairment puts the focus on the person's capacity to make decisions rather than trying to work out causal links and would get around the criticism of functional assessments of mental capacity being discriminatory (as Eilionoir Flynn and Anna Arstein-Kerslake have argued). There is also of course literature critical of the mind/brain dichotomy so it may be timely to omit any mention of this.

### *Clauses 2 and 7 'Best Interests'*

Best interests as a term is not easily defined and I would urge the use of this term be omitted. The Australian Law Reform Commission specifically chose to move away from a 'best interests' standard and instead has as a major principle that:

'the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives' (2014, page 75).

The Commission stated that even if the standard of 'best interests' is defined by giving priority to 'will and preferences':

The standard of 'best interests' is still anchored conceptually in regimes from which the ALRC is seeking to depart...[s]takeholders strongly supported this approach'.

The Commission (page 77) developed the following guidelines as to how best to support the will, preferences and rights of those requiring decision-making support:

### **Will, Preferences and Rights Guidelines**

#### *(1) Supported decision-making*

(a) In assisting a person who requires decision-making support to make decisions, a person chosen by them as supporter must:

- (i) support the person to express their will and preferences; and
- (ii) assist the person to develop their own decision-making ability.

(b) In communicating will and preferences, a person is entitled to:

- (i) communicate by any means that enable them to be understood; and
- (ii) have their cultural and linguistic circumstances recognised and respected.

#### *(2) Representative decision-making*

Where a representative is appointed to make decisions for a person who requires decision-making support:

(a) The person's will and preferences must be given effect.

(b) Where the person's current will and preferences cannot be determined, the representative must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers and other significant people in their life.

(c) If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person's human rights and act in the way least restrictive of those rights.

(d) A representative may override the person's will and preferences only where necessary to prevent harm.

This may provide a better way of framing Clause 7 than its current iteration.

One seemingly minor, but important point:

Clause 7(1) introduces 'P' as a shortened form for the person who is 16 or over and Clause 9(1)(b) introduces 'D' as a shortened form for another person interested in the 'care, treatment or personal welfare of P'.

As a teacher of criminal law and tort law for many years, 'P' is generally used to refer to the 'Plaintiff' and 'D' to the 'Defendant' so I was thrown by the use of these letters. I've

never seen terms in legislation shortened in this way before, so perhaps this could be rethought?

### **Other Comments**

I'm afraid other commitments prevent me commenting on every provision. Suffice to say that the inclusion of provisions dealing with advance decisions, nominated persons, second opinions, independent advocates and deprivation of liberty safeguards are welcome steps towards safeguarding rights.

Overall, however, I would urge the Ad Hoc Committee on the Mental Capacity Bill to reconsider how the Bill could best reflect the obligations placed on State Parties under the CRPD. I am of course happy to answer any queries the Committee may have in this regard.

Yours sincerely,

A handwritten signature in black ink that reads "Bernadette McSherry". The signature is written in a cursive, flowing style.

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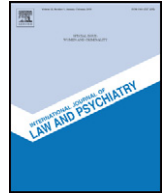


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## The concept of capacity in Australian mental health law reform: Going in the wrong direction?



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### ABSTRACT

The six Australian states and two territories each have legislation that enables the involuntary detention and treatment of individuals diagnosed with mental illness who are considered in need of treatment and where there is evidence of a risk of harm to self or others. A number of governments have undertaken or are currently undertaking reviews of mental health laws in light of the Australian Government's ratification of the Convention on the Rights of Persons with Disabilities. While United Nations bodies have made it clear that laws which enable the detention of and substituted decision-making for persons with disabilities should be abolished, debates in Australia about the reform of mental health legislation have largely focused on Article 12 of the CRPD and what is meant by the right of persons with disabilities to enjoy legal capacity on an equal basis with others. It is argued that a more holistic view of the CRPD rather than the current narrow focus on Article 12 would best serve the needs of persons with mental impairments.

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### 1. Introduction

Article 12(2) of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) recognises that “persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. Such a recognition of universal “legal capacity”, has raised the issue of whether a perceived lack of or impairment of “mental capacity”, which the United Nations CRPD Committee refers to as “the decision-making skills of a person” (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 12), should be used as the basis for restrictions in civil law areas relating to involuntary mental health treatment and guardianship.

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 CRPD. The six Australian states and two territories each have separate mental health acts that enable involuntary detention and treatment where there is evidence that a person is mentally ill, is in need of treatment and there is a risk of harm to self or others.

This article provides an overview of the current debates concerning the concept of “capacity” in mental health law reform in the light of Australia's interpretive declaration (set out below) which states that

the CRPD allows for the “compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability.”

It is argued that the current law reform focus on Article 12 and matters of capacity – as exemplified by the Australian Law Reform Commission's focus on capacity in its 2014 Inquiry into disability and commonwealth laws – has served to keep attention on involuntary detention and treatment, rather than viewing the CRPD as an opportunity to find new ways of ensuring voluntary access to the highest attainable standard of mental health services and community care.

It is further argued that Article 12 is only one article in a Convention that is designed to ensure persons with disabilities are able to exercise their human rights and fundamental freedoms on an equal basis with others. When viewed within the context of the CRPD as a whole, legal capacity is not only “indispensable” for the realisation of other rights (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 8), but other rights, such as the rights to health and to independent living, are critical for the realisation of legal capacity.

The reform of service delivery by offering individually tailored formal and informal decision-making support and a greater range of care and treatment options should be viewed as essential to implementing the support model (Flynn & Arstein-Kerslake, 2014) envisaged by Article 12 and in realising other important rights. Rather than focusing purely on debates about legal capacity as is currently the trend in Australian mental health law reform, it is argued that it is necessary to take a more holistic view to “unleash the CRPD's potential” (Lewis, 2010, p. 105).

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The next section outlines how the CRPD relates to persons with mental impairments<sup>1</sup> and how Australia has interpreted the scope of the CRPD. An overview of Australian mental health laws is then provided followed by an examination of the growing international human rights discourse surrounding legal capacity and whether or not it can be limited by assessments of mental capacity. Finally, it will be argued that the focus of scholarly attention and mental health law reform should be redirected to focus on the way in which a broader construction of the CRPD than the current concentration on the “negative” human rights to legal capacity and to liberty (Article 14) to such “positive” rights as the right to health (Article 25) and the right to independent living (Article 19) could support meaningful change and empowerment for persons with mental impairments.

## 2. The convention on the rights of persons with disabilities and Australia's interpretive declaration

Australia ratified the CRPD on 17 July 2008. It is therefore bound to comply with its provisions.<sup>2</sup> 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.<sup>3</sup>

Neither “disability” or “persons with disabilities” is defined in the CRPD, but Article 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 results from the interaction between individuals with impairments and societal barriers.

While some persons with mental impairments may not want to be labelled as disabled (Nabbali, 2009) 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 Article 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 be included (Minkowitz, 2007, p. 407).

When Australia ratified the CRPD, it included a Declaration which is a form of “interpretative” statement (United Nations Enable, 2014). This differs from a reservation which may serve to limit the legal effect of certain provisions in a Treaty (Kaczorowska, 2010, p. 106). Australia's declaration attempts to clarify its understanding of certain provisions. It 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 [emphasis added].

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 (2010, pp. 148–149) has argued that this declaration “contravenes the spirit of the CRPD” and that, unlike a reservation, “it cannot exclude or alter the legal effect of the CRPD”. Similarly, the Australian Law Reform Commission (2014a, p. 57) has observed that interpretive declarations “may be understood as essentially historical notes, marking a government's understanding at a particular time”.

The CRPD does not refer to the status of interpretative declarations, but Article 46(1) states that reservations “incompatible with the object and purpose of the present Convention shall not be permitted”.<sup>4</sup> 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.

The Australian Law Reform Commission (2014b, p. 9), as part of its Inquiry into disabilities and commonwealth laws, released a Discussion Paper in which it has recommended the Australian Government review its Interpretative Declaration “with a view to withdrawing it”. Similarly, the United Nations CRPD (2013, para. 9) Committee has recommended that Australia review this Declaration “in order to withdraw” its interpretations of the relevant Articles. It is interesting to note, however, that the Australian Law Reform Commission (2014a, p. 58) in its Final Report reframed the issue in terms of “how to advance, to the ... [maximum] ... extent possible, supported decision-making in a federal system” and did not repeat its earlier recommendation that the Interpretive Declaration be reviewed. The Australian Law Reform Commission (2014a, p. 57) recommended that there be domestic law reform “regardless of whether the Declaration itself remains”. On that basis, Australia's declaration should not be viewed as a barrier to law reform endeavours that go beyond the status quo of involuntary detention and treatment.

<sup>1</sup> This article uses the words of Article 1 of the CRPD in referring to persons with ‘mental impairments’ rather than mental illness which is commonly used in legislation.

<sup>2</sup> 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’; Article 29 provides that ‘unless a different intention appears from the treaty or is otherwise established, a treaty is binding upon each party in respect of its entire territory’ and Article 27 provides that ‘a party may not invoke the provisions of its internal law as justification for its failure to perform a treaty...’: Vienna Convention on the Law of Treaties, May 23 1969, 1155 U.N.T.S.331. This means that when a federation enters into a treaty it binds all of the individual states within that federation and the federation cannot use the internal laws that create its federal structure to argue that the treaty is not binding on one part of its territory. This is supported by Section 61 (external affairs power) of the Constitution of the Commonwealth of Australia which gives the Commonwealth Executive the power to enter treaties on behalf of Australia and to bind the states, although in practice the Executive consults with the Commonwealth Parliament and the Treaties Council, part of the Council of Australian Governments (COAG), prior to entering into a treaty: <http://www.dfat.gov.au/treaties/making/>; [https://www.coag.gov.au/treaties\\_council](https://www.coag.gov.au/treaties_council). In addition, Article 4(5) of the CRPD provides that ‘[t]he provisions of the present Convention shall extend to all parts of federal states without any limitations or exceptions.’

<sup>3</sup> *Kioa v West* (1985) 159 CLR 550, 570; [1985] HCA 81.

<sup>4</sup> 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 given that it was permitted at the time of ratification, but given the recent pronouncements by the United Nations Committee, the reliance on substituted decision-making regimes now appears to be incompatible with the object and purpose of the CRPD.



### 3. Overview of Australian mental health laws

Currently, each of the six Australian states and two territories has mental health legislation that enables the involuntary detention and treatment of persons with mental impairments.

The following Table summarises the key criteria for involuntary treatment (Table 1).<sup>5</sup>

In general, the provisions in 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. There is also a “need for treatment” criterion such that the treatment must be linked to the mental illness in addition to a criterion relating to risk, dangerousness or harm to self or others.

Only Section 40(e) of the *Mental Health Act 2013* (Tas) and Sections 25(1)(c) and (2)(c) of the *Mental Health Act 2014* (WA)<sup>6</sup> include a criterion that “the person does not have decision-making capacity” creating a “hybrid” risk and capacity civil commitment model. This means that in Tasmania and Western Australia, a person diagnosed with mental illness who has decision-making capacity may not be detained and treated without consent, even where there is considered to be a risk to his or her own health and safety, or the safety of others.<sup>7</sup>

Some other Australian Mental Health Acts have long had provisions that touch on “mental capacity” in the sense of requiring an assessment of whether or not the individual concerned is “unable to consent” (Section 8 of the now repealed *Mental Health Act 1986* (Vic) and Section 26 of the former *Mental Health Act 1996* (WA)); “lacks the capacity to consent” (Section 14 *Mental Health Act 2000* (Qld)) or is “not capable of giving informed consent” (Section 14 *Mental Health and Related Services Act* (NT)) to treatment. However, these provisions have allowed for the overriding of an unreasonable refusal of treatment, even where the individual is considered able to consent to treatment. For example, Section 14(B)(iii) of the *Mental Health and Related Services Act* (NT) includes the criterion that “the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment” [emphasis added]. Because the majority of decisions by Australian mental health tribunals are not reported, there is no publicly available evidence of any cases in which a person has successfully argued that it was reasonable to refuse treatment. However, Annegret Kämpf (2013, p. 83) makes the point that “refusal of treatment against medical advice is biased towards being interpreted as unreasonable.”

While the major focus of Australian mental health legislation is on risk of harm, in practice, the concept of “insight” plays an important role in tribunal hearings (Diesfeld, 2003; Diesfeld & Sjöström, 2007; Freckelton, 2010). That is, people brought within the civil commitment system are often presumed to have no insight into their illness on the basis that any “rational” person would voluntarily consent to hospital admission and mental health treatment. The refusal of mental health treatment is in itself regarded as indicative of the perception that the

<sup>5</sup> At the time of writing, the mental health legislation in the Australian Capital Territory and Queensland are currently under review.

<sup>6</sup> At the time of writing, the *Mental Health Act 2014* (WA) has not yet been proclaimed. It is possible that parts of the Act will be proclaimed in different stages which means it may be some time before the Act is fully in force.

<sup>7</sup> While capacity to consent to treatment is not a criterion for involuntary treatment under Section 5 of the *Mental Health Act 2014* (Vic), Section 70 requires informed consent to treatment to be sought prior to treatment being given. Section 71 then deals with the situation where a person “has the capacity to give informed consent, but does not give informed consent to the treatment proposed by the authorised psychiatrist” (s 71(1)(a)(ii)). It requires the authorised psychiatrist to consult with a range of stakeholders and make enquiries to try to understand why the person does not wish to consent to treatment and to consider a range of less restrictive treatment options, before giving involuntary treatment. Section 71(3) enables the psychiatrist to override a person’s refusal to give informed consent by stating that “[t]he authorised psychiatrist may make a treatment decision for the patient if the authorised psychiatrist is satisfied that there is no less restrictive way for the patient to be treated other than the treatment proposed by the authorised psychiatrist”. This indicates that Section 71 sets up a “process right” or a right to participate in decision-making rather than a substantive right to refuse treatment.

person concerned is unable to make a valid decision (McSherry, 2012). In addition, one of the justifications for mental health law is to provide access to treatment for those who do not have sufficient “mental capacity” to consent to hospital admission and mental health treatment themselves (Richardson, 2001, p. 420). The next section further explores this idea of mental capacity and its link to legal capacity.

### 4. Article 12 and differing notions of capacity

Paragraph 2 of Article 12 of the CRPD recognises that “persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. That begs the question, what exactly is legal capacity?

The term “capacity” itself can have many different meanings; it may relate to volume, to signifying a specified position or function or it may relate to an ability to learn or understand. It is little wonder then, that when an adjective is put before it, people may be confused rather than enlightened as to its meaning.

This section explores the difference between “legal” and “mental” capacity and why there is a tendency to conflate the two in the mental health field. In doing so, it will describe how this seems to be leading to a confusing and fruitless capacity debate in Australia that may mean that law reform is heading in the wrong direction.

#### 4.1. The concept of “legal capacity”

The Council of Europe Commissioner for Human Rights (2012, p. 7) defines “legal capacity” as “a person’s power or possibility to act within the framework of the legal system”. 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” (McSherry, 2012).

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. 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. Paragraph (1) of Article 12 states “that persons with disabilities have the right to recognition everywhere as 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. The reference to exercising legal capacity in Article 12(3) together with Article 12(2)<sup>8</sup> ensures that legal agency is also encompassed by the concept of legal capacity within the CRPD. 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 Ann Arstein-Kerslake (2012, p. 42) have conceptualised the exercise of legal capacity in terms of it being both a sword and a shield. 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 thus makes it clear that those with disabilities have legal capacity on an equal basis with others. This must be presumed. The question then is: can legal capacity ever be removed and, if so, in which circumstances? This leads on to the idea of mental capacity.

<sup>8</sup> Article 12(2) 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’.

**Table 1**  
Criteria for involuntary treatment.

Jurisdiction	Criteria
<b>Australian Capital Territory</b> <i>Mental Health (Care and Treatment) Act 1994</i> Section 28	<ul style="list-style-type: none"> <li>● The person has a mental illness; and</li> <li>● There are reasonable grounds to believe that because of the illness, the person is likely to               <ul style="list-style-type: none"> <li>○ do serious harm to himself, herself or someone else; or</li> <li>○ suffer serious mental or physical deterioration unless subject to involuntary psychiatric treatment; and</li> </ul> </li> <li>● Treatment will reduce the harm or deterioration (or likelihood of harm or deterioration) and result in an improvement in the person's psychiatric condition; and</li> <li>● Treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person.</li> </ul>
<b>New South Wales</b> <i>Mental Health Act 2007</i> Sections 13–15	<ul style="list-style-type: none"> <li>● Criteria for <i>mentally ill</i> person               <ul style="list-style-type: none"> <li>○ The person is suffering from mental illness; and</li> <li>○ Owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary for protection of patient or others from serious harm.</li> <li>○ 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.</li> </ul> </li> <li>● Criteria for <i>mentally disordered</i> person               <ul style="list-style-type: none"> <li>○ A person (whether or not the person is suffering from mental illness) is a mentally disordered person 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:                   <ul style="list-style-type: none"> <li>○ (a) for the person's own protection from serious physical harm, or</li> <li>○ (b) for the protection of others from serious physical harm.</li> </ul> </li> </ul> </li> <li>● In both cases, an authorised medical officer must be of the opinion that no other care of a less restrictive kind is appropriate and reasonably available to the person.</li> </ul>
<b>Northern Territory</b> <i>Mental Health and Related Services Act</i> Section 14 (Section 15 deals with criteria for admission of those exhibiting signs of "mental disturbance")	<ul style="list-style-type: none"> <li>● The person has a mental illness; and</li> <li>● as a result of the mental illness:               <ul style="list-style-type: none"> <li>○ the person requires treatment that is available at an approved treatment facility; and</li> <li>○ the person:                   <ul style="list-style-type: none"> <li>• is likely to cause imminent harm to himself or herself, a particular person or any other person; or</li> <li>• is likely to suffer serious mental or physical deterioration, unless he or she receives the treatment; and</li> </ul> </li> <li>○ the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and</li> </ul> </li> <li>● there is no less restrictive means of ensuring that the person receives the treatment.</li> </ul>
<b>Queensland</b> <i>Mental Health Act 2000</i> Section 14	<ul style="list-style-type: none"> <li>● The person has a mental illness; and</li> <li>● The illness requires immediate treatment; and</li> <li>● The proposed treatment is available at an authorised mental health service; and</li> <li>● Because of the illness—               <ul style="list-style-type: none"> <li>○ there is an imminent risk that the person may cause harm to himself or herself or someone else; or</li> <li>○ the person is likely to suffer serious mental or physical deterioration; and</li> </ul> </li> <li>● There is no less restrictive way of ensuring the person receives appropriate treatment for the illness; and</li> <li>● The person—               <ul style="list-style-type: none"> <li>○ lacks the capacity to consent to be treated for the illness; or</li> <li>○ has unreasonably refused proposed treatment for the illness.</li> </ul> </li> </ul>
<b>South Australia</b> <i>Mental Health Act 2009</i> Sections 21, 25, 29	<ul style="list-style-type: none"> <li>● The person has a mental illness; and</li> <li>● because of the illness the person requires treatment for               <ul style="list-style-type: none"> <li>○ the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition); or</li> <li>○ the protection of others from harm; and</li> </ul> </li> <li>● there is no less restrictive means than a detention and treatment order of ensuring appropriate treatment of the person's illness.</li> </ul>
<b>Tasmania</b> <i>Mental Health Act 2013</i> Section 40	<ul style="list-style-type: none"> <li>● The person has a mental illness; and</li> <li>● without treatment, the mental illness will, or is likely to, seriously harm—               <ul style="list-style-type: none"> <li>○ the person's health or safety; or</li> <li>○ the safety of other persons; and</li> </ul> </li> <li>● the treatment will be appropriate and effective; and</li> <li>● the treatment cannot be adequately given except under a treatment order; and</li> <li>● the person does not have decision-making capacity.</li> </ul>
<b>Victoria</b> <i>Mental Health Act 2014</i> Section 5	<ul style="list-style-type: none"> <li>● The person has mental illness; and</li> <li>● because the person has mental illness, the person needs immediate treatment to prevent—               <ul style="list-style-type: none"> <li>○ serious deterioration in the person's mental or physical health; or</li> <li>○ serious harm to the person or to another person; and</li> </ul> </li> <li>● the immediate treatment will be provided to the person; and</li> <li>● there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.</li> </ul>
<b>Western Australia</b> <i>Mental Health Act 1996</i> Section 26	<ul style="list-style-type: none"> <li>● The person has a mental illness requiring treatment; and</li> <li>● the treatment can be provided through detention in an authorised hospital or through a community treatment order and is required to be so provided in order—               <ul style="list-style-type: none"> <li>○ to protect the health or safety of that person or any other person; or</li> <li>○ to protect the person from self-inflicted harm, including:                   <ul style="list-style-type: none"> <li>• serious financial harm;</li> <li>• 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; and</li> <li>• serious damage to the reputation of the person; or</li> </ul> </li> <li>○ to prevent the person doing serious damage to any property; and</li> </ul> </li> <li>● the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and</li> </ul>

(continued on next page)

Table 1 (continued)

Jurisdiction	Criteria
<i>Mental Health Act 2014</i> (WA) Section 25 (unproclaimed)	<ul style="list-style-type: none"> <li>● 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.</li> <li>● that the person has a mental illness for which the person is in need of treatment;</li> <li>● that, because of the mental illness, there is— <ul style="list-style-type: none"> <li>○ a significant risk to the health or safety of the person or to the safety of another person; or</li> <li>○ a significant risk of serious harm to the person or to another person;</li> </ul> </li> <li>● that the person does not demonstrate the capacity required by Section 18 to make a treatment decision about the provision of the treatment to himself or herself;</li> <li>● that treatment in the community cannot reasonably be provided to the person;</li> <li>● that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.</li> </ul>

#### 4.2. The concept of “mental capacity”

Owen, Freyenhagen, Richardson, and Hotop (2009, p. 81) have pointed out that the “conceptual literature on mental capacity is complex because it mixes philosophical, legal and psychiatric vocabularies”. The United Nations CRPD Committee (2014, para. 12) defines “mental capacity” as “the decision-making skills of a person”.

Traditionally, an assessment of decision-making skills has focused on a person's cognitive abilities. For example, the *Mental Capacity Act 2005* (England and Wales) takes a cognitive approach to displacing legal capacity and there are moves towards following this approach in Australian mental health laws.<sup>9</sup> Section 2(1) of that Act 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 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 basis, recognising that mental capacity may fluctuate and that it needs to be assessed at a particular time in relation to a particular decision.

#### 4.3. The link between legal and mental capacity

Geneva Richardson (2013, p. 89) writes in relation to the 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

<sup>9</sup> For example, 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 it is established, on the balance of probabilities, 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).

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.

Mental capacity is therefore at present closely linked to legal capacity in certain jurisdictions.

In its Initial Report to the Committee on the Rights of Persons with Disabilities, the Australian Government (2010a, para. 55) stated in relation to Article 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 decision-making 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.

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 Article 12(4) as including substituted decision-making within the phrase “all measures that relate to the exercise of legal capacity”. The focus then becomes one of what “respect” means in relation to the “will and preferences of the person” in making a substituted decision.

The General Comment on Article 12 (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 13) points out that:

the concepts of mental and legal capacity have been conflated so that where an individual is thought to have impaired decision-making skills, often because of a cognitive or psychosocial disability, her legal capacity to make a particular decision is removed ... an individual's disability and or decision-making skills are accepted as a legitimate basis for denying her legal capacity and lowering her status before the law. Article 12 does not permit this discriminatory denial of legal capacity...

Laws that enable involuntary treatment on the basis of a loss of decision-making capacity on this view are therefore discriminatory. Mental capacity should no longer be intrinsically linked to legal capacity. In Geneva Richardson's (2013, p. 92) words, “in its purest form there is no point beyond which legal capacity is lost. There is no binary divide”.

There is thus a division between the “purists” who argue that there can be no exceptions to legal capacity and thus no justifications for

substituted decision-making regimes and those who argue that some form of substituted decision-making based on assessments of the ability to make decisions are necessary and permissible under Article 12.

The [Australian Law Reform Commission \(2014a\)](#) has shied away from clearly stating which approach is preferable, but its recommendations could be interpreted as rejecting the purist approach and instead allowing for some form of substituted decision-making as a last resort. The [Australian Law Reform Commission \(2014a, p. 11\)](#) has recommended the adoption of “National Decision-Making Principles” as a framework for amending laws relating to persons with disabilities including mental health and guardianship laws. The National Decision-Making Principles provide that persons with disabilities should be given support to make their own decisions in accordance with their will and preferences (although they may choose not to receive support) and they contain various safeguards to prevent abuse and undue influence. However, the National Decision-Making Principles also provide for the appointment of a “representative decision-maker” as a “last resort” ([ALRC, 2014a, p. 11](#)). The role of the representative decision-maker is to try to ascertain and give effect to a person’s will and preferences. Where it is not possible to ascertain what a person would have wanted, the representative decision-maker is required to “act to promote and uphold the person’s human rights and act in the way least restrictive of those rights” ([ALRC, 2014a, p. 12](#)). It is unclear what this means, but presumably it would involve some kind of weighing up of the person’s human rights contained in the CRPD or wider international human rights law and choosing the outcome that seems most in accordance with those rights. More importantly, the National Decision-Making Principles include the important proviso that “a representative may override the person’s will and preferences only where necessary to prevent harm” ([ALRC, 2014a, p. 13](#)). This is consistent with a risk of harm or outcome-based approach currently contained in Australia’s mental health laws. It also signals a shift away from the mental capacity based approach that was suggested in the [Australian Law Reform Commission’s \(2014b, p. 61\)](#) earlier Discussion Paper which included a cognitive test for “decision-making ability” reflecting the one set out in the *Mental Capacity Act 2005* (England and Wales).

In relation to mental health laws, the [Australian Law Reform Commission \(2014a, p. 288\)](#) has recommended:

that state and territory governments review mental health legislation, with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model. This might involve, for example, moving towards supported decision-making models similar to those contained in the Victorian Legislation and in the WA Bill.<sup>10</sup>

This recommendation appears to assume that the Victorian and Western Australian reforms to mental health legislation comply with Article 12, despite concerns that recent reforms do not truly reflect a supported decision-making model. No government in Australia has signalled its preparedness to abolish mental health laws or indeed to try a different model of treatment and care for those with mental impairments. The Australian Law Reform Commission’s recommendation to reform mental health legislation in light of its National Decision-Making Principles which allow for representative decision-makers may therefore be more palatable to governments than following the urging of the United Nations Committee to abolish its substitute decision-making regimes.

### 5. A critique of the current narrow focus on mental and legal capacity

It is not surprising, in the context of the discussion above, that the right to equal recognition before the law, as a key civil and political right, has drawn the attention of lawyers working in the field. Tina

[Minkowitz \(2007, p. 408\)](#), for example, has argued that Article 12(2) is the primary focus for those with mental health problems:

This guarantee (of legal capacity on an equal basis with others) is the heart of the Convention for people with psychosocial disabilities. All laws directed at restricting our freedom and self-determination are premised on an equation of psychosocial disability with legal incapacity, and legal incapacitation is the primary way that the law deals with persons with psychosocial disabilities. A guarantee of legal capacity on an equal basis with others in all aspects of life should result in the elimination of all such legal regimes.

This focus is understandable given the concerns of psychiatric user and survivor groups to achieve full autonomy in healthcare decision-making during the negotiations leading to the CRPD, even though express agreement to ban involuntary detention and treatment was never reached ([Minkowitz, 2007](#)).

However, the focus on the right to legal capacity at the expense of the body of the CRPD suggests an unduly narrow approach to its interpretation and implementation. The CRPD as a whole combines civil and political rights, which are often referred to as “negative” rights in the sense of *freedom from* state interference, with economic, social, and cultural rights, which are often referred to as “positive” rights in placing *obligations on* States Parties to ensure certain rights are upheld. The rights to legal capacity and the right to liberty (Article 14), as “negative” civil and political rights, can be viewed as being subject to “immediate realisation”, whereas in comparison, “positive” socio-economic rights have been viewed as being subject to “progressive realisation” ([Office of the United Nations High Commissioner for Human Rights, 2008, p. 13](#); Article 4(2) CRPD).

While these two sets of rights have been described as “indivisible and interrelated” ([United Nations, 1993, para.5](#)), in practice, civil and political rights “have dominated the international agenda” ([Alston, 2008, p. 120](#)). This helps explain why 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 mental impairments ([Donnelly, 2008](#)). As well as the considerable focus on the right to legal capacity discussed in this paper, there has also been much attention on the right to liberty set out in Article 14 and what this means for mental health laws.

As with interpretations of Article 12, the debate about the precise meaning of Article 14 in relation to mental health laws can be divided into a “purist” approach and a more moderate approach. The debate has revolved around the meaning of the words set out in Article 14(1)(b) “the existence of a disability shall in no case justify a deprivation of liberty” ([McSherry, 2014](#)). The [Office of the High Commissioner for Human Rights \(2014, para. 1\)](#) has insisted that this means that laws permitting the involuntary detention of persons with disabilities are incompatible with the right to liberty:

[L]egislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. *This practice is incompatible with Article 14 as interpreted by the jurisprudence of the CRPD committee... it is contrary to Article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the right to liberty (emphasis added. See also Committee on the Rights of Persons with Disabilities, 2013, para. 34; Minkowitz, 2010).*

Nevertheless, some states, including Australia, have interpreted Article 14 as meaning that while persons with a disability cannot be involuntarily detained “solely” because of their disability, a deprivation

<sup>10</sup> The WA Bill now being the Mental Health Act 2014 (WA).

of liberty can be justified if there is a risk of harm to self or others (United Nations Enable, 2004). This approach appears to be supported by paragraph 19 of the United Nations Human Rights Committee's General Comment on the right to liberty set out in Article 9 of the *International Covenant on Civil and Political Rights* (United Nations Human Rights Committee, 2014). Paragraph 19 states that “[t]he existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others” (emphasis added).

To further complicate matters, it has been argued that Article 14 may permit involuntary detention provided it is “de-linked” from disability and is drafted in terms that are “disability neutral”. This would potentially undermine the right to liberty more generally, as it would permit states to implement preventive detention regimes for all people whom states consider dangerous (Bartlett, 2012a, p. 773).

As with Article 12, interpretations of Article 14 have largely met a stalemate and it is unlikely that Australian governments will act to repeal mental health legislation in the near future. What is important is that the CRPD has changed the traditional relationship between civil and political and socio-economic rights, so that the division between the two is more “nebulous” than ever before (Bartlett, 2012a, p. 757), thereby reinforcing the indivisibility and interdependent character of rights. It is timely then to consider how the context of the CRPD may move the focus beyond the current stalemate in interpreting negative rights.

The narrow focus of the debate about legal capacity and mental capacity means the emphasis remains on involuntary rather than voluntary treatment. This directs much needed attention and resources away from the voluntary mental health and community care sector. It also means taking the focus away from the development and funding of support systems to ensure equality before the law, liberty and the right to independent living. That there needs to be a shift in focus towards voluntary treatment and access to services and the development and availability of community services to realise the rights in the CRPD is considered further in the next section.

### 5.1. Switching the focus to voluntary care and access to treatment

Legal academics such as Penelope Weller (2008) and Annegret Kämpf (2008, 2010) have explored the potential effects on mental health laws of the concept of non-discrimination which is set out in Article 5 of the CRPD, as well as the right to freedom from torture (Article 15) and the right to physical and mental integrity (Article 17). Relatively little, however, has been written about the obligations placed on States under some of the positive rights set out in the CRPD. For example, highlighting the obligations in Article 25 of the CRPD, which sets out the right to enjoyment of the highest attainable standard of health, and Article 19, which refers to the right to live in the community, may help switch the focus from involuntary detention and treatment to voluntary care and access to treatment.

It has only been during the past two decades that any discussion of the right to health and the associated right to access health services has carried over to the mental health arena (Gostin & Gable, 2004).

Switching the focus is important because the current emphasis 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 (1986, p. 55) have pointed out that broadening the scope of civil commitment criteria in Washington State's 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 was reduced drastically”.

Certainly, there is evidence in Australia that far fewer persons with mental impairments access health services when compared to those with physical disorders (Australian Government, 2010b, p. 17). 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” (Olesen, Butterworth & Leach, 2010, p. 829).

While some mental health laws contain separate provisions for those who are being treated on a voluntary basis (McSherry, 2010), 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,<sup>11</sup> 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 (2013: p. 567) 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 enter the forensic system) or satisfy the criteria for involuntary treatment (and are civilly committed).

Law reform to strengthen rights to treatment in the voluntary system would be beneficial in assisting persons with mental impairments in realising their right to health by ensuring more timely intervention and possible prevention of further disabilities. In some cases, this will mean that they can be engaged in treatment before their condition deteriorates to the point that the only option is to become an involuntary patient.

### 5.2. Individualised care and treatment

Mary Donnelly (2010) has observed that persons with mental impairments rarely reject all care and treatment options where they have the power to refuse medical treatment. This is where Article 25 of the CRPD becomes relevant.

Article 25 of the CRPD reiterates Article 12(1) of the *International Covenant on Economic Social and Political Rights* in requiring States to recognise “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

However, Article 25 goes further than Article 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... [emphasis added].

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 (United Nations, 2000) of the United Nations Committee on Economic, Social and Cultural Rights. Paragraph 9 of the 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

<sup>11</sup> Australian Research Council Federation Fellowship FF0776072 *Rethinking Mental Health Laws: An integrated Approach* awarded to Professor Bernadette McSherry 2007–2012.

health". Article 25 of the CRPD sets out the steps that should be taken to ensure that these facilities and services are provided.

The *Australian Institute of Health and Welfare* (2013a, p. viii) has estimated that during 2011–2012, Australia spent \$140.2 billion or 9.5% of the Gross Domestic Product on health. Around 8% of that total figure is spent on "mental disorders",<sup>12</sup> indicating that 92% of health spending goes elsewhere. A 2013 Report by the health insurer, *Medibank Private and Nous Group* claims that the amount of mental health funding is higher than previously indicated, but that the main problem is poor system design (p. 30). As well as identifying fragmentation and insufficient coordination of services, this report found (p. 75) that "[s]atisfaction levels with mental health services are low relative to other health services".

Shifting the focus from involuntary treatment towards resourcing high quality mental health services, particularly in the community, will not only serve to implement Article 25 of the CRPD, but ensure that individuals with mental impairments are able to access the care they need.

### 5.3. Supporting the exercise of legal capacity

Returning to the concept of legal capacity, Article 12(3) of the CRPD sets out that "States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". To date, when this paragraph is discussed, the emphasis is on support in relation to decision-making. For example, Gerard Quinn (*Clifford*, 2008, p. 90) observes:

Incapacity is not really a black and white issue, it is very much an individualized process. The first thing that a political authority should do is to put in the supports that enable individuals to make decisions, rather than take away this opportunity and do the easier thing of letting another person make the decision for them.

While mental health law reforms in some Australian states have given some formal acknowledgment to the involvement of informal support or "nominated" persons in assisting persons through the involuntary commitment and treatment process, there has been less formal recognition or funding for professional supporters and advocates. While the Australian Law Reform Commission has considered the use of funding under the National Disability Insurance Scheme (a flexible funding scheme currently being trialled in Australia) for persons with mental impairments to pay for supports as part of their funding package, not all persons with mental impairments will qualify for funding under the scheme and the scheme does not typically fund services that it considers ought to be provided by the health or other service systems.

If recognition of legal capacity is to be more than the "right to be left alone", then proper supports must be in place for those persons with mental impairments who want them, or those with the highest needs may only achieve formal legal equality, rather than the substantive equality envisaged by the CRPD.

### 5.4. Towards a broader conception of support for persons with disabilities

It is essential that support to exercise legal capacity should be viewed as going beyond support to make *treatment* decisions. It should be viewed more holistically in terms of support systems that can be developed to assist and empower persons with mental impairments in relation to broad lifestyle needs.

Using the obligations under Article 25 to expand the range of care and treatments on offer so that care plans can be individually tailored and targeted with the participation of persons with mental impairments, may have more practical value than the recognition of legal capacity alone. It makes little sense to focus on gaining legal capacity to make mental health care decisions in a mental health system which gives minimal care and treatment options in which to actually exercise the hard-won "right to choose".

Accordingly, the development and wider availability of a broader range of treatment options is necessary for the realisation of the rights to legal capacity and liberty. For example, it is difficult to view the right to liberty for persons with disabilities in isolation from the supports that are available for them in the community. This is especially the case where the reality is that de-institutionalisation has not been implemented, or has only been partially implemented, in many states and so that many persons still spend all or large parts of their lives in institutions (*Rimmerman*, 2013 p.138). The right to liberty means little if there is nowhere for people to go and still receive support and the right to equality before the law cannot be realised where it effectively leads to a choice between homelessness, squalid and unsafe rooming-houses, prison or accommodation otherwise unsuitable for individual needs. Compliance with the CRPD, as *Terry Carney and Fleur Beaupert* (2013) note, goes well beyond law reform, to reforms in service provision and social attitudes.

Therefore, Articles 12 and 14 need to be read in conjunction with Article 19, the right to independent living. Article 19 provides that:

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

As *Rosemary Kayess and Philip French* (2008, p. 29) note:

Article 19 equates the right to liberty with the right of persons with disability to live in and be a part of the community. It will operate as a prohibition on institutional models of supported accommodation for persons with disability, and require national investment in community based living options.

Arie Rimmerman (2013, p. 137) has also pointed out that Article 19 is 'central to social inclusion'. It clearly places obligations on States to provide adequate, tailored accommodation and support services rather than assuming de-institutionalisation alone complies with the CRPD. The Council of Europe *Commissioner for Human Rights* (2012, 5) refers to the three essential elements of Article 19 as "choice; individualised supports that promote inclusion and prevent isolation; and making services for the general public accessible to people with disabilities".

Ultimately, as *Peter Bartlett* (2012b, p. 834) has observed:

If appropriate services and supports are provided, the argument goes, compulsion will be no more necessary for people with mental disabilities than for anyone else. There is much to recommend this view in many circumstances, including those related to psychiatric

<sup>12</sup> 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% of the health budget was spent on 'mental disorders' between 2008 and 2009: <http://www.aihw.gov.au/australias-health/2012/spending-on-health/> and \$6.9 billion on mental health related services between 2010 and 2011: (*Australian Institute of Health and Welfare*, 2013b, p. 28).

and related detention. Thus, in much of Europe, provision of proper community housing and community support would provide an option likely to be preferred by many people with mental disabilities. If services are provided that people want, it will not be necessary to force them to use them. For a large number of people in psychiatric and related institutions this is almost certainly a convincing argument. And, if the state refuses to offer services that people do want to use, it is ethically dubious to force them to use services they do not want to use.

Therefore, a focus on shifting resources to the voluntary sector may be ultimately more important in implementing the CRPD, giving persons with mental impairments real self-determination and lifting their status and participation in society, than legal debates about the precise meaning of Article 12 of the CRPD.

## 6. Conclusion

Current debates concerning mental health laws and legal capacity are stuck on a binary choice between detaining and treating persons with mental impairments without consent or, in Darold Treffert's (1973, p. 1041) oft-quoted phrase, leaving them "dying with their rights on". Similarly, the debates about the right to liberty centre on the extent to which disability can be used as a justification for detention. Instead of getting tangled up in capacity and "disability neutral" matters, the focus for policymakers should be on the positive rights set out in the CRPD. 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 be a midway point between involuntary treatment on the one hand and no treatment at all on the other. More importantly, the need for involuntary treatment may diminish or disappear altogether.

Kristen Booth Glen (2012, pp. 98–99) has observed:

[The CRPD] sees incapacity as socially constructed, insists on the full legal capacity of every person with [disabilities], and does away with substituted decision-making in favor of society's obligation to provide appropriate supports to permit everyone to make his or her own decisions. Like every emerging paradigm, this challenges our perceptions and our understanding of when, how, and even if the state may intervene in a person's life, and it has the potential to be deeply unsettling. And, unsurprisingly, it takes time. ... This new conceptualization based on international human rights may initially appear hopelessly utopian, or dangerously naive. Why? Because it is a new way of thinking, a radically different view, a reorientation rather than an incremental change (emphasis in original).

The danger in getting stuck on debates about what Article 12 means for notions of capacity and what Article 14 means for detention is that the potential for a new way of thinking in relation to mental health care will be lost. Indeed, the capacity debate may benefit from being refocused in a new direction, as a way of breaking the deadlock between legal capacity "purists" and those advocating for exceptions to legal capacity in certain situations. While the liberty debate may benefit from the creation of real alternatives to detention that support the vision of persons with disabilities as having active and independent lives within the community.

Bolstering the voluntary mental health and community care system will assist in realising the right to the highest attainable standard of health by enabling early intervention and minimization of further disabilities before people enter the involuntary system. The development of a wider range of mental health services will also give substance to the right of persons with mental impairments to choose which interventions and support services they need, assisting them to exercise their rights to make health-care decisions and to independent and socially inclusive living.

Ultimately, it is only by emphasising the obligations placed on States Parties and, in particular, the obligation to provide services adapted to individual needs, that the law can be used to bring about true reform in mental health care and treatment.

## References

- Alston, P. (2008). Putting economic, social and cultural rights back on the agenda of the United States. In W. F. Schulz (Ed.), *The future of human rights: U.S. policy for a new era*. Philadelphia: University of Pennsylvania Press.
- Australian Government (2010a). Australia's initial report under the Convention on the Rights of Persons with Disabilities. Retrieved from <http://www.ag.gov.au/RightsAndProtections/HumanRights/TreatyBodyReporting/Documents/AustraliasinitialreportundertheConventionontheRightsofPersonswithDisabilities.pdf>
- Australian Government (2010b). National Mental Health Report 2010. Retrieved from [http://www.health.gov.au/internet/main/publishing.nsf/Content/58B9C24B0D74E79ACA257BF0001FEADF/\\$File/report10v3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/58B9C24B0D74E79ACA257BF0001FEADF/$File/report10v3.pdf)
- Australian Institute of Health and Welfare (2013a). Health expenditure Australia 2011–12. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544656>
- Australian Institute of Health and Welfare (2013b). Mental health services – In brief 2013. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544723>
- Australian Law Reform Commission (2014a). Equality, capacity and disability in commonwealth laws, report no 124. Retrieved from [http://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc\\_124\\_whole\\_pdf\\_file.pdf](http://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf)
- Australian Law Reform Commission (2014b). Equality, capacity and disability in commonwealth laws. Discussion Paper, Retrieved from [http://www.alrc.gov.au/sites/default/files/pdfs/publications/whole\\_dp81.pdf](http://www.alrc.gov.au/sites/default/files/pdfs/publications/whole_dp81.pdf)
- Bartlett, P. (2012a). The United Nations Convention on the Rights of Persons with Disabilities and mental health law. *The Modern Law Review*, 75(5), 752–778.
- Bartlett, P. (2012b). A mental disorder of a kind of degree warranting confinement: Examining justifications for psychiatric detention. *The International Journal of Human Rights*, 16(6), 831–844.
- Carney, T., & Beaupert, F. (2013). Public and private bricolage – Challenges balancing law, services and civil society in advancing CRPD supported decision-making. *The University of New South Wales Law Journal*, 36(1), 175–201.
- Clifford, J. (2008). Promoting a paradigm shift. *The Equal Rights Review*, 2, 83–93.
- Commissioner for Human Rights (2012). *Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*. (CommDH/IssuePaper(2012)2) Strasbourg: Council of Europe.
- Committee on the Rights of Persons with Disabilities (2013, September 2–13). *Concluding observations on the initial report of Australia adopted by the committee at its tenth session*. (UN Doc CRPD/C/AUS/CO/1 (21 October)).
- Council of Europe Commissioner for Human Rights (2012). *The right of people with disabilities to live independently and be included in the community*. France: Council of Europe Publishing (<<https://wcd.coe.int/ViewDoc.jsp?id=1917847>>).
- Diesfeld, K. (2003). Insight: Unpacking the concept in mental health law. *Psychiatry, Psychology and Law*, 10(1), 63–70.
- Diesfeld, K., & Sjöström, S. (2007). Interpretive flexibility: Why doesn't insight incite controversy in mental health law. *Behavioral Sciences and the Law*, 25(1), 85–101.
- Donnelly, M. (2008). From autonomy to dignity: Treatment for mental disorders and the focus for patient rights. In B. McSherry (Ed.), *International trends in mental health law* (pp. 37–61). Sydney, Australia: Federation Press.
- Donnelly, M. (2010). *Healthcare decision-making and the law: Autonomy, capacity and the limits of liberalism*. Cambridge, England: Cambridge University Press.
- Durham, M., & Pierce, G. (1986). Legal intervention in civil commitment: The impact of broadened commitment criteria. *Annals of the American Academy of Political and Social Science*, 484, 42–55.
- Flynn, E., & Arstein-Kerslake, A. (2014). Legislating personhood: Realising the right to support in exercising legal capacity. *International Journal of Law in Context*, 10(1), 81–104.
- Freckelton, I. (2010). Extra-legislative factors in involuntary status decision-making. In B. McSherry, & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 203–230). Oxford, England: Hart Publishing.
- Glen, K. B. (2012). Changing paradigms: Mental capacity, legal capacity, guardianship, and beyond. *Columbia Human Rights Law Review*, 44(1), 93–169.
- Gostin, L. O., & Gable, L. (2004). The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health. *Maryland Law Review*, 63, 20–121.
- Kaczorowska, A. (2010). *Public international law* (4th ed.). Oxford, England: Routledge.
- Kämpf, A. (2008). The disabilities convention and its consequences for mental health in Australia. In B. McSherry (Ed.), *International trends in mental health laws* (pp. 10–36). Sydney: Federation Press.
- Kämpf, A. (2010). Involuntary treatment decisions: Using negotiated silence to facilitate change? In B. McSherry, & I. Freckelton (Eds.), *Rethinking rights-based mental health laws* (pp. 129–150). Oxford: Hart Publishing.
- Kämpf, A. (2013). Coercive care: The role of the law in treatment decisions. In B. McSherry, & I. Freckelton (Eds.), *Coercive care: Rights, law and policy* (pp. 76–92). Oxford, England: Routledge.
- Kayess, R., & French, P. (2008). Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities. *Human Rights Law Review*, 8(1), 1–34.
- Lewis, O. (2010). The expressive, educational and protective roles of human rights: An analysis of the United Nations Convention on the Rights of Persons with Disabilities.

- In B. McSherry, & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 97–128). Oxford: Hart Publishing.
- McSherry, B. (2010). The right of access to mental health care: Voluntary treatment and the role of the law. In B. McSherry, & P. Weller (Eds.), *Rethinking Rights-Based Mental Health Laws* (pp. 379–395). Oxford: Hart Publishing.
- McSherry, B. (2012). Legal capacity under the Convention on the Rights of Persons with Disabilities. *Journal of Law and Medicine*, 20, 22–27.
- McSherry, B. (2014). Mental health laws: Where to from here? *Monash University Law Review*, 40(1), 175–197.
- Medibank Private Limited and Nous Group (2013). The case for mental health reform in Australia: A review of expenditure and system design. Retrieved from [http://www.medibank.com.au/Client/Documents/Pdfs/The\\_Case\\_for\\_Mental\\_Health\\_Reform\\_in\\_Australia.pdf](http://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf)
- Minkowitz, T. (2007). The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions. *Syracuse Journal of International Law and Commerce*, 34(2), 405–428.
- Minkowitz, T. (2010). Abolishing mental health laws to comply with the Convention on the Rights of Persons with Disabilities. In B. McSherry, & P. Weller (Eds.), *Rethinking rights-based mental health laws* (pp. 151–177). Oxford: Hart Publishing.
- Nabbali, E. M. (2009). A “mad” critique of the social model of disability. *The International Journal of Diversity in Organisations, Communities and Nations*, 9(4), 1–12.
- Office of the High Commissioner for Human Rights (2014). *Statement on Article 14 of the Convention on the Rights of Persons with Disabilities*. Geneva: United Nations (Retrieved from < <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E>>).
- Office of the United Nations High Commissioner for Human Rights (2008). *Frequently asked questions on economic, social and political rights, fact sheet 33*. Geneva: United Nations (Retrieved from < <http://www.ohchr.org/Documents/Publications/FactSheet33en.pdf>>).
- Olesen, S., Butterworth, P., & Leach, L. (2010). Prevalence of self-management versus formal service use for common mental disorders in Australia: Findings from the 2007 national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry*, 44(9), 823–830.
- Owen, G. S., Freyenhagen, F., Richardson, G., & Hotop, M. (2009). Mental capacity and decisional autonomy: An interdisciplinary challenge. *Inquiry*, 52(1), 79–107.
- Quinn, G., & Arstein-Kerslake, A. (2012). Restoring the ‘human’ in ‘human rights’: Personhood and doctrinal innovation in the UN disability convention. In C. Gearty, & C. Douzinas (Eds.), *The Cambridge companion to human rights law* (pp. 36–55). Cambridge: Cambridge University Press.
- Richardson, G. (2001). Reforming mental health law: Principle or pragmatism. *Current Legal Problems*, 54, 415–438.
- Richardson, G. (2013). Mental capacity in the shadow of suicide: What can the law do? *International Journal of Law in Context*, 9(1), 87–105.
- Rimmerman, A. (2013). *Social inclusion of people with disabilities, national and international perspectives*. Cambridge: Cambridge University Press.
- Treffert, D. A. (1973). Letters: “Dying with their rights on”. *American Journal of Psychiatry*, 130(9), 1041.
- United Nations (1993). *The Vienna Declaration and Programme of Action: Report of the World Conference on Human Rights* (UN Doc A/CONF. 157/24 (13 October)).
- United Nations Committee on Economic, Social and Cultural Rights (2000, August 11). *General Comment No 14: The right to the highest attainable standard of health (Art. 12)*. (U.N. Doc E/C.12/2000/4).
- United Nations Committee on the Rights of Persons with Disabilities (2013, October 21). *Concluding observations on the initial report of Australia, adopted by the committee at its tenth session*. (U.N. Doc. CRPD/C/AUS/CO/1).
- United Nations Committee on the Rights of Persons with Disabilities (2014, April 11). *General Comment No 1 Article 12: Equal recognition before the law*. U.N. Doc. CRPD/C/GC/1.
- United Nations Enable (2004, May 26). *Daily summary of discussions related to Article 10: Liberty and security of the person*. (Retrieved from < <http://www.un.org/esa/socdev/enable/rights/ahc3sum10.htm>>).
- United Nations Enable (2014). *Declarations to the convention and optional protocol – Types of declarations to the convention and optional protocol*. (Retrieved from <http://www.un.org/disabilities/default.asp?id=233> (No date provided on website)).
- United Nations Human Rights Committee (2014). *General Comment No 35: Article 9 (liberty and security of person)*. (CCPR/C/GC/35, 16 December 2014. Retrieved from <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/244/51/PDF/G1424451.pdf?OpenElement>>).
- Weller, P. (2008). Supported decision-making and the achievement of non-discrimination: The promise and paradox of the disabilities convention. In B. McSherry (Ed.), *International trends in mental health laws* (pp. 85–110). Sydney: Federation Press.
- Wilson, K. (2013). Law reform or systemic reform? Stakeholder perceptions of resource constraints in mental health in Australia, New Zealand and Canada. *Psychiatry, Psychology and Law*, 20(4), 553–557.



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# Legal issues

Editor: Bernadette McSherry\*

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## SUPPORT FOR THE EXERCISE OF LEGAL CAPACITY: THE ROLE OF THE LAW

*In 2014, the Australian Law Reform Commission released a report dealing with recognition before the law and legal capacity of people with disability. The report recommended that “supported decision-making” should be introduced into relevant Commonwealth laws and legal frameworks. This column explores what is meant by “support” to exercise legal capacity and what role the law may play in attempting to move beyond the traditional substituted decision-making model for those with mental and intellectual impairments.*

### INTRODUCTION

In July 2013, the Australian Law Reform Commission (ALRC) began an inquiry into Commonwealth laws and legal frameworks that have an impact on the legal capacity of those with disabilities, including mental and intellectual impairments.<sup>1</sup> A Discussion Paper was released in May 2014<sup>2</sup> and a Final Report completed in August 2014.<sup>3</sup> As the ALRC began its inquiry, a pilot of the National Disability Insurance Scheme (NDIS) was launched with the aim of establishing “a new way of providing community linking and individualised support for people with permanent and significant disability, their families and carers”.<sup>4</sup>

This column explores what is meant by “support” to exercise legal capacity and outlines how law reform endeavours may be taking too narrow an approach to the meaning of Art 12 of the *Convention on the Rights of Persons with Disabilities* (CRPD). It is argued that it may be timely to move beyond concepts of “supported decision-making” to a broader notion of support to exercise legal capacity in the form of providing access to services and measures for full participation in the community.

### THE EXERCISE OF LEGAL CAPACITY

The CRPD, which Australia has ratified, directs State parties to ensure “respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”.<sup>5</sup> Article 12(2) of the CRPD recognises that “persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. In a previous column, the differences between legal capacity and mental capacity were explored.<sup>6</sup> In brief, the Council of Europe’s Commissioner for

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<sup>1</sup> The terms mental and intellectual impairments are used throughout this column because these terms are used in Art 1 of the *Convention on the Rights of Persons with Disabilities*, UN GAOR, 61st sess, 76th plen mtg, UN Doc A/RES/61/106 (24 January 2007), <http://www.un.org/disabilities/convention/conventionfull.shtml>.

<sup>2</sup> Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (May 2014), <https://www.alrc.gov.au/publications/disability-dp81>.

<sup>3</sup> Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (August 2014), <https://www.alrc.gov.au/publications/equality-capacity-disability-report-124>.

<sup>4</sup> Department of Families, Housing, Community Services and Indigenous Affairs, *One Big Difference to Lots of Lives: An Introduction to DisabilityCare Australia* (July 2013) p 3, <http://www.ndis.gov.au/sites/default/files/documents/An%20Introduction%20to%20DisabilityCare%20Australia.PDF>.

<sup>5</sup> *Convention on the Rights of Persons with Disabilities*, Art 3a.

<sup>6</sup> McSherry B, “Legal Capacity under the Convention on the Rights of Persons with Disabilities” (2012) 20 JLM 22 at 27.



Human Rights defines “legal capacity” as “a person’s power or possibility to act within the framework of the legal system”.<sup>7</sup> The United Nations Committee on the CRPD defines “mental capacity” as “the decision-making skills of a person”.<sup>8</sup>

Decision-making skills have traditionally been closely linked to legal capacity in the sense that if a person is considered able to make decisions, he or she is generally taken to be able to act within the framework of the legal system by being able to make contracts, buy and sell property, make a will, marry, vote and so on, as well as consent to or refuse medical treatment. It is when individuals are assessed as not having adequate decision-making skills that they have traditionally been viewed as not having legal capacity. In Geneva Richardson’s words, “their decisions and choices will not be respected and decisions will be made by others on their behalf”.<sup>9</sup>

Interpretations of the CRPD are, however, challenging the link between decision-making skills and legal capacity. In 2014, the United Nations Committee on the CRPD in its General Comment on Article 12 stated that “[u]nder article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity”.<sup>10</sup> It pointed out that:

the concepts of mental and legal capacity have been conflated so that where an individual is thought to have impaired decision-making skills, often because of a cognitive or psychosocial disability, her legal capacity to make a particular decision is removed ... Article 12 does not permit this discriminatory denial of legal capacity.<sup>11</sup>

This has given rise to a debate between those who argue that there can be no exceptions to legal capacity and thus no justifications for substituted decision-making regimes at all and those who argue that some form of substituted decision-making based on assessments of the ability to make decisions are necessary and permissible under Art 12.<sup>12</sup> Putting that debate to one side, a current focus for law reformers has been on the obligations set out under Art 12(3) of the CRPD which states:

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

What is envisaged by “support” in this regard is unclear. If legal capacity is delinked from mental capacity, it would seem that the term “support” should be read as widely as possible to encompass the provision of adequate services as well as anti-discriminatory social attitudes. What appears to be occurring, however, is a reading down of the word “support” to mean purely “supported decision-making”. This is understandable given the traditional link between legal capacity and decision-making skills, but it may be that law reformers are taking too narrow an approach to the exercise of legal capacity. This is explored in the next section.

## FROM SUPPORT TO SUPPORTED DECISION-MAKING

The United Nations Committee on the CRPD has interpreted Art 12(3) in a broad sense:

“Support” is a broad term that encompasses both informal and formal support arrangements, of varying types and intensity ... Support to persons with disabilities in the exercise of their legal capacity might include measures relating to universal design and accessibility – for example, requiring private and public actors, such as banks and financial institutions, to provide information in an understandable

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<sup>7</sup> Council of Europe Commissioner for Human Rights, *The Right of People with Disabilities to Live Independently and be Included in the Community* (June 2012) p 7, <https://wcd.coe.int/ViewDoc.jsp?id=1917847>.

<sup>8</sup> United Nations 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 (11 April 2014) at [12], <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>.

<sup>9</sup> Richardson G, “Mental Capacity in the Shadow of Suicide: What Can the Law Do?” (2013) 9 *International Journal of Law in Context* 87 at 89.

<sup>10</sup> United Nations Committee on the Rights of Persons with Disabilities, n 8 at [13].

<sup>11</sup> United Nations Committee on the Rights of Persons with Disabilities, n 8 at [13].

<sup>12</sup> McSherry B, “Mental Health Laws: Where to From Here?” (2014) 40 *Monash University Law Review* 175; McSherry B and Wilson K, “The Concept of Capacity in Australian Mental Health Law Reform: Going in the Wrong Direction?” (2015) 40 *International Journal of Law and Psychiatry* 60.

format or to provide professional sign language interpretation – in order to enable persons with disabilities to perform the legal acts required to open a bank account, conclude contracts or conduct other social transactions. Support can also constitute the development and recognition of diverse, non-conventional methods of communication ... For many persons with disabilities, the ability to plan in advance is an important form of support.<sup>13</sup>

Rather than these forms of support, law reform endeavours have focused primarily on supported decision-making as the key to enabling individuals with disabilities to exercise their legal capacity.

The ALRC, for example, has recommended the adoption of “National Decision-Making Principles” as a framework for amending laws relating to persons with disabilities, including mental health and guardianship laws.<sup>14</sup> These Principles provide that persons with disabilities should be given support to make their own decisions in accordance with their will and preferences (although they may choose not to receive support) and they emphasise the need for various safeguards to prevent abuse and undue influence. However, the Principles also provide for the appointment of a “representative decision-maker” as a “last resort”.<sup>15</sup> The role of the representative decision-maker is to try to ascertain and give effect to a person’s will and preferences.

Where it is not possible to ascertain what a person would have wanted, the representative decision-maker is required to “act to promote and uphold the person’s human rights and act in the way least restrictive of those rights”.<sup>16</sup> This would presumably involve some kind of weighing up of the person’s human rights contained in the CRPD or wider international human rights law and choosing the outcome that seems most in accordance with those rights.

The Principles include the proviso that “a representative may override the person’s will and preferences only where necessary to prevent harm”.<sup>17</sup> This signals a shift away from the approach that was suggested in the ALRC’s earlier Discussion Paper, which included a cognitive test for “decision-making ability”.<sup>18</sup> What is encompassed by the prevention of harm remains open to interpretation. What is clear, however, is that law reformers are taking a narrow approach to the meaning of support in exercising legal capacity, focusing on support for decision-making rather than wider measures as envisaged by the United Nations Committee.

## DEFINITIONS OF SUPPORTED DECISION-MAKING

Robert Dinerstein defines supported decision-making “as a series of relationships, practices, arrangements, and agreements, of more or less formality and intensity, designed to assist an individual with a disability to make and communicate to others decisions about the individual’s life”.<sup>19</sup> Michelle Browning, Christine Bigby and Jacinta Douglas have identified supported decision-making as originating from the work of Canadian disability organisations in the early 1990s which conceived it as a means of overcoming the longstanding barriers preventing persons with intellectual impairments from becoming self-determining members of society.<sup>20</sup>

Despite this existence of supported decision-making within the disability discourse for over 20 years, as a practice it remains ill-defined and subject to interpretation.<sup>21</sup> Browning, Bigby and

<sup>13</sup> United Nations Committee on the Rights of Persons with Disabilities, n 8 at [17].

<sup>14</sup> Australian Law Reform Commission, Report No 124, n 3, p 11.

<sup>15</sup> Australian Law Reform Commission, Report No 124, n 3, p 11.

<sup>16</sup> Australian Law Reform Commission, Report No 124, n 3, p 12.

<sup>17</sup> Australian Law Reform Commission, Report No 124, n 3, p 13.

<sup>18</sup> Australian Law Reform Commission, Discussion Paper No 81, n 2, p 61.

<sup>19</sup> Dinerstein R, “Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making” (2012) 19 *Human Rights Brief* 8 at 10.

<sup>20</sup> Browning M, Bigby C and Douglas J, “Supported Decision Making: Understanding How its Conceptual Link to Legal Capacity is Influencing the Development of Practice” (2014) 1 *Research and Practice in Intellectual and Developmental Disabilities* 34 at 35.

<sup>21</sup> Browning, Bigby and Douglas, n 20 at 36.

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Douglas advocate that clarifying what is meant by the term “will have a significant influence on the successful implementation of this new paradigm in legislation, policy and practice”.<sup>22</sup>

The ALRC referred to Terry Carney’s work in providing examples of supported decision-making.<sup>23</sup> In 2013, Carney wrote:

Supported decision-making encompasses a range of processes to support individuals to exercise their legal capacity, and these consist of:

- Effective communication, including in the provision of information and advice to a person and through ensuring that a person is able to communicate their decision to others;
- Spending time to determine a person’s preference and wishes;
- Informal relationships of support between a person and members of their social networks;
- Agreements or appointments to indicate that a relationship of support exists; and
- Statutory relationships of support – whether through private or court/tribunal appointment.<sup>24</sup>

Small-scale and short-term Australian pilot projects involving supported decision-making, such as in South Australia between 2010 and 2012<sup>25</sup> and the Australian Capital Territory in 2013,<sup>26</sup> provide important first steps towards the implementation of support for the exercise of legal capacity in a narrow sense.

## DOES THE LAW HAVE A ROLE?

Carney has noted that supported decision-making possibly may not require engaging with the law at all:

[c]ircles of support, micro-boards, or friendship networks, may better be cultivated purely within civil society, overseen simply by the advocacy, service protocols, health and welfare professional standards and other processes of the myriad of informal community, self-help, non-government and government human services agencies.<sup>27</sup>

Similarly, Piers Gooding has pointed out that, in practice, supported decision-making “can reasonably span beyond narrow legislative reform, to include policy, programming and other forms of extra-legal regulation, such as professional ethics guidelines”.<sup>28</sup> The central feature of these arrangements is an emphasis on the will and preferences of the individual concerned.<sup>29</sup>

Examples of where the law has been used to enable supported decision-making include the formalisation of “support networks” in Canadian guardianship law, mental health advance directives and the Swedish personal ombudsman system.<sup>30</sup>

In relation to non-statutory schemes, the Office of the Public Advocate in South Australia established a decision-making trial carried out between 2010 and 2012 involving an agreement between a person with a disability and a supporter. The decision supporter was either a family member or friend who signed an agreement to help the individual concerned make decisions about “healthcare,

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<sup>22</sup> Browning, Bigby and Douglas, n 20 at 37.

<sup>23</sup> Australian Law Reform Commission, Report No 124, n 3, p 51.

<sup>24</sup> Carney T, “Participation and Service Access Rights for People with Intellectual Disability: A Role for Law?” (2013) 38 *Journal of Intellectual and Developmental Disability* 59 at 60.

<sup>25</sup> Carney, n 24 at 47.

<sup>26</sup> Carney, n 24 at 48.

<sup>27</sup> Carney T, “Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective” (2015) 4 *Laws* 37 at 53.

<sup>28</sup> Gooding P, “Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law” (2013) 20 *Psychiatry, Psychology and Law* 431 at 442.

<sup>29</sup> Flynn E and Arstein-Kerslake A, “The Support Model of Legal Capacity: Fact, Fiction or Fantasy?” (2014) 32(1) *Berkeley Journal of International Law* 124 at 124.

<sup>30</sup> Gooding, n 28 at 443-444.

accommodation and lifestyle”.<sup>31</sup> An independent evaluation showed some positive outcomes for the individuals concerned, but noted there was a need to clarify the boundaries that such a model would have with current laws of guardianship.<sup>32</sup> Other such schemes are currently being trialled in other Australian jurisdictions.

Eilionóir Flynn and Anna Arstein-Kerslake argue that the law is “particularly critical for the right to support in exercising legal capacity” on the basis that “[t]he positive obligations that the right carries make it difficult to imagine how supported decision-making could be implemented and formally recognized without statutory language”.<sup>33</sup>

However, Carney has warned of the possible chilling effect that legally formalistic supported decision-making may have on the willingness of persons to provide support to those with mental and intellectual impairments and the “egregious social policy cost” resultant from this.<sup>34</sup> Instead, he suggests that accountability of informal supporters can possibly best be achieved through public education, through oversight by the various Offices of the Public Advocate/Guardian or even via the existing avenues of redress available through the courts.<sup>35</sup>

There is certainly a need for empirical research in relation to supported decision-making schemes. As Carney states:

[i]t is only through rigorous, independent, and adequately funded research into such questions that the risks of another “experiment” in bad policymaking might be mitigated and the “enigmatic” mystery of supported decision making rendered more comprehensible and meaningful in practice.<sup>36</sup>

However, Gooding has pointed out that there is a lack of empirical research into the effects of substituted decision-making regimes as well,<sup>37</sup> so this perhaps should not be used as an argument to curtail moves towards supported decision-making.

Carney has advocated a course of “hastening slowly”<sup>38</sup> by, for example, prioritising the implementation of a prototype supported decision-making law as a replacement or addition to existing Commonwealth laws which include some quasi (or actual) substitute decision-making provisions (for example, NDIS plan nominees).<sup>39</sup> Carney and Fleur Beaupert have been highly critical of policy-making “muddling through” this issue, given its importance to not only individuals with mental and intellectual impairments but also the public at large.<sup>40</sup> Their argument is that supported decision-making should exist “as one step along the stairway from autonomous to substitute decision-making, alongside other new models in the neglected long middle portion”.<sup>41</sup>

<sup>31</sup> De Mestre M, “Supported Decision Making as an Alternative to Guardianship Orders: The South Australian Trial” (2014) 8 *Elder Law Review* 1 at 2.

<sup>32</sup> Wallace M, *Evaluation of the Supported Decision Making Project* (Office of the Public Advocate South Australia, November 2012) p 46, [http://www.opa.sa.gov.au/files/batch1376447055\\_final\\_supported\\_decision\\_making\\_evaluation.pdf](http://www.opa.sa.gov.au/files/batch1376447055_final_supported_decision_making_evaluation.pdf).

<sup>33</sup> Flynn and Arstein-Kerslake, n 29 at 137.

<sup>34</sup> Carney, n 27 at 53.

<sup>35</sup> Carney, n 27 at 53.

<sup>36</sup> Carney T, “Clarifying, Operationalising, and Evaluating Supported Decision Making Models” (2014) 1 *Research and Practice in Intellectual and Developmental Disabilities* 46 at 50.

<sup>37</sup> Gooding P, “Navigating the ‘Flashing Amber Lights’ of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns” (2015) 15 *Human Rights Law Review* 45 at 68.

<sup>38</sup> Carney T, “Supporting People with Cognitive Disability with Decision Making: Any Australian Contributions to International Debates?” in Bigby C and Douglas J (eds), *Supporting People with Cognitive Disability with Decision Making: Learnings from Recent Australian Research and International* (Proceedings of the 8th Annual Roundtable on Intellectual Disability Policy, Living with Disability Research Centre, La Trobe University, 2015).

<sup>39</sup> Carney, n 27 at 53.

<sup>40</sup> Carney T and Beaupert F, “Public and Policy Bricolage – Challenges Balancing Law, Services and Civil Society in Advancing CRPD Supported Decision-Making” (2013) 36 *University of New South Wales Law Journal* 175 at 199-200.

<sup>41</sup> Carney and Beaupert, n 40 at 200.

## CONCLUSION

The ALRC Final Report has highlighted the need for the law to embrace supported decision-making as part of Australia's obligations under Art 12 of the CRPD. While the implementation of supported decision-making schemes is now occurring, it is important not to lose sight of the broader interpretation of support for the exercise of legal capacity envisaged by the United Nations Committee.

The reform of service delivery by offering individually tailored formal and informal decision-making support and a greater range of care and treatment options should be viewed as essential to implementing the support model envisaged by Art 12.<sup>42</sup> Supported decision-making should thus be seen as one prong of a range of social services and civil society measures available to assist those with mental and intellectual impairments.<sup>43</sup> Only then will the challenge set out in Art 1 of the CRPD be met, namely for policy-makers "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".

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<sup>42</sup> Flynn E and Arstein-Kerslake A, "Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity" (2014) 10 *International Journal of Law in Context* 81.

<sup>43</sup> Carney and Beaupert, n 40 at 199.