

AN EVOLVING REVOLUTION: EVALUATING AUSTRALIA'S COMPLIANCE WITH THE *CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES* IN MENTAL HEALTH LAW

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I INTRODUCTION

In 2012 we reported that Australian mental health legislation was on the verge of a revolution.¹ That revolution has begun. It has been clear for some time that the criteria for detention and involuntary treatment for mental illness would need to be revised and remodelled in light of the requirements of the United Nations *Convention on the Rights of Persons with Disabilities* ('*CRPD*').² Article 12, one of the key provisions of the *CRPD*, requires states parties to replace involuntary treatment provisions in mental health laws with a new model of 'supported decision-making'. While there is still some debate about exactly what a supported decision-making model would entail in mental health, in broad terms it requires that treatment decisions must be made by the person themselves as often as possible – rather than through involuntary orders made by doctors and tribunals – with support being made available to assist the person in making decisions if they wish. It also requires that substituted decision-making, including via involuntary treatment orders, may occur only in very limited circumstances, if indeed it is to be permitted at all. In any case, substituted decisions must reflect the person's known 'will and preferences' (using the language of the *CRPD*)³ rather than paternalistic formulae such as the 'best interests' tests traditionally used in guardianship schemes.

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1 Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health Law in Australia' (2012) 46 *Australian & New Zealand Journal of Psychiatry* 611.

2 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). See also *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, GA Res 61/106, UN GAOR, 61st sess, 76th plen mtg, Agenda Item 67(b), Supp No 49, UN Doc A/RES/61/106 (24 January 2007, adopted 13 December 2006) annex II. Australia ratified the *CRPD* in July 2008, and the *Optional Protocol* in August 2009.

3 *CRPD* art 12(4).

The *CRPD*, and article 12 in particular, has presented a major challenge for states parties as traditional involuntary treatment clearly fails to meet its requirements. The challenge has been further complicated by an intense and often divisive debate around the interpretation of the *CRPD* and by the controversial *General Comment No 1, Article 12: Equal Recognition before the Law* ('*General Comment*') issued by the United Nations Committee on the Rights of Persons with Disabilities ('the Committee') in 2014.⁴ The *General Comment* stated that compliance with the *CRPD* required the outright abolition of 'mental health laws that permit forced treatment'⁵ – a demand that was received with concern, if not dismay, in many quarters.⁶ With no government in Australia or elsewhere seriously contemplating such a radical move, especially given the absence of a well-developed alternative, the question has now become one of how to interpret and implement the *CRPD*'s important goals, notwithstanding some of the troublesome aspects of the interpretation preferred by the administering Committee.

At the time of writing, all but one of eight Australian jurisdictions have undertaken substantial reviews of their mental health laws.⁷ All of the reviewing authorities have acknowledged the impact of the *CRPD* and, to varying degrees, have sought to make amendments that would improve compliance with human rights obligations, and particularly the central challenge established in article 12. Five states and the Australian Capital Territory now have new legislation,⁸ and the Chief Psychiatrist of South Australia has recently completed a review of the *Mental Health Act 2009* (SA).⁹ This article reviews and contextualises these legislative efforts, focusing on the criteria for involuntary treatment and on those provisions that aim to support decision-making by people who fall within the scope of the legislation.

In order to address these legislative developments, it will first be necessary to review some aspects of the oftentimes fraught debate around the interpretation of the *CRPD*, including some of the more troublesome edicts in the *General Comment*, so that some practical criteria for evaluating reform efforts can be established. Applying our own pragmatic scheme for evaluating *CRPD*

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

5 *Ibid* 2 [7].

6 See, eg, John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the *UNCRPD*' (2015) 40 *International Journal of Law and Psychiatry* 70; Michael L Perlin, "'God Said to Abraham/Kill Me a Son": Why the Insanity Defense and the Incompetency Status Are Compatible with and Required by the *Convention on the Rights of Persons with Disabilities* and Basic Principles of Therapeutic Jurisprudence' (Research Paper, New York Law School Legal Studies, 11 November 2015) <<http://dx.doi.org/10.2139/ssrn.2683480>>.

7 All except the Northern Territory.

8 *Mental Health Act 2015* (ACT) ('*ACT Act*'); *Mental Health Amendment (Statutory Review) Act 2014* (NSW), amending *Mental Health Act 2007* (NSW) ('*NSW Act*'); *Mental Health Act 2016* (Qld) ('*Queensland Act*'); *Mental Health Act 2013* (Tas) ('*Tasmanian Act*'); *Mental Health Act 2014* (Vic) ('*Victorian Act*'); *Mental Health Act 2014* (WA) ('*WA Act*').

9 Office of the Chief Psychiatrist, 'Review of the *Mental Health Act 2009*' (Report, Department of Health and Aging (SA), 23 May 2014).

compliance, we conclude that the requirements of the *CRPD* have not been fully realised in most jurisdictions, with the notable exceptions of Queensland and the Australian Capital Territory, where innovative law reform has occurred.

II WHAT DO MENTAL HEALTH LAWS DO?

Mental health law regulates the circumstances under which treatment for mental illness can be given. Within this broad remit, legislation makes provision for involuntary treatment of patients in inpatient units or in the community via community treatment orders. While mental illness is common¹⁰ and is, for the most part, treated informally without any recourse to the law,¹¹ the latest available statistics indicate that there were over 44 000 involuntary admissions in 2013–14 nationwide.¹² The terms under which involuntary treatment is given now occupies a place at the epicentre of current legal interest in mental health law reform.

The traditional structure of mental health laws is that involuntary treatment will be permitted where a person: (1) has a mental illness; and (2) is deemed to be at risk of harm to themselves or others if treatment is not given,¹³ subject to a general caveat that involuntary treatment must be the least restrictive

10 The Australian Bureau of Statistics has reported that:

In 2007, almost half (45% or 7.3 million) of Australians aged 16–85 years reported that they would have met the criteria for a diagnosis of a mental disorder at some point in their life ... One-in-five (3.2 million) Australians had experienced symptoms in the 12 months prior to interview (12-month mental health disorder).

Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results* (Publication No 4326.0, 23 October 2007) <<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>>>.

- 11 The Australian Institute of Health and Welfare estimated that approximately 17 million general practitioner encounters across Australia in 2013–14 involved the management of a mental health-related problem: Australian Institute of Health and Welfare, 'Mental Health Services – In Brief 2015' (Mental Health Series No 12 Cat No HSE 169, 16 December 2015) 6. Overall, in 2008–09, community-based treatment accounted for almost two-thirds of total mental health spending by state and territory governments in Australia: Department of Health and Ageing (Cth), 'National Mental Health Report 2013: Tracking Progress of Mental Health Reform in Australia, 1993–2011' (Report, October 2013) 4.
- 12 Australian Institute of Health and Welfare, *Specialised Admitted Mental Health Care Patient Characteristics* (December 2015) Mental Health Services in Australia <<http://mhsa.aihw.gov.au/services/admitted-patient/specialised-patient-characteristics/>>.
- 13 Though largely beyond the scope of this article, it is worth noting that the structure of traditional mental health legislation has also been coming under considerable pressure from another quarter in the form of the realisation that it is not possible to usefully categorise people in psychiatric crisis into persons who are at relatively higher or lower risk of coming to serious harm or of causing serious harm to others. This realisation is based on empirical work revealing the lack of utility in so-called risk factors. For further discussion of this issue, see Matthew M Large and Christopher J Ryan, 'Suicide Risk Categorisation of Psychiatric Inpatients: What It Might Mean and Why It Is of No Use' (2014) 22 *Australasian Psychiatry* 390; Christopher J Ryan and Matthew M Large, 'Suicide Risk Assessment: Where Are We Now?' (2013) 198 *Medical Journal of Australia* 462; Michael B Paton, Matthew M Large and Christopher J Ryan, 'Debate: Clinical Risk Categorisation Is Valuable in the Prevention of Suicide and Severe Violence – No' (2014) 22 *Australasian Psychiatry* 10.

alternative.¹⁴ Where doctors (or tribunals) feel these criteria have been met, they may make an order for treatment without patient consent. As such, the process or structure is a form of substituted decision-making.

This stands in marked contrast to the law of healthcare decision-making generally, where a competent person is permitted to refuse medical treatment of any kind, regardless of whether any personal risk may be involved. At common law, providing treatment to a competent person without consent constitutes an actionable assault and battery.¹⁵ However, treatment without consent can be given to a person who lacks competence where treatment is urgently required and is necessary to save life or limb, or with substituted consent under guardianship legislation, or pursuant to a court order. The guiding principle to be applied under all these forms of traditional substituted decision-making for persons who lack competence is that treatment must be in the person's best interests.¹⁶

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- 14 The 'least restrictive alternative' requirement, like all criteria for involuntary treatment, is formulated slightly differently in each of the eight jurisdictions: see *ACT Act* s 5; *NSW Act* s 12; *Mental Health and Related Services Act 1998* (NT) s 14; *Queensland Act* s 3(2); *Mental Health Act 2009* (SA) s 7; *Tasmanian Act* s 12; *Victorian Act* s 5; *WA Act* s 25.
- 15 This is the position throughout the common law world. In the United States, see *Schloendorff v Society of New York Hospital*, 105 NE 92, 93 (Cardozo J) (NY, 1914); *Bouvia v Superior Court of Los Angeles County*, 179 Cal App 3d 1127, 1137, 1139–41 (Beach J) (Ca, 1986). In Canada, see *Nancy B v Hôtel-Dieu Québec* (1992) 86 DLR (4th) 385, 390–2 (Dufour J) (Quebec Superior Court); *Malette v Shulman* (1990) 67 DLR (4th) 321, 328 (Robins JA) (Ontario Court of Appeal). In England and Wales, see *Airedale NHS Trust v Bland* [1993] AC 789, 857 (Lord Keith), 864 (Lord Goff); *Re T* [1993] Fam 95, 102–3 (Lord Donaldson); *Re MB* [1997] 2 FLR 426, 432 (Butler-Sloss LJ); *Re B* [2002] 2 All ER 449, 455–6 [16]–[21] (Dame Butler-Sloss P). In New Zealand, see *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 245 (Thomas J). In Australia, see *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 91–2 [9]–[15] (McDougal J); *Brightwater Care Group Inc v Rossiter* (2009) 40 WAR 84, 91 [26] (Martin CJ); *H Ltd v J* (2010) 107 SASR 352, 364–9 [33]–[46] (Kourakis J).
- 16 Although this is the thrust of guardianship law, the formulation varies across state and territory legislation. Broadly speaking the applicable principles include that substituted decision-makers must exercise their functions in a manner that:
- (1) promotes the person's
 - (a) best interests: *Guardianship and Management of Property Act 1991* (ACT) s 4(2); *Guardianship and Administration Act 2000* (Qld) sch 1 cl 12(1)(b)(ii); *Guardianship and Administration Act 1995* (Tas) s 43(1)(b); *Guardianship and Administration Act 1986* (Vic) s 4(2)(b); *Guardianship and Administration Act 1990* (WA) s 110ZD(8); or
 - (b) wellbeing: *Guardianship Act 1987* (NSW) ss 32(b), 40(3)(c), 44(2)(c); *Guardianship and Administration Act 2000* (Qld) s 64(1)(b), sch 1 cl 12(1)(b)(i); *Guardianship and Administration Act 1995* (Tas) s 43(2)(e); *Guardianship and Administration Act 1986* (Vic) s 38(1)(f);
 - (2) is the least restrictive of the person's rights and freedoms: *Guardianship and Management of Property Act 1991* (ACT) ss 4(2)(d), 11; *Guardianship and Administration Act 2000* (Qld) sch 1 cl 12(1)(a); *Guardianship and Administration Act 1993* (SA) s 5(d); *Guardianship and Administration Act 1986* (Vic) s 4(2)(a); and
 - (3) takes into account the person's wishes: *Guardianship and Management of Property Act 1991* (ACT) s 4(2)(a)–(b); *Guardianship Act 1987* (NSW) ss 40(3)(a), 44(2)(a)(i); *Guardianship and Administration Act 2000* (Qld) sch 1 cl 12(2)(a); *Guardianship and Administration Act 1993* (SA) s 5(a)–(b); *Guardianship and Administration Act 1995* (Tas) s 43(2)(a); *Guardianship and Administration Act 1986* (Vic) s 4(2)(c).

While the formulation of capacity tests vary, most modern statutes adopt a functional approach, focusing on a person's ability to make a decision.¹⁷ The typical formulation is that adults are presumed to have capacity unless it can be shown that the person is: (1) 'unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision'; or (2) 'unable to use and weigh the information as part of the process of making the decision'.¹⁸ In this article, we shall refer to this formulation as 'decision-making capacity'. Decision-making capacity is also sometimes called 'competence' or 'mental capacity', such as under the *Mental Capacity Act 2005* (UK) c 9.¹⁹

In traditional mental health law however, the presence or absence of decision-making capacity has not always been a determining factor in considering whether involuntary treatment can be given.²⁰ Thus, mental health law was already anomalous in its approach to personal autonomy in medical decision-making in that mentally ill persons who retained decision-making capacity could still be made the subject of involuntary orders if the treatment criteria were met. In this sense, mental health law was already *prima facie* discriminatory – well before the more complex demands of the *CRPD* arose.

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- 17 Functional capacity tests focus on a person's ability to make a decision, and may be contrasted with 'status' and 'outcomes' based approaches that focus on the attributes of the person and the content of a decision, respectively. These are now widely rejected as being insufficiently protective of the right to autonomy in healthcare decision-making. For discussion, see Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Substitute Decision-Making for People Lacking Capacity* (2010); Law Commission (UK), *Mental Incapacity*, Report No 231 (1995).
- 18 This is the description given in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 93 [25] (McDougall J), relying on authority in *Re MB* [1997] 2 FLR 426, 436–7 (Butler-Sloss LJ).
- 19 Section 3(1) of the *Mental Capacity Act 2005* (UK) c 9 provides that:
- a person is unable to make a decision for himself if he 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).
- 20 Prior to the reforms commencing in 2014 (see above n 8) the concept of decision-making capacity was referred to in some state and territory legislation, however, a person who retained capacity and who refused treatment could still be treated under an involuntary order even in those jurisdictions: see *Mental Health and Related Services Act 1998* (NT) s 14(b)(iii); *Mental Health Act 2000* (Qld) s 14(1)(f), as repealed by *Queensland Act* s 801; *Mental Health Act 1996* (Tas) ss 5AA, 72G, as repealed by *Tasmanian Act* s 231, sch 6; *Mental Health Act 1986* (Vic) s 8(1), as repealed by *Victorian Act* s 374(1); *Mental Health Act 1996* (WA) s 26(1)(c), as repealed by *WA Act* s 588(a). In the ACT, NSW and SA (prior to the commencement of new *ACT Act*, the new *NSW Act* and the *Mental Health Act 2009* (SA)), decision-making capacity was not a consideration at all: *Mental Health (Treatment and Care) Act 1994* (ACT) ch 6, as repealed by *ACT Act* s 148; *Mental Health Act 1990* (NSW) pt 2 div 1, as repealed by *NSW Act* s 200; *Mental Health Act 1993* (SA) s 18–20, as repealed by *Mental Health Act 2009* (SA) sch 2 cl 1.

III WHAT DOES THE *CRPD* REQUIRE?

A Article 12 and the 'Paradigm Shift'

The *CRPD* has extended the account of discrimination in disability, objecting to the automatic use of substituted decision-making whenever a person fails to meet a functional test of decision-making capacity. This has far-reaching consequences not only for mental health law, but also for traditional guardianship and general common law principles.

The key provision in this respect is article 12, which requires states parties to 'recognize that persons with disabilities enjoy legal capacity on an equal basis with others'. Article 12 states that:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

In many respects, the language of the *CRPD* offers all the clarity of the riddles of the Delphic Oracle. It is the result of what observer Schulze described as 'tedious, detailed and sometimes excruciating discussions'²¹ and reflects an ultimately unresolved disagreement between the delegates on key questions such as whether substituted decision-making could ever be allowed. In abandoning the task of providing a clear legislative direction to state parties, much of the work of making sense of the novel terms coined in the *CRPD* (many of which remain undefined either in existing human rights jurisprudence or in the *CRPD* itself) has been left to academic commentators following the conclusion of the drafting process. An important example of the task of reforming involuntary treatment provisions has been evaluating the meaning of the term 'legal capacity', and determining what it means to require that 'persons with disabilities enjoy legal capacity on an equal basis with others'. Does it mean, for example, that people with disabilities who lack decision-making capacity should be susceptible to substituted decision-making – in the same way that people who do not have disabilities are? Or does 'legal capacity' have a broader meaning?

21 Marianne Schulze, *Understanding the UN Convention on the Rights of Persons with Disabilities* (Handicap International, 3rd ed, 2010) 86.

A consensus appears to have been reached that the term ‘legal capacity’, as it is used in the *CRPD*, comprises two concepts that have hitherto been separated in general law: (1) ‘legal standing’ – the status of being a person before the law; and (2) ‘legal agency’ – the ability to act to enforce certain rights.²² This is a substantially different understanding of capacity to that applied in the general law, which is concerned solely with agency and the ability to make a decision. However, in rolling these two concepts together, article 12 is now understood to mean that a person can retain *legal capacity*, at least in the sense of retaining legal status, if not legal agency, even if the person has impaired *decision-making* ability. Decision-making ability is not a necessary precondition for exercising legal capacity – and in this way, article 12 brings about a ‘paradigm shift’ in the way legal agency is understood, and departs from the way it has been traditionally formulated and protected in law.²³

In addition, article 12(3) appears to require that, where decision-making ability is impaired, states parties must provide the person with support in order to allow him or her to exercise legal capacity ‘on an equal basis with others’. This is a new positive right in which the exercise of capacity must be actively facilitated if necessary. Article 12(4) further requires that support measures ‘respect the rights, will and preferences of the person’.

Read as a whole, article 12 has been interpreted as requiring a move away from paternalistic substituted decision-making arrangements focused on risk avoidance or furthering the person’s ‘best interests’. This is part of the *CRPD*’s program for shifting models of disability law based on the medicalisation of disability and reduction of physical risk to a social model in which the subjective experience of people with disabilities is honoured, and all people are treated with dignity and respect. In place of traditional substituted decision-making regimes, a new supported decision-making paradigm is envisaged, which focuses on supporting the person to make his or her own decisions even when the person has impairments, and on respecting the rights, will and preferences of the person in all circumstances.

22 *General Comment*, UN Doc CRPD/C/GC/1, 3 [12]; Bernadette McSherry, ‘Legal Capacity under the Convention on the Rights of Persons with Disabilities’ (2012) 20 *Journal of Law and Medicine* 22; Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Issues Paper No 44 (2013); Tina Minkowitz, World Network of Users and Survivors of Psychiatry, ‘Legal Capacity as Right, Principle and Paradigm’, Submission to Committee on the Rights of Persons with Disabilities, 17 June 2011 <http://www.wnusp.net/documents/2012/WNUSP_Article12_Submission.doc>; Santos Cifuentes et al, ‘Legal Opinion on Article 12 of the *CRPD*’ (Centre for Disability Studies, University of Leeds, 21 June 2008) <<http://disability-studies.leeds.ac.uk/files/library/legal-opinion-LegalOpinion-Art12-FINAL.pdf>>.

23 Legal status has never been dependent on decision-making capacity in general law, so at least this much is widely accepted. However, the more revolutionary implication of art 12 is that legal agency – the ability to make a legally enforceable decision – should also be independent of functional decision-making capacity, and that the right to decide, and to have one’s decisions protected in law from interference, should be extended to all people, regardless of decision-making ability. This account is also sometimes called ‘universal capacity’: see Amita Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?’ (2007) 34 *Syracuse Journal of International Law and Commerce* 429.

This has presented a major challenge to mental health laws, which have traditionally been concerned with avoiding risk of harm to the person themselves or others, without any requirement to take into account the person's wishes, or their ability to make a decision for themselves.

B Tug of Paradigms?

Despite wide agreement on the overarching principles of the *CRPD* – the right of all persons to non-discrimination and full and effective enjoyment of all human rights – ongoing debate about important details, particularly in relation to article 12, complicates the task of 'reviewing compliance'. In light of continuing disagreement in the literature on some key matters, it will be necessary to undertake a short review of the main areas of controversy in order to establish a set of working criteria by which we might evaluate compliance.

Of critical relevance to mental health law is the question of whether any kind of arrangement where one person makes a decision *on behalf of another person* – which we will refer to as 'substituted decision-making' – should be allowed within the *CRPD*'s supported decision-making paradigm. While some aspects of article 12, notably 12(4), seem to allow room for substituted decision-making, at least where it is necessary to prevent 'abuse' and where it is 'proportional and tailored to the person's circumstances', the crucial question of whether substituted decision-making is permitted *at all* is not expressly dealt with, despite the fact that it was extensively discussed by the delegates.²⁴

In attempting to address this uncertainty, a number of states parties registered interpretive declarations at the time of signing, stating their understanding of what article 12 bound them to do.²⁵ Australia's declaration was in the following terms:

Australia declares its understanding that the *CRPD* 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.²⁶

However, since the *Convention* was adopted, there has been a split in the discourse between those who argue that an attenuated form of substituted decision-making can, and should, be part of a broadly conceived 'supported

24 Annegret Kämpf, 'Involuntary Treatment Decisions: Using Negotiated Silence To Facilitate Change?' in Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 129, 144–5.

25 For the text of all declarations and reservations to the *CRPD*, see United Nations, *Chapter IV Human Rights – 15 Convention on the Rights of Persons with Disabilities* (16 April 2014) United Nations Treaty Collection <https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4&lang=en>. See in particular the declarations of Australia, Norway, Estonia and Canada.

26 *Ibid.*

decision-making model',²⁷ and those who argue that if legal capacity is to be regarded as a universal human attribute (rather than a right restricted to those who have *mental capacity* applying functional tests) substituted decision-making of any kind is impermissible.²⁸ Even in cases of severe functional incapacity, the absolutist interpretation of the *CRPD* holds that a person may be regarded as being supported to make their own decision, theoretically even to the point that 100 per cent support is being given.²⁹

The United Nations Committee on the Rights of Persons with Disabilities is the body charged with reviewing states parties' compliance with the *CRPD* and with making interpretative declarations on the meaning of the *CRPD* from time to time in general comments. General comments are not legally binding themselves, but are regarded as authoritative interpretations of the binding obligations in treaties. The Committee has adopted an absolutist interpretation of the *CRPD* and has taken a hardline approach in interpreting the provisions of article 12, heavily criticising most nations' compliance with the *CRPD*. In its 2013 review of Australian law, the Committee recommended that Australia should:

repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.³⁰

It further stated that Australia should review its interpretive declarations 'with a view to withdrawing them'.³¹ Without any established alternatives to capacity-based approaches to medical treatment, nor any broad-based support for abolishing involuntary treatment in mental health, these recommendations looked to be impossible to meet.

Shortly after the release of its report on Australian compliance, and in the wake of what it saw as a 'general misunderstanding' by states parties of their obligations,³² the Committee released a draft general comment on article 12. Submissions on the draft sought clarification on practical concerns such as how

27 See, eg, Michael Bach and Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity' (Working Paper, Law Commission of Ontario, October 2010) <<http://www.lco-cdo.org/disabilities/bach-kerzner.pdf>>; Dawson, above n 6; Jill Stavert, 'The Exercise of Legal Capacity, Supported Decision-Making and Scotland's Mental Health and Incapacity Legislation: Working with *CRPD* Challenges' (2015) 4 *Laws* 296; Essex Autonomy Project, Submission to the Committee on the Rights of Persons with Disabilities in response to the *Draft General Comment on Article 12 – On Equal Recognition before the Law*, 21 February 2014 <<http://www.ohchr.org/Documents/HRBodies/CRPD/GC/EAPArt12.doc>>.

28 See, eg, Dhanda, above n 23; Minkowitz, above n 22.

29 See, eg, Dhanda, above n 23; Schulze, above n 21, 87.

30 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5 [34].

31 *Ibid* [9].

32 Committee on the Rights of Persons with Disabilities, *General Comment on Article 12: Equal Recognition before the Law: Draft Prepared by the Committee*, 11th sess, UN Doc CRPD/C/11/4 (25 November 2013) 2 [3].

the *CRPD* should be interpreted in emergency situations.³³ A number of these submissions raised concerns about apparent inconsistencies between the Committee's draft general comment, which appeared to give a person's expressed 'will and preferences' an unassailable status, with broader human rights jurisprudence,³⁴ which requires a balancing of the right to autonomy (the focus of article 12) with other rights – such as the right to life³⁵ and the right to health.³⁶ Australia specifically sought guidance on 'the most human rights compatible approach in situations where a person does not have ... the capacity to make or communicate a decision'.³⁷

While the final *General Comment* did provide useful clarification on some matters, particularly of articles 12(2) and 12(3), it was not the practical document for which many had hoped.³⁸ It also made clear that the Committee was committed to the notion of universal legal capacity,³⁹ and absolutely rejected substituted decision-making in all forms, including in guardianship legislation and in 'mental health laws that permit forced treatment'.⁴⁰

The following paragraphs set out the key elements of the Committee's position:

In order to fully recognize 'universal legal capacity', whereby all persons, regardless of disability or decision-making skills, inherently possess legal capacity,

33 Equality and Human Rights Commission et al, Submission to the Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12*, 28 February 2014, 4–5 <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/EHRC_ECNI_NIHRC_SHRC_Art.12.doc>; Australian Government, Submission to the Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12*, 2014, [11], quoted in Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 55.

34 Equality and Human Rights Commission et al, above n 33, 2–3; Essex Autonomy Project, above n 27, 4–5; Jill Stavert, Submission to the Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12 – On Equal Recognition before the Law*, 20 February 2014 <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/JillStavertEdinburghNapierUniversity_Art12.doc>.

35 *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 6(1). See also *Second Optional Protocol to the International Covenant on Civil and Political Rights*, opened for signature 15 December 1989, 1642 UNTS 414 (entered into force 11 July 1991) art 1; *CRPD* art 10.

36 *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) art 25(1).

37 Australian Government, Submission to the Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12*, 2014, [16] quoted in Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 55.

38 For example, the Commonwealth Attorney-General's Department noted:

In their comments on the draft, a number of States, including Australia, indicated their understanding that article 12 permits 'substituted decision-making' in certain circumstances. It is unfortunate that the Committee did not incorporate the views of States on the interpretation of the Convention, given the importance under international law of States' interpretation of their own obligations.

Attorney-General's Department (Cth), Submission No 113 to Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (30 June 2014) 4 <http://www.alrc.gov.au/sites/default/files/subs/113._org_attorney-generals_department.pdf>.

39 This is the idea that legal capacity is a 'universal human attribute' and can never be lost because of functional impairment: see *General Comment*, UN Doc CRPD/C/GC/1, 2 [8], 4 [15], 6 [25].

40 *Ibid* 2 [7].

States parties must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.⁴¹

The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, *when the person does not pass the assessment, it then denies him or her a core human right – the right to equal recognition before the law.*⁴²

On the basis of the initial reports of various States parties that it has reviewed so far, the Committee observes that there is a general misunderstanding of the exact scope of the obligations of States parties under article 12 of the Convention. Indeed, there has been a general failure to understand that *the human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making.*⁴³

States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities.⁴⁴

*The ‘will and preferences’ paradigm must replace the ‘best interests’ paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others.*⁴⁵

Furthermore, it appeared that on the Committee’s interpretation, the rights established in article 12 were to be considered absolute and non-derogable.⁴⁶ This meant that the doctrine of progressive realisation would not apply,⁴⁷ and regimes permitting proxy consent could not continue in parallel with the gradual implementation of new supported decision-making models which, for the time being, have not been fully developed.

Unsurprisingly, the *General Comment* did not end the debate, and itself became something of a problem to be managed by those charged with translating the *CRPD*’s requirements into domestic law reform. Academic criticism centered on the unintended consequences of the absolutist position, especially in the absence of well-conceived and tested alternatives to existing legal models, in which substituted decision-making may be permitted where a person lacks capacity and serious harm is likely to arise, such as in emergencies. In this respect Dawson observed the following:

Involuntary psychiatric treatment, for instance, could both limit a person’s autonomy and promote their social inclusion, health, and standard of living. Would it therefore violate or promote the person’s rights under the Convention as a whole? In many legal systems, a key concept in settling the balance between these competing imperatives or rights is that of capacity ... on the part of the person to take the necessary action or make the relevant decision. If they have the capacity to decide on their own need for treatment, for example, it would usually

41 Ibid 6 [25].

42 Ibid 4 [15] (emphasis added).

43 Ibid 1 [3] (emphasis added).

44 Ibid 10 [41].

45 Ibid 5 [21] (emphasis added).

46 Ibid 2 [5], 2–3 [9], 8–9 [34].

47 Ibid 7–8 [30].

violate their right to autonomy and integrity to impose treatment without their consent, even if the treatment proposed would assist their health or promote their social inclusion. The balance between those different interests would be for them to decide. If they lacked the capacity to make the relevant decision, on the other hand, the state would have the power (and often the duty) to intervene, to promote their positive entitlements, even if that might require their involuntary treatment.⁴⁸

Still others expressed concern that the notion of 100 per cent decision-making support for people with serious impairments was a 'legal fiction', and one that amounted to nothing more than informal substituted decision-making – but without the oversight that would normally be required where substituted decision-making was recognised as such.⁴⁹

Particular concerns about implementation in mental health also remain. Practical and legal dilemmas will inevitably arise where a person is in the grip of temporary symptoms that seriously affect his or her functional abilities and/or preferences, particularly where giving effect to the person's stated preferences will lead to a serious harm.⁵⁰ The *General Comment* had nothing useful to say about what would be the most human rights compatible resolution of a situation where a person's expressed preferences had been communicated in circumstances where their mental capacity was severely impaired by mental illness, and which, if carried out, would lead to serious physical harm.

For its part, the Australian Law Reform Commission ('ALRC'), in its report on *Equality, Capacity and Disability in Commonwealth Laws*, was critical of the nature of scholarly discussions around the implementation of the *CRPD*, noting that 'there is an evident tension in the way that the labels of "supported decision-making" and "substitute decision-making" are used' and that '[t]he discourse around art 12, and particularly the [*General Comment*] ... has exacerbated this tension', and concluding that 'conceptual confusion' was ultimately 'impeding reform'.⁵¹

For now, unresolved theoretical and practical difficulties evident in the *General Comment* have meant that some of its more problematic edicts have

48 Dawson, above n 6, 71.

49 Callaghan and Ryan, above n 1; Louise Harmon, 'Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment' (1990) 100 *Yale Law Journal* 1; Gerald Quinn, 'Personhood & Legal Capacity: Perspectives on the Paradigm Shift of Article 12 *CRPD*' (Paper presented at HPOD Conference, Harvard Law School, 20 February 2010) 17. Quinn asks:

whats [sic] worse: stretching a fiction (100% support) to the point that it is visibly at odds with reality – a factor that is only likely to be seized on by States acting out of abundant caution and enter declarations or reservations ring-fencing substitute decision-making – or, admitting the obvious and then using our talents to lock in the exception and transform how decisions are 'made for' people?

50 Callaghan and Ryan, above n 1; Genevra Richardson, 'Mental Disabilities and the Law: From Substitute to Supported Decision-Making?' (2012) 65 *Current Legal Problems* 333.

51 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014), 48 [2.55], 49 [2.59].

been politely sidelined in the few major law reform reports concluded since.⁵² One such report produced by the Essex Autonomy Project, advised the United Kingdom Ministry of Justice that ‘the Committee’s findings are *not binding* on the UK’, remarking that ‘the claims of the Committee’s *General Comment* go beyond anything that is explicitly stated in the text of the *CRPD*’ and that some of its more extreme demands, such as the abolition of substituted decision-making in its entirety, need not be followed.⁵³ The ALRC similarly noted that the *General Comment* is provided merely ‘by way of guidance’ and is not binding on Australia.⁵⁴ It also declined to recommend withdrawing Australia’s interpretive declaration as called for by the Committee, remarking that, notwithstanding any ‘confusion ... or negative messaging’ that it may carry, ‘[i]nsofar as the Declaration is simply stating that there are occasions when a person may be appointed to act on behalf of another – as a substitute – the ALRC considers that this is a correct understanding of the *CRPD*’.⁵⁵

Notwithstanding the *General Comment*, the ALRC ultimately recommended a two-tiered decision-making model which includes support for decision-making by the person themselves, but also makes provision for ‘representative decision-making’ where a person is unable to make their own decisions.⁵⁶ Representative decision-making involves proxy consents being given by a decision-maker who is ideally appointed by the person themselves. The representative is bound to give effect to the person’s will and preferences so far as they can be ascertained. Representative decision-making is still substituted decision-making, but it is attenuated by the need to have the person’s will and preferences at the magnetic centre of the process as the object towards which any decision made by the proxy must draw.⁵⁷

Recent detailed legal reviews of mental capacity laws by the governments of Australia,⁵⁸ the State of Victoria,⁵⁹ Ontario,⁶⁰ and Northern Ireland⁶¹ have all

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- 52 The only comprehensive law reform reports produced since the *General Comment* was released are: *ibid*; Department of Health, Social Services and Public Safety (Northern Ireland) and Department of Justice (Northern Ireland), *Draft Mental Capacity Bill (NI) – Consultation Summary Report* (2015) <<https://www.dhsspsni.gov.uk/sites/default/files/consultations/dhssps/mental-capacity-consultation-summary.pdf>>; Wayne Martin et al, ‘Achieving *CRPD* Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN *Convention on the Rights of Persons with Disabilities*? If Not, What Next?’ (Report, Essex Autonomy Project, 22 September 2014) <<http://autonomy.essex.ac.uk/unCRPD-report>>.
- 53 Martin et al, above n 52, 12–13 (emphasis in original). Similar remarks were made by the Commonwealth Attorney-General’s Department in its submission to the ALRC: see Attorney-General’s Department (Cth), above n 38, 4.
- 54 Australian Law Reform Commission, *Equality, Capacity and Disability Report*, above n 51, 48 [2.56].
- 55 *Ibid* 57 [2.96]–[2.97].
- 56 *Ibid* 77.
- 57 *Ibid* 78 [3.58]–[3.62].
- 58 *Ibid* 57 [2.96].
- 59 Victorian Law Reform Commission, *Guardianship*, Report No 24 (2012).
- 60 Law Commission of Ontario, *Legal Capacity Decision Making and Guardianship*, Discussion Paper (2014) <<http://lco-cdo.org/en/capacity-guardianship-discussion-paper>>.
- 61 Department of Health, Social Services and Public Safety (Northern Ireland) and Department of Justice (Northern Ireland), above n 52.

settled on a similar 'continuum' of support approach to the implementation of the *CRPD*. Under all these proposals, the provision of support for autonomous decision-making is preferred, but substituted decision-making (by one name or another) is also permitted in limited circumstances, subject to safeguards. We note in this respect that the term substituted decision-making has receded in favour of alternatives such as 'facilitated' or 'representative' decision-making, and more terms will surely emerge. This change in language signals a change in underlying principle, away from traditional paternalism and towards the 'will and preferences' approach. We suspect that the term 'involuntary treatment' in mental health will also eventually need to go for the same reasons, but as this is still likely to be some way off,⁶² we will leave questions of language aside for the purposes of this review.

C A Working Model for Assessing Compliance

Having acknowledged the complexities of the debate on the interpretation of the *CRPD* so far, we suggest that a useful path may be cut through some of its more disorienting thickets by focusing on the basic matters upon which those tasked with law reform (if not those involved in surrounding scholarship) are now broadly agreed.

It is clear, for example, that the *CRPD* condemns any laws that discriminate against people on the basis of disability, and that article 12 rejects 'best interests' approaches to decision-making in favour of one based on 'will and preferences'. Taking a pragmatic view of the *CRPD*'s requirements, we suggest that compliance requires the implementation of a supported decision-making model, but that this may include substituted decision-making in certain limited circumstances where a person does not have decision-making capacity despite the provision of support. A supported decision-making model will involve support *for* decision-making in order to ensure that decisions are made by the person him or herself as much as possible, and that to the extent that proxy decision-making is permitted (or substituted decision-making, to use the much-maligned term), it must seek to identify the will and preferences of the person, and to give effect to them as far as possible, circumscribed only by the need to prevent an identifiable risk to the person's other rights and only in proportion to that risk.

In order to operationalise the assessment of compliance of Australian mental health laws, we have devised the four criteria below (two concerning capacity and two supported decision-making). We consider that, *at the very least*, article 12 requires the following criteria be met.

Evaluation Criteria – Capacity

1. The right to exercise legal capacity (including the capacity to consent to or refuse inpatient medical treatment) should not be extinguished merely

62 We note that the *Queensland Act* uses the term 'treatment authority' in place of the traditional 'involuntary treatment order': see, eg, *Queensland Act* ch 2 pt 4.

on the basis that a person has a mental illness. Thus, at a *minimum*, a person with mental illness who retains decision-making capacity in relation to a decision about their own treatment, must not be treated without consent – in line with the general legal position that persons with capacity are entitled to refuse medical treatment, regardless of risk of harm.

2. Capacity assessment must not be used as a tool to deprive people of the right to participate in decision-making. Capacity must be presumed, and people with mental illness must be offered the support to exercise capacity. Any evaluation of decision-making capacity should take into account the capacity that a person is able to exercise with support from others (article 12(3)). Furthermore, capacity should only be tested where there is reason to believe that a person lacks capacity and that giving effect to their will and preferences will harm their other rights.

Evaluation Criteria – Supported Decision-Making

1. Persons subject to mental health legislation must be supported to make their own decisions as far as possible, and supported to express and give effect to their will and preferences.
2. A person *may* decide on behalf of another person only where a person lacks decision-making capacity even with the provision of support, and only where the person's other rights may be infringed by the decision to the extent that the person may suffer harm. Any substituted decision-making of this kind (whether described as 'proxy' or 'representative' decision-making, or some other term) must, in any case, be subject to safeguards (article 12(4)). This means that:
 - a. A person must have the opportunity to appoint their own proxy decision-maker;
 - b. All treatment decisions must respect the 'rights, will and preferences of the person' and must give effect to them as far as possible; and
 - c. Any mechanisms which permit a person's current will and preferences to be overridden:
 - i. may only permit this to the extent that it is necessary to protect the person's other rights – such as the right to life and the right to health; and
 - ii. must be proportional and tailored to the risk to other rights (article 12(4)).

(Note that a person need not have another person decide on their behalf merely because they lack decision-making capacity.)

IV EVALUATING NEW MENTAL HEALTH LEGISLATION IN AUSTRALIA

A Capacity

We have stated, in our first evaluation criterion, that to achieve basic equality with general healthcare decision-making rights, psychiatric treatment must not be given without the consent of a person who retains decision-making capacity.

While this is already the position taken in some jurisdictions, this approach has not been universally adopted. So far the new mental health laws have dealt with patients who have capacity to consent to treatment, or to refuse it as the case may be, in two different ways. The first approach has been to adopt a strict incapacity-based standard for involuntary treatment. This has been done in Tasmania, Western Australia and Queensland, where an order for involuntary treatment cannot be made unless the person does *not* have decision-making capacity as defined in each legislative instrument.⁶³ The legislative definitions all take into account the decision-making abilities typically required in functional capacity tests, such as the ability to understand information relevant to the decision, and to use and weigh that information to make a decision.⁶⁴ These tests restrict involuntary treatment only to those patients who are unable to consent to treatment themselves.

The *Queensland Act* further requires, in line with our second evaluation criterion, that a person 'may be supported by another person' to understand the matters required to meet the Act's definition of capacity.⁶⁵ Providing support to achieve decision-making capacity is an important addition in the Queensland legislation that is missing from the other Acts. If lack of decision-making capacity is to be a threshold for involuntary treatment, it should involve an assessment of the decision-making capacity that is achievable with support.

The second approach to the capacity issue (taken in the *ACT Act*, *NSW Act* and *Victorian Act*) falls short of implementing a strict incapacity criterion among the conditions required for involuntary treatment. While decision-making capacity is a factor to be taken into account in these instruments, involuntary treatment of competent patients is still permitted in some circumstances.

In this respect, New South Wales has adopted a disappointingly minimalist approach in amending its legislation. After a review of the 2007 Act, no change was made to the provisions permitting involuntary treatment, which allow treatment and detention without consent if a person has a mental illness (as defined by the Act), and where treatment is necessary to protect the person or others from serious harm, provided that 'no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably

63 *Queensland Act* s 12(1)(b); *Tasmanian Act* s 40(e); *WA Act* ss 25(1)(c), (2)(c).

64 *Queensland Act* s 14; *Tasmanian Act* s 7; *WA Act* s 18.

65 *Queensland Act* s 14(3).

available to the person'.⁶⁶ Amendments on this issue were limited to the insertion of a new 'principle for care and treatment' that ensures

every effort that is reasonably practicable should be made to obtain the consent of people with a mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans.⁶⁷

This addition, at least, acknowledges the importance of consent and capacity, but it falls well short of prohibiting the treatment of those who retain decision-making capacity without their consent. The injunction to make 'every effort that is reasonably practicable ... to support people who lack that capacity to understand treatment plans and recovery plans' is in line with the support required in our second evaluation criterion, but again it falls short of what is required. The extent to which a patient's capacity is actually considered and to which a patient is actually provided decision-making support under the amended Act will depend on the views of doctors and the Mental Health Review Tribunal as to what is 'reasonably practicable'. In the absence of clear guidelines *requiring* a change in approach, there is very little to ensure that the process of ordering involuntary admissions and the justifications for them will change as a result of these amendments.

In contrast to the minor amendments in New South Wales, Victoria's mental health legislation was entirely redrafted, with a major ambition being to achieve compliance with the *CRPD*.⁶⁸ However, even in the entirely new *Victorian Act*, new treatment provisions expressly permit involuntary treatment if the patient '*has the capacity to give informed consent, but does not give informed consent to treatment proposed by the authorised psychiatrist*'.⁶⁹ In the place of a strict protection of treatment refusals by competent patients, the *Victorian Act* places general limitations on when treatment may be given. Among them is the requirement that the 'psychiatrist may make a treatment decision for the patient [only] if ... satisfied that *there is no less restrictive way for the patient to be treated*',⁷⁰ listing factors to which the psychiatrist must have regard, 'to the extent that is reasonable in the circumstances', when determining whether there are no less restrictive options.⁷¹ The first of these factors is 'the patient's views and preferences about treatment ... and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes that the patient would like to achieve'.⁷²

It may well have been the intention of the drafters that the patient's views and preferences should carry significant weight when deciding whether or not a person can be given treatment without consent. After all, the Act states that

66 *NSW Act* ss 12, 14, 15.

67 *NSW Act* s 68(h1).

68 Victoria, *Parliamentary Debates*, Legislative Assembly, 12 March 2014, 689–91 (Ted Baillieu).

69 *Victorian Act* s 71(1) (emphasis added).

70 *Victorian Act* s 71(3) (emphasis added).

71 *Victorian Act* s 71(4).

72 *Victorian Act* s 71(4)(a).

people are presumed to have capacity⁷³ and several new objects and principles of the Act promote human rights and dignity,⁷⁴ participation in decision-making,⁷⁵ a preference for voluntary treatment,⁷⁶ respect for a patient's views and preferences,⁷⁷ tolerance for decisions that involve a degree of risk,⁷⁸ and respect and promotion of patients' autonomy.⁷⁹ In practice, however, the extent to which any of these measures will protect a patient's ability to refuse even when he or she has capacity, will depend entirely on the admitting clinician's interpretation of what would be 'reasonable in the circumstances'. Just as in New South Wales, we might expect that any real change in practice would require a change in culture among treating psychiatrists, for there is little legal imperative for treating psychiatrists to depart from established values and procedures outside of these soft-law nudges in the direction of involving patients in decision-making.⁸⁰

The *ACT Act* builds significantly upon the principles-guided approach taken in New South Wales and Victoria. Section 5(b) of the *ACT Act* makes it an object of the Act to 'promote the capacity of people with a mental disorder or mental illness to determine, and participate in, their assessment and treatment, care or support, taking into account their rights in relation to mental health under territory law'. In addition, a new set of 'Principles of decision-making capacity' further bolsters a patient's ability to exercise rights to self-determination.⁸¹ Section 8(1) requires that 'a person must be assumed to have decision-making capacity' until this is rebutted by evidence, and that 'a person must not be treated as not having decision-making capacity unless all practicable steps to assist the person to make decisions have been taken'.

However, despite extensive supportive measures and a clear commitment to a patient-centred approach, at least in principle, the *ACT Act* still permits an involuntary order to be made in respect of a patient who 'has decision-making capacity ... but refuses to consent', although a psychiatric treatment order made in these circumstances must take into account an elaborate set of 'rights' enumerated in the 'Principles applying to the Act'.⁸² These are more detailed than

73 *Victorian Act* s 70.

74 *Victorian Act* s 10(b).

75 *Victorian Act* ss 10(d), 11(c).

76 *Victorian Act* s 11(a).

77 *Victorian Act* s 11(c).

78 *Victorian Act* s 11(d).

79 *Victorian Act* s 11(e).

80 Arguably the Victorian Mental Health Tribunal might have a role in changing the attitudes of psychiatrists if it were to include a consideration of patients' decision-making capacity and their views and preferences about treatment in its determination of whether or not patients meet the least restrictive element of the treatment criteria: *Victorian Act* s 5(d). To date, however, the Tribunal has generally interpreted the Act in such a way that 'there is no role vested in the Tribunal in relation to the treatment decision-making process under section 71': *QMT* [2014] VMHT 9 (8 August 2014), although on occasion the Tribunal has stressed that 'it did want to understand and consider [a patient's] preferences, including treatment she would agree to of her own choice' and that this was relevant to the identically worded least restrictive element of the criteria for a Security Treatment Order: *Victorian Act* s 276(1)(b)(iv); *FER* [2014] VMHT 6 (15 July 2014).

81 *Victorian Act* s 8.

82 *ACT Act* ss 6, 58(2)(b)(ii).

those contained in the *Victorian Act* and are subject to safeguards. For example, patients are explicitly accorded the right to ‘consent to, refuse or stop treatment, care or support’⁸³ and to ‘determine the person’s own recovery’.⁸⁴ In addition, if a psychiatric treatment order is made in circumstances where *the person had decision-making capacity but refuses to consent*, the ACT Civil and Administrative Tribunal (‘ACAT’) must be satisfied that the *potential for harm or deterioration in the person’s condition is ‘of such a serious nature that it outweighs the person’s right to refuse to consent’*.⁸⁵ While this also rests on normative judgments about what harms might be sufficiently ‘serious’ to override a ‘right to refuse treatment’, the Act makes clear that the patient’s right to refuse to consent is to be considered paramount, and reasons that outweigh that right must be given for it to be overridden. In addition, this decision is to be made by the Tribunal, not an individual treating doctor, and detailed guidelines for the administration of this criterion will be governed by a Code of Practice. As the Explanatory Statement for the Bill stated,

The occasions where risk outweighs the persons [sic] assessed capacity are expected to be rare, for example where the person is believed to be contemplating a course of action which involv[es] such risk to themselves or others that it casts doubt on whether enough is yet known about the persons [sic] decision-making capacity.⁸⁶

In requiring involuntary treatment orders to be made by an independent tribunal with a code of practice, rather than clinicians, and with reference to a clearly described set of patient rights, the *ACT Act* may be considerably more protective of patient rights than those of New South Wales or Victoria. Indeed, in view of the requirement that the person be consulted and that their wishes be taken into account regardless of a lack of capacity – and that any overriding of those wishes must be justified on the basis of a balancing of rights⁸⁷ – the approach taken in the Australian Capital Territory may in fact be more protective of patient rights overall than the approaches of those states which have adopted a strict incapacity threshold for involuntary orders.

Indeed, there is a seductive legal realist argument that, in practice, strict capacity-based criteria for involuntary orders may not protect patient rights to any greater extent than they are already protected under current risk-based legislation, as the same patients may simply be found to lack capacity, rather than being ‘at risk of harm’. While there is now a body of research data that indicates that psychiatrists and other medical professionals *can* reliably assess capacity in

83 *ACT Act* s 6(b)(i).

84 *ACT Act* s 6(c).

85 *ACT Act* s 58(2)(d) (emphasis added).

86 Explanatory Statement – Revised, Mental Health (Treatment and Care) Amendment Bill 2014 (ACT) 126–7.

87 The Explanatory Statement notes that ‘the ACAT must hold the view that ... the likelihood of serious harm, or the serious mental or physical deterioration, is of such a serious nature that it *outweighs* the person’s right to refuse to consent’: *ibid* 126 (emphasis added).

people with mental illness,⁸⁸ there remains scepticism about whether doctors *will* do so in an impartial way – especially if capacity is the main determinant of whether or not a person will receive treatment. Impartial assessments may be challenging where, for instance, there is any *doubt* about the person's capacity, doctors strongly disagree with the person's decisions, and the risks of not treating the person are thought to be high. In 1999, the Richardson Committee compiled a detailed report on how best to modernise mental health laws in England and Wales, recommending that involuntary treatment should generally only be available where a patient lacked decision-making capacity.⁸⁹ However, it noted a 'disinclination [among practitioners] to allow someone with a mental disorder, whether or not they formally retain capacity, to deteriorate beyond a certain point'.⁹⁰

This scepticism is supported, at least to an extent, by evidence from the United States. There, the right of competent patients to refuse treatment (but not detention) has been recognised at a state level since 1979.⁹¹ The evidence indicates that, where capacity is contested, most patients who seek to refuse treatment for a mental disorder are found by practitioners, and then by courts, to lack capacity.⁹² In this respect, Donnelly has noted that 'the way in which the law deals with patients without capacity is often of more practical significance than whether, as a theoretical proposition, the right of autonomy of patients with capacity is respected'.⁹³ This is where the *CRPD*'s supported decision-making paradigm is perhaps most significant. We turn to this next.

B Supported Decision-Making

Although it is surely important to be concerned that patients should be able to refuse treatment where they have the relevant decision-making capacity, this, as

88 See, eg. Ruth Cairns et al, 'Reliability of Mental Capacity Assessments in Psychiatric In-Patients' (2005) 187 *The British Journal of Psychiatry* 372. This study involved 55 newly admitted patients to the acute psychiatric ward at the Maudsley Hospital in London. The patients were interviewed by two interviewers up to seven days apart. Each interviewer made a yes/no capacity judgement, guided by the MacArthur Competence Assessment Tool for Treatment (MacCAT-T). Four senior clinicians then used transcripts of the interviews to judge capacity without speaking to the patients. The results showed that: 'There was excellent agreement between the two interviewers for capacity judgements made at separate interviews ($\kappa = 0.82$). A high level of agreement was seen between senior clinicians for capacity judgements of the same interview (mean $\kappa = 0.84$):' at 372.

89 Expert Committee, Department of Health (UK), *Review of the Mental Health Act 1983* (Report, November 1999) 70–1 [5.94]–[5.96].

90 *Ibid* 20 [2.9].

91 *Rogers v Okin*, 478 F Supp 1342, 1465–9 (Tauro J) (Mass, 1979).

92 Mary Donnelly, 'From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights' (2008) 26 *Law in Context* 37, 46. Citing several key US studies and reviews, Donnelly notes that when psychiatric patients wished to refuse treatment, they were generally found to lack the capacity to do so. In addition to this, several studies

showed a finding of patient incapacity in well over 90 per cent of the treatment refusal cases which went to a formal hearing. Thus, refusing patients were rarely left untreated, if their psychiatrists chose to pursue the matter, because the review mechanism in place generally led to a finding of incapacity and an order for treatment.

93 *Ibid* 49.

we have seen, may not yet result in a great deal of practical benefit for many people with mental illness who do not wish to follow their doctor's advice. It is in such cases where the CRPD's insistence on the provision of supported decision-making, operationalised in our third and fourth evaluation criteria, has the potential to make the most difference in people's lives, for it requires the involvement of persons in decision-making under all circumstances.⁹⁴

1 Supported Decision-Making in Mental Health

Many of the Australian legislative reviews have expressed the importance of supported decision-making and the intention to incorporate mechanisms for support in revised legislation. However, the provisions that have been made thus far mostly involve relatively minor process-type accommodations – that is, a degree of support *for* decision-making, alongside overarching statutory principles requiring that persons receiving services should be involved, to some degree, in decisions that affect them, at least where 'reasonably practicable'.⁹⁵ Almost all provisions fall short of establishing a true supported decision-making model with strong mandatory provisions requiring that any substituted decisions be guided by the 'rights, will and preferences' of the person.

All of the new instruments include at least some basic provisions for support *for* decision-making, many of which were carried over from the old legislation. These include very elementary measures such as requiring interpreters to be made available for non-English speakers,⁹⁶ requiring that efforts should be made to communicate in a way that the patient is likely to understand,⁹⁷ and allowing sufficient time for decisions.⁹⁸

All new legislation also includes provisions allowing patients to nominate a formal supporter who is entitled to receive information, to be consulted and informed about treatment decisions, to be present when patients are required to make decisions themselves, to have access to documents, and so on.⁹⁹

In addition, some of the new Acts make provision for patients to nominate their own proxy decision-maker¹⁰⁰ who is formally authorised to give substituted consent for treatment should the person be unable to. Substituted consent provided by a patient-nominated proxy can then be used instead of an involuntary

94 Ibid.

95 See *NSW Act* s 68(h); *Queensland Act* s 5(b); *Tasmanian Act* sch 1 cl 1(k); *Victorian Act* s 11(1)(c); *WA Act* ss 10(1)(c), 11, sch 1 principle 5. These are not always backed up with strong operative provisions in the legislation that go to issues of consent or the criteria for imposing involuntary treatment that are discussed below. The requirements are largely aspirational, and to be provided where 'reasonably practicable'.

96 *NSW Act* s 70; *Tasmanian Act* s 135; *WA Act* s 9(2).

97 *ACT Act* ss 15–17; *NSW Act* s 68(i); *Queensland Act* ss 5(f)–(h); *Tasmanian Act* ss 8(4), 15, sch 1 cl 1(d); *Victorian Act* s 8; *WA Act* s 9(2).

98 *Victorian Act* ss 69(1)(c), (3)(a); *WA Act* s 20.

99 *ACT Act* ss 15(4), 19–23; *NSW Act* ss 71–2; *Queensland Act* s 25(2); *Tasmanian Act* s 3 (definition of 'representative'); *Victorian Act* ss 23–4; *WA Act* pt 16 div 3.

100 Usually a guardian or attorney appointed under separate guardianship statutes.

order.¹⁰¹ Allowing patients control over who their proxy decision-maker is, and the conditions under which decisions can be made by that person (through the terms of a grant of power of attorney, for example), is an important development in mental health law and a more concrete step towards the supported decision-making model envisaged in the *CRPD*. However, while proxy decision-makers are permitted to provide consent, none of the new statutes permit those proxies to refuse treatment on behalf of a patient in such a way that would prevent treatment being given under an involuntary order.

While providing support *for* decision-making can be seen as an important first step in implementing a supported decision-making model in mental health, more will certainly be required to fully comply with the *CRPD*. Specifically, a true supported decision-making model will require that *all* decisions are guided by a patient's will and preferences – even where decision-making is made via a substituted decision-maker. This kind of approach has been attempted, with varying degrees of commitment, in each jurisdiction. Most rely on soft-law obligations similar to, and often overlapping with, those we saw in relation to capacity assessment – obligations that merely require the patient's wishes to be 'considered' by substituted decision-makers, and usually with a proviso that this need only be done where 'practicable'. Soft-law provisions do not include clear obligations to give effect to a patient's views or to provide reasons where those views are not considered or followed, but rather only nudge decision-makers in the direction of taking into account patient preferences.

The softest of all approaches is evident in New South Wales and Tasmania. In New South Wales, new and amended statutory principles require the wishes of the person receiving services to be 'considered'.¹⁰² In Tasmania, decision-makers under the Act should 'have regard' to the 'Mental Health Service Delivery Principles', which require the wishes of persons receiving services and those of their families and support persons to be 'respected' to 'the maximum extent consistent with the health and safety of those persons and the safety of others'.¹⁰³

In a marginally less-soft approach, the Australian Capital Territory, Queensland, Victorian and Western Australia legislative provisions require the views of patients to be considered as part of the formal statutory process for making involuntary treatment orders. In these states, in addition to general principles encouraging patient participation in decision-making,¹⁰⁴ doctors and tribunals are positively *required* to take patients' wishes into account as part of the statutory processes for making involuntary orders – at least to the extent that

101 *Queensland Act* ss 13, 48; *Victorian Act* s 75; *WA Act* ss 13(2), 17. In the ACT, any treatment not consented to by the patient is provided under an order made by the ACAT. However, guardians, attorneys and health attorneys appointed by the patient under separate legislation have a role including mandatory consultation on matters involving detention and treatment: *ACT Act* ss 54, 62(5); and, may give substituted consent for some treatments: ss 28(5), 30–1.

102 *NSW Act* ss 68(h)–(h1), (j).

103 *Tasmanian Act* s 15, sch 1 cl 1(m).

104 *Queensland Act* s 5(b); *Victorian Act* s 11(1)(c).

it is ‘reasonable’ to do so.¹⁰⁵ But even here, there are no provisions that state that the patient’s will and preferences must actually be followed (subject only to protecting other rights), or even that they must be given substantial weight in decisions about treatment. It remains to be seen how effective these nudges will be in achieving a more patient-centred approach to mental health treatment.

2 Advance Care Planning

So far, the most promising initiative in Australian efforts to institute a supported decision-making model in mental health has been the introduction of advance care planning in several of the new Acts. Binding advance care directives are a familiar tool in general medicine, allowing a person to set out preferences for future medical treatment, and to consent to and refuse specific treatments. They are commonly utilised in end-of-life decision-making and in the treatment of chronic conditions where a loss of capacity is contemplated.¹⁰⁶ The usual approach to advance care directives both at common law and under various statutory schemes¹⁰⁷ is that they are made when the person still has decision-making capacity, with the intention that they will come into effect at a specified future time when the person no longer has capacity to make treatment decisions themselves.¹⁰⁸

Although the Committee on the Rights of Persons with Disabilities has rejected capacity-based thresholds, both for creating a valid advance care plan and as the trigger for it coming into effect, the *General Comment* strongly supports the broad notion that ‘the ability to plan in advance is an important form of support’ for people with psychosocial disabilities, since it enables a process whereby people ‘can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to

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- 105 For example, in Victoria, when consenting to medical treatment on behalf of a patient who does not have capacity to give informed consent, psychiatrists must ‘to the extent that is reasonable in the circumstances’ have regard to ‘the patient’s views and preferences’: *Victorian Act* s 76(2). They must also ‘have regard’ to ‘the patient’s views and preferences’ when making involuntary orders ‘to the extent that is reasonable in the circumstances’: *Victorian Act* s 71(4). Similar provisions are in place in the ACT: *ACT Act* ss 56(1), 62(5)–(6); Queensland: *Queensland Act* s 53; and WA: *WA Act* s 7(2).
- 106 An advance care directive refusing treatment is legally binding at common law if it is made by a competent person, is clear and unambiguous, and goes to the situation at hand: *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 91–2 [9]–[15], 97 [40] (McDougall J); *Brightwater Care Group Inc v Rossiter* (2009) 40 WAR 84, 91 [26] (Martin CJ); *H Ltd v J* (2010) 107 SASR 352, 364–9 [33]–[46] (Kourakis J).
- 107 Six Australian jurisdictions have enacted legislation governing advance care directives regarding general medical treatment: *Medical Treatment (Health Directions) Act 2006* (ACT); *Advance Personal Planning Act 2013* (NT); *Powers of Attorney Act 1998* (Qld) ch 3 pt 3; *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Advance Care Directives Act 2013* (SA); *Medical Treatment Act 1988* (Vic); *Guardianship and Administration Act 1990* (WA) pt 9B.
- 108 Statutory schemes tend to operate in parallel with the common law, mirroring it to differing degrees and imposing additional restraints on the operation and applicability of advance care directives. For discussion, see Lindy Willmott, ‘Advance Directives and the Promotion of Autonomy: A Comparative Australian Statutory Analysis’ (2010) 17 *Journal of Law and Medicine* 556.

others'.¹⁰⁹ We, and others,¹¹⁰ believe that advance care directives are likely to become one of the central features of supported decision-making models as envisaged by the *CRPD*, partly because of their familiarity in existing law, and perhaps also because they seem more straightforward, and therefore less costly, than developing other more complex measures of ascertaining and supporting a person's will and preferences.

A number of the new instruments set out provisions for advance care directives under which patients may indicate their wishes about future treatment, and which will inform decisions during a later hospital admission. However, the status of these advance care directives varies, ranging from being generally binding, enforceable statements in the Australian Capital Territory and Queensland,¹¹¹ to being among a variety of matters that clinicians and tribunals are required to 'take into account' when making treatment decisions.

The most comprehensive scheme for advance directives in mental health to date appears in the Australian Capital Territory provisions. Under the Australian Capital Territory scheme, an advance agreement and/or an advance consent direction may be made by an adult with decision-making capacity in consultation with their treating team. Detailed advance consent directions constitute binding advance consent and/or refusal of specific treatments, and can be made when a person has decision-making capacity and has consulted with his or her treating team about options for treatment, care and support.¹¹² Advance consent directions provide legal authority to treat the person in accordance with their stated wishes.¹¹³ A person who consents to treatment via an advance care direction can be treated as a voluntary patient.

Importantly, in the Australia Capital Territory legislation, advance consent directions are not Ulysses contracts in the sense that they do not provide a power to compel a person to accept previously consented treatment if he or she later expresses a wish to go without it – even if the person does lack decision-making capacity. Where a person objects to treatment previously consented to in an advance consent direction, it can only be given under an order made by the ACAT. However, this order may only permit the direction to be followed – it cannot order that another type of treatment be given.¹¹⁴

In addition, clinicians must not give a person any treatment that has been consented to under an advance consent direction if the clinician believes that that

109 *General Comment*, UN Doc CRPD/C/GC/1, 4–5 [17].

110 Australian Law Reform Commission, *Equality, Capacity and Disability Report*, above n 5151, 47 [2.51]–[2.52]; Sudeep Saraf, 'Advance Statements in the New Victorian *Mental Health Act*' (2015) 23 *Australasian Psychiatry* 230; Jill Stavert, 'Added Value: Using Human Rights to Support Psychiatric Advance Statements' (2013) 17 *Edinburgh Law Review* 210; Penny Weller, 'Psychiatric Advance Directives and Human Rights' (2010) 17 *Psychiatry, Psychology and Law* 218.

111 In Queensland, an applicable advance health directive made under the *Powers of Attorney Act 1998* (Qld) is deemed a less restrictive form of treatment that must be utilised in preference to an involuntary order called a 'treatment authority': see *Queensland Act* ss 13, 18(2), 48.

112 *ACT Act* s 27(2).

113 *ACT Act* s 28.

114 *ACT Act* s 28(4).

course would be ‘unsafe or inappropriate’. In this case, treatment can only be given either with the assent of the patient and the consent of his or her nominated proxy, or under a Tribunal order.¹¹⁵ Again, Tribunal orders given in this situation are of limited effect and will only provide ‘authority to give the person the particular treatment that is an alternative to the treatment regarded as unsafe’.¹¹⁶

It appears that involuntary orders may still be made notwithstanding a contrary advance agreement; however, in this case, the Tribunal must still take account of advance agreements and consent directions when considering a mental health order.¹¹⁷

Queensland, Western Australia and Victoria also make provision for advance planning but the provisions are not nearly as extensive as they are in the Australia Capital Territory, nor do they bind clinicians or Tribunals to the same extent. The *Queensland Act* makes allowance for the use of ‘advance health directives’ made under the *Powers of Attorney Act 1998* (Qld).¹¹⁸ An applicable advance health directive is deemed to be a less restrictive form of treatment that must be utilised in preference to an involuntary order,¹¹⁹ and treatment for involuntary patients must take into account ‘the views, wishes and preferences’ of the person, including any set out in an advance health directive.¹²⁰ In Western Australia, informed consent to treatment can be given via an ‘advance health directive’ made under either section 4 of the *Guardianship and Administration Act 1990* (WA) or the common law. However, a clinician can order involuntary treatment contrary to the wishes expressed in an advance health directive, provided only that reasons are given.¹²¹ The need to ‘give reasons’ is presumably intended to ensure that treating clinicians think about why the patient’s wishes are being overridden, and perhaps to encourage reflection on whether or not the compromise to patient autonomy is justified. However, there are no specific criteria for determining when, how, and upon what basis a patient’s wishes may be overridden, so it is not clear how this might be judged, other than perhaps by reflection on the objects of the Act. It would seem unfair to expect that the objects of the *WA Act* would be front-of-mind for the average doctor in clinical practice and, in any case, such general legislative provisions barely hint at the clinical and practical issues doctors are likely to consider relevant in this situation. As the ALRC noted some 40 years ago in relation to the failure by police to give effect to the presumption in favour of bail, ‘[w]hen the [relevant] law is so vague, it is not difficult to proceed without much overt reference to

115 *ACT Act* s 28(5).

116 Explanatory Statement – Revised, Mental Health (Treatment and Care) Amendment Bill 2014 (ACT) 111.

117 *ACT Act* ss 56(1)(c), 99(1)(c).

118 *Queensland Act* s 222; *Powers of Attorney Act 1998* (Qld) ch 3 pt 3.

119 *Queensland Act* ss 13, 18, 48.

120 *Queensland Act* ss 53(b), 205(4).

121 *WA Act* s 179(2)(c).

it'.¹²² Certainly it is clear that once reasons are given, treatment can go ahead without any further enquiry as to whether the reasons are 'good enough'.

Similarly obtuse obligations are in place in Victoria. A provision of the new Act defines an 'advance statement' as 'a document that sets out a person's preferences in relation to treatment in the event that the person becomes a patient'.¹²³ An authorised psychiatrist or the Mental Health Tribunal must, when making a treatment order, have regard to 'the views and preferences of the person expressed in his or her advance statement', 'to the extent that is reasonable in the circumstances'.¹²⁴ Advance statements must also be taken into account in determining leaves of absence.¹²⁵ However, a patient's treatment preferences in an advance statement may be overridden where the treatment 'is not clinically appropriate' or 'is not a treatment ordinarily provided by the designated mental health service'.¹²⁶

There are no provisions at all for advance care directives in the Tasmanian or amended New South Wales legislation.

While the take-up of mechanisms permitting people with mental illness to set up advance care plans is encouraging, some difficulties remain. One is inherent in the idea of providing advance consent, and the other is practical. The practical concern is that experience in general medicine shows that the take-up of options for advance care planning is low, even among people who have chronic illnesses and where loss of capacity is readily contemplated.¹²⁷ Legislative structures that specifically encourage and facilitate the making of advanced care plans by patients in consultation with treating teams (such as demonstrated in the *ACT Act*) may do better in ensuring that advanced care plans are actually made by patients and are taken seriously by clinicians and substituted decision-makers.

Another problem inherent in the concept of advance care planning is the status of previously expressed wishes where they conflict with currently expressed wishes – whether or not the person currently retains decision-making capacity. It is a vexed question whether a person's current wishes should ever be able to be overridden by their previously expressed wishes – even where those previous wishes were made when the person was competent, and seem safer or otherwise better than the preference the person indicates now. These tricky

122 Australian Law Reform Commission, *Criminal Investigation*, Report No 2 (1975) 82 [178] <<http://www.alrc.gov.au/report-2>>.

123 *Victorian Act* s 19.

124 *Victorian Act* ss 48(2)(b), 55(2)(b).

125 *Victorian Act* s 64(3)(b).

126 *Victorian Act* s 73(1).

127 There is very little formal data on the degree of uptake of advance care directives in Australia, though several small studies of populations where one might expect high rates of uptake – nursing home residents, for example – have demonstrated uptake rates of between 0.5 and 5 per cent: Baishali Nair et al, 'Advance Care Planning in Residential Care' (2000) 30 *Australian and New Zealand Journal of Medicine* 339; Andrew J Bezzina, 'Prevalence of Advance Care Directives in Aged Care Facilities of the Northern Illawarra' (2009) 21 *Emergency Medicine Australasia* 379. This is consistent with international experience (with the exception of some US states): Jane Seymour and Gillian Horne, 'Advance Care Planning for the End of Life: An Overview' in Keri Thomas and Ben Lobo (eds), *Advance Care Planning in End of Life Care* (Oxford University Press, 2011) 16.

philosophical questions have been resolved in various ways in general medicine, and the common law and various statutory provisions place different limits on the application of advance directives. It is unlikely that any particular resolution to this question will be indisputably the right one, but we note that the detailed reasoning set out in the *ACT Act* strikes a carefully considered practical balance between past and current preferences, and in this respect is the most thoroughly conceived of the legislative model for advanced care planning in mental health to date.

V WHERE TO NOW?

There is still much to do in achieving compliance with the *CRPD* in terms of instituting supported decision-making in mental health law. One of the most important priorities is to undertake research into the effectiveness of the methods currently proposed, such as patient appointment of supporters and proxy decision-makers, provision for support *for* decision-making, advance care planning, and requirements that substituted decision-makers take the patient's wishes into account. We currently do not know the extent to which any of these methods will *really* increase patient autonomy as is hoped. It will be crucial, as policy develops, to ensure that new measures actually do what they set out to do – that is, to facilitate participation in decision-making and put the patient's own will and preferences at the centre of decisions – and that we do not simply have substituted decision-making by another name.¹²⁸

In addition, Australian federalism presents its usual hurdles for the take-up of the major law reform challenges posed by the *CRPD*. With resources for legislative review having to be replicated in each of several jurisdictions, and with a separate political consensus having to be struck in each place on notoriously difficult questions in mental health policy, it is perhaps no surprise that the revolutionary changes demanded by the *CRPD* have been both slow to come about and inconsistently realised. The *CRPD*'s challenge to eradicate the heavy-handed paternalism which characterised old-fashioned mental health and guardianship laws has been especially challenging in mental health, given risk management rather than the traditional focus of mental health law on risk prevention rather than on obtaining consent for treatment. Supported decision-making is a brave new world for mental health, and one to which practitioners and health departments responsible for reviewing legislation have had to adapt remarkably quickly.

128 For detailed discussion, see Terry Carney, 'Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?' (2015) 4 *Laws* 37; Terry Carney, 'Clarifying, Operationalising, and Evaluating Supported Decision Making Models' (2014) 1 *Research and Practice in Intellectual and Developmental Disabilities* 46; cf Piers Gooding, '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.

By comparison, the guardianship sector has been gradually and conscientiously reforming its approach to substituted decision-making for some time. As the ALRC noted, particular 'guiding philosophies' had become 'strongly entrenched in Australian laws for guardians' by the 1990s, including 'the presumption of competence; normalisation; least restrictive option; respect for autonomy; and fostering self-management', and the principles for substituted decision-making in Australia have increasingly involved elements of supported decision-making and substituted judgment.¹²⁹ Until recently, mental health has remained on the fringes of this cultural revolution, focusing on *treatment* and on protecting against risks of harm to the person and others, rather than on the process of *decision-making* itself. Nevertheless, it is clear that mental health law *does* engage rights in relation to personal decision-making rather acutely, and that the same international human rights imperatives apply to mental health law as those that apply to guardianship. Mental health law has therefore found itself with rather a lot of catching up to do, which can be expected to take some time.

VI CONCLUSION

Until recently, there has been only superficial engagement by Australian legislators with the great challenge of conceptualising and operationalising the *CRPD*'s call for supported decision-making in mental health. However, the momentum for change is now firmly established, and a more thoroughly realised commitment to developing a new approach is evident – particularly in the most recent legislative models put forward in the ACT and Queensland. But these important and innovative examples aside, most states could do much better in terms of establishing a thorough supported decision-making model for persons covered by the legislation. Of particular concern are the two states and one territory that will still permit a competent person's refusal of treatment to be overridden – in clear breach of the *CRPD*'s call for equal treatment.¹³⁰ In addition, it remains to be seen how effective soft-law nudges to clinicians and tribunals will be in ensuring that the patient's will and preferences are actually given effect to, particularly where the only firm requirement is that those wishes should be 'taken into account' – and even then, only where it is practicable, reasonable or safe to do so.

Certainly there is more work ahead in law reform, policy and practice development in the process of transforming decision-making in mental health from a risk-management model to one centred on promoting and protecting the rights, will and preferences of persons with mental illness as demanded by the *CRPD*. So we will all still need to watch carefully as the revolution in mental

129 Australian Law Reform Commission, *Equality, Capacity and Disability Report* above n 51, 50 [2.63], quoting Robin Creyke, 'Who Can Decide? Legal Decision-Making for Others' (Report No 19, Department of Human Services and Health (Cth), 1995) 38.

130 New South Wales, Victoria and the Australian Capital Territory.

health law continues to evolve, as practice develops and as the reform movement clarifies its vision for the future.