

Article

Should Supported Decision-Making Replace Substituted Decision-Making? The Convention on the Rights of Persons with Disabilities and Coercive Treatment under Queensland's *Mental Health Act 2000*

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Abstract: In 2013, and again in 2014, the UN Committee on the Rights of Persons with Disabilities (CRPD) has recommended that Australia abolish its existing mental health laws which authorise involuntary treatment and detention, and replace them with a regime of supported decision-making. The Australian Law Reform Commission has also recommended the introduction of supported decision-making to replace mental health and guardianship laws. This paper critically evaluates the concepts of autonomy and discrimination and the social model of disability which provide the theoretical underpinning of the CRPD. Focussing on coercive treatment of adults with severe mental illness under Queensland's *Mental Health Act 2000*, it then evaluates the advantages and disadvantages of supported decision-making, and concludes that the proposed abolition of involuntary treatment laws is not justified.

Keywords: convention on the rights of persons with a disability; mental illness; autonomy; relational autonomy; supported decision-making

1. Introduction

Queensland's *Mental Health Act 2000* (like mental health legislation in all Australian States and Territories) provides a framework for the involuntary detention and psychiatric treatment in certain

defined circumstances of a person who is suffering a mental illness¹. The Act enshrines a version of substituted decision-making, according to which a person with a mental illness² may be detained and treated in hospital or compulsorily treated in the community, if the person satisfies “treatment criteria” broadly based on notions of lack of capacity and dangerousness.

Concerns have been expressed, including by the courts, that compulsory mental health powers have the potential for misuse³, and risk unacceptable encroachment on the “liberty of a person and an interference with their rights, privacy, dignity and self-respect”⁴. These concerns have reached new levels of expression in the UN Convention on the Rights of Persons with Disabilities (“CRPD”)⁵, particularly as it has been interpreted by the United Nations Committee on the Rights of Persons with Disabilities (“the CRPD Committee”).

The CRPD Committee has recommended that Australia repeal its mental health laws authorising involuntary treatment and detention, and replace them with a regime of supported decision-making ([2], para. 34). Recently, the Australian Law Reform Commission (“ALRC”), considering Australia’s obligations under the CRPD, has recommended that State and Territory governments review mental health laws (as well as other laws such as guardianship laws) to incorporate four National Decision-Making Principles, one of which is to provide support in decision-making to those who require it ([3], para. 10.74, proposal 3-3). Many commentators, relying on the CRPD, have supported recommendations to introduce supported decision-making in mental health law. By contrast, in the current review of Queensland’s mental health laws [4], no mention has been made of the CRPD or the concept of supported decision-making.

This paper briefly reviews the CRPD and the comments of the CRPD Committee regarding Australian mental health laws. It then critically evaluates the concepts of autonomy and discrimination and the social model of disability which provide the theoretical underpinning of the CRPD. This conceptual framework provides the foundation for an evaluation of arguments for the inclusion of supported decision-making in Queensland’s *Mental Health Act 2000*, and for the rejection of the CRPD Committee’s proposed abolition of involuntary treatment laws. The paper focusses on coercive treatment of adults with severe mental illness in a civil context, and does not consider involuntary treatment in the forensic context.

¹ “Mental illness” is defined as “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory”: *Mental Health Act 2000* (Qld), s 12.

² Some commentators prefer terms like “psychosocial disability” or “diminished cognitive capacity”, arguing that “mental illness” and “impairment” have pejorative or discriminatory connotations. See [1]. This paper adopts the term “mental illness”, in conformity with the *Mental Health Act 2000* (Qld).

³ *Harry v Mental Health Review Board* (1994) 33 NSWLR 315 at 322 per Kirby P; *Kracke v Mental Health Review Board* [2009] VCAT 646 at [709].

⁴ *Wilson v Mental Health Review Board* [2000] VSC 404 at [32].

⁵ GA Res 61/106, 13 December 2006, opened for signature on 30 March 2007, entered into force 3 May 2008.

2. The CRPD and Its Interpretation by the UN CRPD Committee

2.1. The Convention on the Rights of Persons with Disabilities

The CRPD is the latest in a number of international human rights instruments which “impose obligations upon Australian governments to recognise and advance the civil and economic rights of people with a mental illness” ([5], p. 34). The Australian government ratified the CRPD on 17 July 2008 ([6], p. 197). Although the purpose of the CRPD may have been largely to clarify and specifically affirm that persons with disabilities possess the same rights contained in existing international human rights instruments⁶, in some respects the drafting of the CRPD represents a significant extension of these rights. Commentators have observed that compliance with the CRPD requires “reshaping of societies in a way required by no other human rights treaty” ([7], p. 618; [8], p. 10; [9], p. 351). This is certainly true in relation to the treatment of people with mental illness, if the CRPD is to be implemented in the manner in which it has been interpreted by the CRPD Committee.

The CRPD does not define disability, but Article 1 includes “those who have long-term physical, mental, intellectual or sensory impairments”, clearly including people with enduring mental illness. The CRPD takes a social approach to disability, recognising that this “impairment”, in interaction with various barriers, may hinder the full and effective participation in society on an equal basis with others ([8], p. 26; [10], p. 22)⁷.

Three Articles of the CRPD are of central relevance to involuntary treatment and detention for severe mental illness. Article 17 enshrines a right to respect for a person’s “physical and mental integrity on an equal basis with others”. Article 14 contains a “right to liberty and security of person”. Article 12 affirms that all people, regardless of impairment, have a right to equality in the enjoyment of legal capacity. It asserts that people with mental illness are capable of making their own decisions, and requires a State to ensure that they have access to the “support they require in exercising their legal capacity”. In this way, Article 12 radically “shifts the focus from substituted decision-making to supported decision-making” ([7], p. 597; [10], p. 25; [11], p. 426–29). Compliance with Article 12 would require fundamental reform of mental health laws ([8]; [9], p. 344).

2.2. Australia’s Interpretative Declarations to the CRPD

Australia has made three Interpretative Declarations in relation to the CRPD, two of which are of relevance in the present context⁸:

[Re Art. 12:] Australia recognizes that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the

⁶ Including the *Universal Declaration of Human Rights 1948*, GA Res 217A (III), proclaimed on 10 December 1948; the *International Covenant on Civil and Political Rights 1966*, GA Res 2200A (XXI), opened for signature on 16 December 1966, entered into force 23 March 1976; and the *International Covenant on Economic, Social and Cultural Rights 1966*, GA Res 2200A (XXI), opened for signature on 16 December 1966, entered into force 3 January 1976.

⁷ Art. 1.

⁸ An “Interpretative Declaration” is a unilateral statement in which Australia purports to specify or clarify the meaning or scope of certain provisions of the treaty.

Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards;

[Re Art. 17:] Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards;

Australia's interpretation of the CRPD is that the notion of support in decision-making is not incompatible with substituted decision-making (or "fully supported" decision making) in regimes such as guardianship and mental health law. It also recognises a continuing role for involuntary treatment of patients under mental health laws "as a last resort and subject to safeguards".

2.3. Comments of the CRPD Committee

These Interpretative Declarations have been questioned. The CRPD Committee has recommended that Australia review all its Interpretative Declarations with a view to withdrawing them ([2], para. 9), a recommendation with which the ALRC agreed ([3], para. 2.84).

In September 2013, Australia appeared for the first time before the CRPD Committee. The Committee recommended that Australia:

"repeal all legislation that authorises 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" ([2], para. 34).

In April 2014, in its *General Comment No 1 (2014)*, the CRPD Committee reiterated its opinion that compliance with Art. 12 requires State parties to abolish laws authorising substitute decision-making and replace them with supported decision-making regimes "which respect the person's autonomy, will and preferences" ([12], para. III.26). In the Committee's view, it will not be sufficient to develop supported decision-making systems "in parallel with the retention of substituted decision-making regimes" ([12], para. III.28).

The CRPD Committee's opinion is that any involuntary detention under mental health law is not lawful, but is an "arbitrary deprivation of liberty and violates articles 12 and 14" ([12], para. IV.40; [13], p. 752). This is because the basis of the detention is the existence of a mental illness, and Article 14(1)(b) of the CRPD asserts "that the existence of a disability shall in no case justify a deprivation of liberty". The CRPD Committee does not consider that the qualifying words in Article 14(1)(b), which provide that States must ensure that "any deprivation of liberty is in conformity with the law", allow for the possibility of coercive detention in some situations involving mental illness⁹.

⁹ The words could still be given operation in ensuring persons with mental illness who are imprisoned due to their criminal conduct are treated with due process "in conformity with the law".

The CRPD Committee is also opposed to coercive psychiatric treatment in the community, which it claims violates the right to equal recognition before the law, the right to personal integrity, freedom from torture, and freedom from violence, exploitation and abuse ([12], para. IV.42). In its emphasis on legal capacity and its opposition to involuntary psychiatric treatment, the views of the CRPD Committee mirror those of advocates such as Minkowitz¹⁰ ([14], p. 105; [15], p. 167; [16]).

The abolition of coercive treatment of people with mental illness—whether in a mental health facility or in the community—is unquestionably a radical recommendation. Bartlett recognises that:

“This would be a hard sell to governments, to medical stakeholders, to many family carers, and to broader society. Certainly, a great deal more can be done by way of engagement with people with mental disabilities on a voluntary basis, but the overwhelming social perception at this time is that in hard cases, this may not be enough” ([13], p. 774).

The ALRC has not fully endorsed the CRPD Committee’s views. It has recommended the adoption of a supported decision-making model in State mental health laws in preference to substituted decision-making regimes ([3], para. 10.74), a view supported by some commentators relying on Article 12 of the CRPD [10,11,13]. It also recommended that decisions for adults who are unable to make their own decisions should be made on the basis of the person’s “will, preferences and rights”, not their “best interests” ([3], proposal 3-5). But the ALRC recognises a continued role for representative decision-making “as a last resort” and for a limited time based on “what the person would likely want” ([3], proposals 3-6 and 3-7).

Under the current *Mental Health Act 2000* (Qld), involuntary treatment of a person with a mental illness may be authorised in circumstances where the person’s illness requires immediate treatment because of an imminent risk that the person may cause harm¹¹ to the person or to someone else; or the person is likely to “suffer serious mental or physical deterioration”¹². Involuntary treatment may be provided in circumstances where the person “lacks capacity to consent” to treatment, or the person “has unreasonably refused proposed treatment for the illness”¹³. Treatment is based on an assessment of danger to the person themselves, to others, or to the person’s health, and is authorised only where it is immediately required, and “there is no less restrictive way of ensuring the person receives appropriate treatment for the illness”¹⁴.

Although Queensland has recently conducted a review of the *Mental Health Act 2000* [4], and circulated a draft *Mental Health Bill 2015*, neither the review nor the draft Bill has proposed incorporating supported decision-making or abolishing involuntary treatment laws.

¹⁰ Minkowitz herself, a lawyer and survivor of psychiatry, represented the World Network of Users and Survivors of Psychiatry in the drafting and negotiation of the CRPD.

¹¹ Proposed amendments to the legislation would limit this to “imminent serious harm to the person or others”: clause 12(1)(c)(i) of the *Mental Health Bill 2015*.

¹² Paragraph 14(1)(d) of the *Mental Health Act 2000* (Qld).

¹³ Paragraph 14(1)(f) of the *Mental Health Act 2000* (Qld). Proposed changes to the treatment criteria would remove the “unreasonably refused proposed treatment” criterion, and restrict involuntary treatment to patients who lack capacity: clause 12(1)(b) of the *Mental Health Bill 2015*.

¹⁴ Paragraphs 14(1)(b) and (e) of the *Mental Health Act 2000* (Qld).

This paper accepts that supported decision-making has the potential to increase the ability of people with mental illness to make autonomous decisions, and to reduce the number of people who are subject to involuntary treatment laws. However, it argues that the CRPD's recommendation to abolish existing mental health laws and replace them entirely with a model of supported decision-making should not be followed in Australia, because it is based on a misunderstanding of the effects of mental illness upon a person's capacity for decision-making, and on an incomplete understanding of human autonomy, which does not consider the relational dimension of human experience.

3. Theoretical Bases of CRPD

The approach of the CRPD is informed by two foundational themes: respect for the autonomy of those with mental illness, and removal of discrimination [17]. Both of these concepts, while important, offer only a partial conceptualisation of human experience, and underemphasise other values such as community and interdependence. An alternative approach to the treatment of severe mental illness is required: one which recognises and respects autonomy, but acknowledges the unique difficulties faced by people with mental illness, and attempts to treat these holistically in a relational context.

3.1. Autonomy

The CRPD clearly embraces a human rights-based approach to disability. One of its dominant themes is the autonomy and liberty of people with disability. Autonomy is a foundational concept in human rights jurisprudence, and is the first of the general principles contained in Article 3. The Convention contains a number of key liberty rights which foster an individual's autonomy by giving a person freedom from unwanted interventions. These include: liberty and security of the person (Art. 14), respect for physical and mental integrity (Art. 17), and freedom from torture and other cruel, inhuman and degrading treatment (Art. 15).

Current mental health law in Qld also embodies the principle of autonomy, although not as strongly as the CRPD. Under the *Mental Health Act 2000* (Qld), a person is presumed to have capacity to make decisions¹⁵, thus is presumed to be capable of autonomous action, although that presumption can be rebutted. A person may be treated involuntarily only if the person lacks capacity or has unreasonably refused consent to treatment¹⁶. Although an unreasonable refusal of treatment may be evidence that a person, by virtue of the phase of their illness, lacks capacity to consent, it may also occur where the person possesses legal capacity but his or her treatment choices do not accord with what is considered "reasonable" by assessing psychiatrists. In this respect, the Act demonstrates a reduced respect for the autonomy of those who make "eccentric" [18] or "irrational" decisions¹⁷.

The *Mental Health Act 2000* (Qld) adopts an explicit rights-based framework¹⁸: the general principles contained in section 8 expressly state that a person with mental illness has the same basic human rights as all persons, including a right to respect for his or her human dignity; the right to make

¹⁵ *Mental Health Act 2000* (Qld) s 8(1)(b).

¹⁶ *Mental Health Act 2000* (Qld) s 14(1)(f).

¹⁷ Proposed changes to the treatment criteria would remove the "unreasonably refused proposed treatment" criterion, and restrict involuntary treatment to patients who lack capacity: clause 12(1)(b) of the *Mental Health Bill 2015*.

¹⁸ *Mental Health Act 2000* (Qld) ss 4(a) and 8(1)(a).

decisions concerning treatment “to the greatest extent practicable”; and the right to confidentiality of information¹⁹. Specifically in relation to coercive treatment and detention, the guiding principle is that a person’s liberty and rights should be “adversely affected only if there is no less restrictive way to protect the person’s health and safety or to protect others”; and to the minimum extent “necessary in the circumstances”²⁰. It may be disputed whether terminology such as “to the greatest extent practicable” sufficiently protects the decision-making rights of persons with mental illness, and whether the treatment criteria adopted in the Act are the optimal way to protect such rights. However, it should not be controversial that there will inevitably be some situations where some people are incapable of making their own decisions, and in these situations involuntary commitment and treatment may be considered as a “last resort”²¹.

The *Mental Health Act 2000* (Qld) also recognises that the protection of autonomy is not the only ethical principle of value. Rather, it must be balanced with a more paternalistic protection of the patient and the community from harm²², and the beneficent purpose of ensuring people with mental illness receive the care and treatment required to prevent “serious mental or physical deterioration”²³ ([17], p. 36; [19], p. 563; [20], p. 776). Clearly, such laws involve “a restriction upon the liberty of a person and an interference with their rights, privacy, dignity and self-respect” [21,22]²⁴, but a restriction which is arguably necessary in the circumstances to protect the mental health of a person suffering from mental illness, or to prevent danger to others.

It is these paternalist and beneficent objectives that recent commentators, particularly the CRPD Committee, have taken issue with. Article 12(4) of the CRPD refers to “measures relating to the exercise of legal capacity” that are “proportional and tailored”, “apply for the shortest time possible” and are subject to regular independent review. This appears to contemplate the existence of legislation applying in circumstances where capacity is lacking, and aims to set appropriate standards and safeguards for such laws. One legitimate form of enquiry would be to consider whether the Mental Health Act (Qld) complies with those safeguards.

The CRPD Committee’s interpretation of the CRPD is much more absolute. It asserts that coercive treatment of people with mental illness is an “arbitrary deprivation of liberty” contrary to Article 14, and violates the right to equality in the exercise of their legal capacity (Art. 12). It has recommended the abolition of substitute decision-making and the “best interests” paradigm, replacing it with laws based on supported decision-making and the “will and preferences” of the individual ([12], paras. 21, 26, 28). In this regard, the comments of the CRPD Committee reflect the extreme views of disability rights activists such as Minkowitz. Minkowitz argues in the most forceful terms that non-consensual

¹⁹ *Mental Health Act 2000* (Qld) ss 8(1)(a), (b) and (i).

²⁰ *Mental Health Act 2000* (Qld) ss 9 and 14(1)(e).

²¹ There may also be issues as to the way in which the treatment criteria are implemented or interpreted in practice, but this is not the appropriate place to address those questions.

²² For example, the “imminent risk of harm” to self or others in the treatment criteria: *Mental Health Act 2000* (Qld) s 14(1)(d). See also *Mental Health Act 2000* (Qld) s 4(b).

²³ *Mental Health Act 2000* (Qld) s 14(1)(d)(ii).

²⁴ *Wilson v Mental Health Review Board* [2000] VSC 404 at [32] per O’Byrne J. See also *Kracke v Mental Health Review Board* [2009] VCAT 1548 at [431]–[432] per Bell J; *Harry v Mental Health Review Board* (1994) 33 NSWLR 315 at 322 per Kirby P ([19], p. 173; [20], p. 37).

psychiatric treatment always constitutes a human rights violation, as it ostensibly violates the right to respect for physical and mental integrity and constitutes torture ([1], pp. 412–26). In her view, psychiatrists should be criminally prosecuted and reparations made to victims and survivors ([1], p. 405).

In this author's opinion, the views of the CRPD Committee go beyond what is stated in the text of the CRPD itself, and although Australia is a signatory to the CRPD it is not bound to give effect to the CRPD Committee's interpretation of the CRPD ([18], p. 13). The generally accepted view of human rights is that, while fundamental, they are not absolute, but may be "sacrificed if countervailing societal interests are important enough, in particular circumstances, for limited times and purposes, to the extent strictly necessary" ([23], p. 4).

3.2. Discrimination

In addition to the principle of autonomy, a second theme structurally embedded throughout the CRPD is equality and non-discrimination, the subject matter of Article 5. "Non-discrimination" is the second of the general principles in Article 3, emphasising the importance ascribed to it. Discrimination on the basis of disability is defined in Article 2 as any "[d]istinction, exclusion or restriction...which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms...". Many substantive articles contain the words "on an equal basis with others"²⁵, as a reminder of the safeguard of equality before the law contained in Article 5. A pervading theme of the CRPD is "reasonable accommodation": namely, specific measures to ensure that people with disabilities receive the support they require to participate fully in the community and enjoy their rights to the same extent as others²⁶.

A growing number of commentators [9,10,13,24,25], especially after the ratification of the CRPD, have argued that the existence of separate mental health laws is discriminatory. This discrimination is said to be evidenced by the presence of separate laws governing consent to treatment by people with mental illness, and by the fact that mental health laws specifically restrict the rights of people with mental illness based on the criteria of dangerousness or lack of capacity.

3.2.1. Capacity Criterion

A number of commentators have recommended that involuntary treatment for mental illness be based on an assessment of absence of legal capacity, rather than an assessment of dangerousness or the risk of harm posed by their behaviour [10,26,27]. This is the foundation for the "fusion law" proposal in England [9,28], which advocated the merger of guardianship and mental health laws into a single legal model based on lack of capacity. This proposal would obviate the need for specific mental health laws, which "discriminate" on the basis of mental illness. Instead, it would apply a "functional test" to any person who lacks decision-making capacity, whether by reason of mental illness, ageing, intellectual disability, physical injury or other cause. It is beyond the scope of this paper to explore the merits of this suggestion. However, it is important to observe that the adoption of a functional test of capacity

²⁵ See CRPD, Articles 7, 9, 10, 12, 13, 14, 17, 18, 19, 21, 22, 23, 24, 27, 29, 30.

²⁶ See CRPD, Articles 5(3), 5(4), 6(2), 9, 12(3), 19. See also [3], para. 2.27.

does not preclude involuntary treatment of specific individuals who lack capacity to consent to treatment: it merely alters the criteria by reference to which the decision is made.

The concept of legal capacity which is included in the CRPD has been interpreted to mean “the capacity and power to exercise rights and undertake obligations by way of one’s own conduct”. This comprises two elements: capacity as the potential holder of rights and obligations (passive capacity) and the capacity to exercise those rights and undertake those duties (capacity to act) ([18], p. 23; [29], pp. 13–14). It seems non-controversial to observe that while the capacity to possess rights may be universal, the capacity to act varies between individuals ([29], p. 20).

The CRPD Committee, however, asserts that any law which recognises a person as lacking legal capacity impermissibly discriminates against that person on the basis of their impairment. Building on this premise, the Committee has stated that substitute decision-making regimes (including both guardianship and mental health laws) are a discriminatory denial of the right to legal capacity, on the basis of a cognitive or psychosocial disability ([12], paras. I.7, II.15). Instead, the Committee argues, laws should recognise the continued existence of legal capacity, and a person with perceived or actual deficits in mental capacity should be supported to exercise this capacity to make decisions in the manner which their circumstances requires ([1], p. 408; [12], para. II.13; [13], p. 765).

3.2.2. Consent Criterion

Several commentators have argued that to permit non-consensual medical treatment in the case of mental illness but to require free and informed consent to medical treatment in all other cases is discriminatory ([1], pp. 405–07; [13], pp. 771–72; [25], p. 3), and violates a person’s right under Article 17 of the CRPD to respect for his or her physical and mental integrity “on an equal basis with others” ([13], pp. 771–72). A competent patient possesses the right to refuse medical treatment²⁷, even if that refusal is based on reasons which may be “irrational, unknown or even non-existent”²⁸, and notwithstanding that the patient may suffer harm or even death as a result of their refusal of treatment. By contrast, a person with severe mental illness, even if legally competent, may be subjected to compulsory medical treatment without consent.

3.2.3. Dangerousness Criterion

Others have argued that the law is discriminatory in its use of dangerousness as a criterion for the involuntary detention and treatment of people with severe mental illness ([22], p. 42; [30], p. 593). It is argued that other, more dangerous, behaviours, such as alcohol or drug abuse, which pose a significantly higher risk of serious violence [22,24,30] do not result in individuals being subjected to prophylactic detention and treatment.

²⁷ See *Hunter and New England Area Health Service v A* [2009] 74 NSWLR 88 at [5–7] per McDougall J; *F v R* (1983) 33 SASR 189 at 193 per King J; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

²⁸ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102.

4. Critique of Autonomy and Non-Discrimination in Their Application to Involuntary Treatment for Severe Mental Illness

There are a number of problems with the CRPD Committee's interpretation of the CRPD as precluding any form of substitute decision-making in the treatment of people with mental illness. Firstly, it denies the reality of impairment, and assumes that any difference experienced by people with mental illness is not something requiring "treatment", but rather something society needs to accommodate. This denies the law any legitimate function in intervening to restore the autonomy of those with mental illness. Secondly, it is based on an assumption that any discrimination is undesirable, whereas traditionally, only discrimination on non-relevant grounds has been proscribed. Where difference is real, discrimination may be legitimately justified, and indeed required, to achieve appropriate societal purposes. Thirdly, the focus on liberty rights and autonomy is premised on a notion of independence which ignores the reality of people's lived experience as interdependent beings, part of a family or community.

4.1. "Impairment" Is Real

The CRPD embodies a social model of disability which interprets disability as a "social construct in which differences in human conditions have led to the exclusion and marginalisation of persons with disabilities" ([8], p. 26). Under this model, impairment or differences between people are accepted "as a positive dimension of human diversity", not as something requiring treatment, cure or protection ([31], p. 6). Instead, it is the role of society to adopt a variety of measures designed to facilitate the full participation and inclusion of people with disabilities within society ([7], p. 572; [8], p. 22).

The social model of disability usefully highlights the contribution of society to the construction of disability for people living with mental illness. However, the CRPD takes this to an extreme, embodying a "radical social constructionist view of disability, in which impairment has no underlying reality ([31], p. 7)". It is neither appropriate nor correct to assert that impairment has no objective basis in reality. Numerous commentators have observed that the impairments experienced by people with mental illness are not simply social constructs, but are real and genuine ([13], p. 759; [17], p. 34; [18], pp. 21–22; [31], p. 34), and the differences they generate cannot in all cases "be equalised by merely supportive social responses" ([13], p. 759). Mental illness, by its nature, is not a permanent disability but a cyclical one. The impairment is measured not by reference to some postulated external standard of "normal", but by reference to the individual's own, subjective, self. Fundamentally, mental illness involves the alienation of persons "from their normal selves" ([17], p. 37).

The CRPD Committee's view that Article 12 of the CRPD means that a person can never lack legal capacity "border[s] on a complete denial of the instrumental limitations associated with cognitive impairments" ([31], p. 7). Although many people with disabilities, including mental illness, will retain legal capacity to act as agents, there will inevitably be some people who, at least in certain circumstances, are unable to exercise such legal agency, even with support ([18], p. 23). In these circumstances, supported decision-making is not possible, and some form of substituted decision-making will be required. In this context, specific laws targetted at addressing the issues faced by individuals due to mental illness can be considered appropriate. These may include mental health laws authorising involuntary treatment,

which, although controversial, have been clinically demonstrated to be an effective means of restoring many people with mental illness to their “normal selves”, as well as reducing hospitalization [32].

It needs to be recognized that autonomy in decision-making, although a central component of the legal capacity protected by Article 12 of the CPRD, is not the only value the CRPD seeks to protect. Other central rights include the right to life (Art. 10) and the right to the “highest attainable standard of [mental] health” (Art.25). Article 25(b) of the CRPD obliges State parties to provide those health services required by people with disabilities “specifically because of their disabilities, including... services designed to minimize and prevent further disabilities”. Arguably, psychiatric treatment aimed at restoring a person to full mental health can be considered to be a specific service designed to minimise and prevent future episodes of severe mental illness. While Article 25(d) mandates the provision of health care on the basis of free and informed consent, it does not address the situation where a person lacks the capacity to provide consent (or has not provided consent via an advance health directive). If psychiatric treatment can only be made available to people who are capable of giving free and informed consent, this may result in a denial of precisely the health services required to restore the capacity for agency. Instead, it abandons people with mental illness to the choices they express, notwithstanding that they may lack insight into the nature of their condition ([14], p. 101; [22], p. 47; [33], p. 363).

4.2. Discrimination Does not Prohibit All Differential Treatment

The argument against the existence of separate mental health laws is premised on the notion of discrimination. Specifically, it alleges that any law which uses “mental illness” as the criterion of operation is on its face discriminatory on the basis of disability ([12], para. IV.42)²⁹. While it is undeniable that specific mental health laws do discriminate directly on the basis of disability, it has long been recognised that as a legal concept, “discrimination” does not mean any form of differential treatment, but only “unjustified differential treatment” ([22], p. 38). As Gaudron, Gummow and Hayne JJ explained in *Austin v Commonwealth*:

“The essence of the notion of discrimination is said to lie in the unequal treatment of equals or the equal treatment of those who are not equals, where the differential treatment and unequal outcome is not the product of a distinction which is appropriate and adapted to the attainment of a proper objective”³⁰.

Accordingly, it is not sufficient to simply assert that mental illness and physical illness must always be treated identically in legislation ([17], p. 36), or that “mental illness” can never be the subject of specific legislative provisions. Rather, the proper question is whether there is any relevant ground for treating people with severe mental illness differently from others, and if so, whether the laws so enacted are appropriate and adapted to the achievement of that purpose, or whether some other, less restrictive, means could have been employed.

²⁹ See CRPD Article 14(1)(b).

³⁰ (2003) 215 CLR 185 at [247]. That case concerned the notion of discrimination inherent in the implied immunity of States from Commonwealth laws, but their Honours also referred to the concept of discrimination contained in ss 51(ii), 102, 117 and 92 of the Constitution, implying a general formula of discrimination not limited to the specific constitutional context.

4.2.1. Discrimination on the Basis of “Dangerousness”

One legitimate reason for depriving people with severe mental illness of their autonomy may be the prevention of harm to others or to themselves, based on present or predicted future danger. There is precedent in numerous other areas of law for the prophylactic deprivation of liberty on the basis of “dangerousness”, or the risk of harm to others, whether from individual anti-social behaviour or a danger to public health. Preventative detention and other severe deprivations of liberty are used in criminal laws relating to dangerous sexual offenders³¹, anti-terrorism laws³² and laws controlling criminal associations³³. In the public health context, involuntary detention (and sometimes treatment) occurs *in situations* involving infectious diseases³⁴, quarantine³⁵ and other dangers to public health (such as chemical, biological, radiological emergencies)³⁶.

While some of these situations are exceptional in nature, not all are. In the case of domestic violence orders³⁷, significant legal consequences issue based on a fear of harm, in the absence of actual harm. It is clear from the foregoing that autonomy is not absolute: individuals are subjected to infringements of their liberty, including detention against their will, both in the public health context and in the criminal context, in order to prevent harm to others ([22], p. 42). The distinguishing feature in the case of mental health laws based on dangerousness is that the laws discriminate directly on the ground of disability, whereas the other laws mentioned do not directly apply to a category of persons protected under anti-discrimination law.

Another difficulty posed by laws authorising the involuntary treatment of persons with mental illness based on the concept of dangerousness, is the problem of prediction. In the context of mental illness, studies have shown it is difficult accurately to predict which individuals with mental illness are at significant risk of future harm, either to themselves or others ([26], p. 613)³⁸. Other studies have suggested that a large proportion of mentally ill people who are not violent would need to be

³¹ The *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) provides for the continued detention of convicted sexual offenders beyond the term of their sentence, based on a predicted risk of committing future sexual offences.

³² Division 104 of the *Criminal Code* (Cth) provides for control orders and preventative detention orders on the basis of suspected involvement in future terrorist attacks.

³³ The *Vicious Lawless Association Disestablishment Act 2013* (Qld) prohibits association with others and permits other severe deprivations of liberty on the basis of a propensity to commit criminal acts.

³⁴ The *Public Health Act 2005* (Qld) permits the compulsory hospitalisation and isolation of people infected by a range of serious diseases, including HIV/Aids, avian influenza, influenza, rabies, plague, smallpox, typhoid, yellow fever, Hep C, SARS, syphilis, TB, viral haemorrhagic fevers such as Ebola: s 64 and Schedule 1 of the *Public Health Regulation 2005* (Qld).

³⁵ Sections 35 and 45 of the *Quarantine Act 1908* (Cth) authorise the detention of a person in a vessel, house arrest or detention in a quarantine station, if the person is infected or likely to be infected with a quarantinable disease.

³⁶ Sections 29–34 of the *Public Safety Preservation Act 1986* (Qld) provide for the non-consensual medical examination, isolation and treatment of a person who has been affected by a chemical, biological or radioactive substance.

³⁷ The *Domestic and Family Violence Protection Act 1989* (Qld) makes provision for applications for domestic violence orders (s 13(2)) and protection orders (s 20(1)).

³⁸ The facts of *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 bear this out.

detained in order to protect citizens from violent crimes committed by some people with a mental illness ([30], p. 593) ³⁹.

These issues should not be underestimated. However, despite these difficulties, there remains a demonstrated “connection between mental disorder and violence to others” ([24], p. 73). Richardson, no supporter of involuntary treatment, recognises that in individual cases where there is a high risk of violence, involuntary detention is warranted to protect the public ([24], p. 73). The question then becomes whether the laws in a particular jurisdiction strike an appropriate balance between the liberty rights of people with mental illness and the State’s interests in protecting its citizens from danger. Clear empirical evidence is needed, particularly in Australia, to assess whether or not existing mental health laws provide an acceptable balance.

When the law imposes involuntary treatment to prevent a risk of self-harm, it undertakes a different balancing: between the autonomy rights of persons with mental illness and their rights to life, physical integrity, and health. It is acknowledged that the same difficulties of prediction arise in relation to assessing whether a person with mental illness is at risk of serious self-harm or suicide. Notwithstanding the difficulties in accurately predicting when harm may result, courts, at least in the United Kingdom, have been willing to impose an operational duty on a hospital to take reasonable steps to prevent suicide, even to the point of involuntarily detaining a severely depressed voluntary patient, to prevent her from harming herself ⁴⁰. In *Rabone v Pennine Care NHS Foundation Trust*, Lady Hale specifically adverted to the fact that imposing such a duty would be discriminatory, and that ordinarily, autonomous individuals have the right to commit suicide ⁴¹. The Supreme Court referred to the “special vulnerability of people suffering from mental disorders, especially psychosis” ⁴², which it felt justified the imposition of a special duty which discriminated on the basis of mental disability.

4.2.2. Discrimination on the Basis of “Lack of Capacity”

Differential treatment may also be justified, not based on an assessment of dangerousness, but on the ground of lack of capacity to provide a full and informed consent to or refusal of treatment. It has already been noted that Article 12(3) of the CRPD recognises the need for special measures to provide “support” in the exercise of legal capacity. As will be discussed below, some individuals with severe mental illness will periodically, even with support, lack capacity to make autonomous decisions, for

³⁹ Herring cites statistics in the range of 25%–36% of people wrongly detained in order to halve the rate of violence committed by people with mental illness.

⁴⁰ *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72. Melanie Rabone was admitted as a voluntary hospital patient after a number of suicide attempts over the course of a month. After a little over a week, she applied for two days’ home leave from hospital. The home leave was authorized by the hospital’s consultant psychiatrist. Ms Rabone committed suicide during the period of home leave. Although the risk of suicide was assessed as low to moderate, it was agreed that the decision to allow home leave was one no reasonable psychiatrist would have made, and thus was negligent. The Court also held that the hospital was under a duty to prevent suicide, including by involuntarily detaining Ms Rabone in hospital if that was necessary to prevent her leaving.

⁴¹ *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 at [95]: “people suffering from mental disorders have the same human rights as everyone else and are entitled to enjoy those rights without discrimination on account of their mental status”.

⁴² *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 at [102] per Lady Hale. See also at [34] per Lord Dyson.

example in times of acute crisis or psychosis. A legal regime providing for involuntary treatment in those instances cannot be said to be discriminatory. On the contrary, a legal regime based on the notion that no individual person ever lacks capacity to make decisions would be discriminatory, as that would involve the “equal treatment of those who are not equal”⁴³. The differential treatment contained in the *Mental Health Act 2000* (Qld) will be legitimate if it is appropriate and adapted to the achievement of its purpose, and contains appropriate safeguards for the protection of people with mental illness. The treatment criteria currently contained in the legislation could be tightened, and the proposed changes contained in the *Mental Health Bill 2015* would only allow involuntary treatment of a person who lacks capacity in a situation of “imminent risk of serious danger”. It may be debated whether that is sufficient to safeguard the interests of people with mental illness. Nonetheless, it must be recognised that objectively there will always be situations in which specific individuals lack legal capacity in the sense of the ability to exercise their rights ([18], pp. 21–22), and treating them as retaining capacity to consent or refuse treatment amounts to a refusal to recognise this objective difference.

4.3. *Autonomy Is Not Absolute*

The recommendation of the CRPD Committee that Australia repeal all legislation which authorises treatment for mental illness without the individual’s consent ([12], para. IV.42) embodies an assumption “that patient autonomy should be the first and last principle in medical decision-making” ([32], p. 104; [33], p. 360). This assumption conceptualises a person as an independent, self-sufficient, rational decision-maker, and invokes a limited understanding of autonomy as meaning a “negative freedom from intervention”. Alternative, fuller, conceptualisations of autonomy recognise not only the freedom to make one’s own choices, but also the capacity for agency. Relational theories of autonomy conceive of the individual as partially constituted by social relationships, and as an interdependent and dependent being supported and cared for through these relationships. Incorporating these understandings, involuntary medical treatment in severe cases of mental illness can be seen to foster the restoration of an individual’s autonomy in the sense of capacity or agency, as well as the restoration of social relationships.

4.3.1. *Autonomy Means Both Liberty and Agency*

The assertion of patient autonomy as the single overarching principle governing medical decision-making reflects a Millian approach to freedom, namely “pursuing our own good in our own way”, our individual choices limited only by the requirement to avoid harm to others ([9], p. 339; [34], p. 62; [35], p. 5). It cannot be understood in any Kantian sense of autonomy, which involves a rational moral agent not only making choices, but choosing based on a “recognition of what is objectively good as such, as determined by universal moral principles” ([34], p. 61). The majority of philosophers conceive of autonomy, even relational autonomy, as involving some degree of rationality, rather than merely free will or choice ([9], p. 342). Autonomy, properly understood, is not reducible simply to freedom of choice or freedom from control (the “negative liberty” Isaiah Berlin describes [36], also known as “liberty *from*”). It also encompasses “agency”, or the capacity for intentional action (which

⁴³ *Austin v Commonwealth* (2003) 215 CLR 185 at [247].

Berlin describes as “positive liberty”, or the “liberty to”) ([32], p. 102; [36]; [37], p. 379). This latter conception is broadly equivalent to the capacity for action or agency which is protected by Article 12 of the CRPD.

Philosophers and legal commentators recognise that at some point, a line is drawn, beyond which individuals lack the capacity for autonomy or agency as described ([18], p. 10). Although opinions may differ about which individuals lack capacity for autonomous decision-making, most commentators have recognised a need for a form of substituted decision-making on behalf of some persons ([9], p. 342; [18], pp. 11, 19), whether on the basis of the person’s “best interests”, or their “rights, will and preferences”.

Severe mental illness is an example where a person may, although not invariably, lack this capacity for “agency”, in the sense of the capacity to make choices which are truly one’s own” ([26], p. 617; [32], p. 101; [34], p. 67; [38], p. 65). Matthews explains that mental illness, unlike physical illness, effects a change in the nature of the “self” (meaning one’s personal identity, including one’s relationships with other people, one’s place in the world) ([34], p. 67). In extreme cases, a person may “lack a self capable of governing; or else would have a ‘self’ which was not his or her ‘real self’” ([34], p. 67), such as a person who believes he is a vampire ([39], p. 132), or Jesus Christ. For example, a person with paranoid schizophrenia who refuses treatment on the basis of a delusional belief that MI5 is trying to poison him ([34], p. 69) cannot be described as exercising a truly “autonomous” choice to refuse treatment. It is the illness which governs the choices, not the “self”.

In this situation, asserting the right of people with mental illness to refuse medical treatment on an equal basis with others protects only a part of their autonomy, their freedom to pursue their individual momentary desires. It abandons the person to the (often extreme) consequences of their choices, allowing them, in the oft-quoted words of Darold Treffert, to “die with their rights on” ([40]; [41], p. 436). Although Richardson starts from the presumption that special mental health laws represent “unjustified discrimination” ([9], p. 335), in her view in extreme circumstances, such as a person who is suicidal as a result of mental illness, we ought to “recognize a moral obligation to allow welfare to trump self-determination” ([9], p. 349).

Where persons with severe mental illness have lost the capacity for agency, and are making choices based on a disordered notion of self or a delusional assessment of reality, influenced by the illness, involuntary treatment may, paradoxically, protect their autonomy. Involuntary treatment for mental illness is a short term denial of autonomy in the sense of interference with an individual’s freedom of choice, however, it is justified by reference to the overarching goal of the restoration of “liberty to” act as a truly autonomous agent ([14], p. 101; [17], p. 37; [32], p. 104; [34], p. 67; [37], p. 379). It has also been observed that greater deference to an individual’s choices in a situation where the person lacks decision-making abilities may result in a loss, rather than an increase in autonomy: “[s]ometimes the overall liberty and autonomy of a person is *enhanced* by a strategic and timely restriction of liberty” ([21], p. 29).

4.3.2. Relational Autonomy

In addition to this powerful critique of the nature of autonomy, the concept of autonomy as self-rule free from control or interference by others has been fiercely criticised by feminist scholars as

“fundamentally individualistic and rationalistic” ([42], p. 171; [43], p. 3; [44], p. 152). Feminists such as Nedelsky reject independence as “mythic” ([43], p. 118) and an “illusion” ([43], p. 43), claiming it overlooks the human experience that we exist primarily in relationships with others, as dependent and interdependent beings ([43], pp. 4, 134). A relational conception of autonomy emphasises that persons are “socially embedded” ([45], p. 4), and our identities are formed in the context of social relationships ([43], pp. 3–4) and through a range of “social determinants, such as race, class, gender and ethnicity” ([37], p. 377; [45], p. 4). It acknowledges our dependence at various points in our lives ([46], p. 2), and mutual interdependence and awareness of the needs (as opposed to rights) of others.

A relational understanding of autonomy recognises and affirms the individual’s right to make decisions, but also acknowledges the extent to which decisions are made in a social context ([37], p. 377; [42], p. 172; [43], p. 121; [45]). It also realises that individuals can develop their capacity for autonomy *through* social relationships, not in opposition to these relationships ([32], p. 104; [33], p. 364; [42], p. 170; [43], p. 332). Thus, respecting autonomy “involves more than simply not interfering” ([33], p. 366). It involves respect for and giving space to relationships, as part of the empowering process “that may actually strengthen development of individual rights, such as autonomy through guidance and intervention” ([32], p. 105). Carers explain that they often try to maintain the relationship and support a family member with mental illness without seeking outside assistance, and involuntary treatment is often a last resort in crisis situations where the relationship is at breaking point ([47], p. 53). In this situation, treatment, although not consented to by the individual, can be viewed as a means of restoring the person’s sense of identity sufficiently to enable the person to return to the relationship.

The CRPD does recognise the creative power of relationships in its acknowledgement of the need for support for people with disabilities in the exercise of their legal capacity in Art. 12(3). However, the CRPD Committee, in its insistence that a person always possesses the capacity for action, underemphasises the extent to which interdependence (and sometimes dependence) characterises many human relationships.

A relational account of autonomy goes some way to redressing the absolutism that often accompanies assertions of human rights, in demonstrating the capacity for relationships to support and develop our autonomy. Moreover, it asserts that in a fundamental sense we actually develop our sense of self, our identity as a person ([44], p. 153), in and through our relationships (or lack of relationships): family, kinship, cultural ties and friendships. In situations of serious mental illness, these constitutive relationships are often damaged or fractured by the challenging behaviour of the mentally ill person. Treatment aimed at restoring mental health looks beyond the immediate views of the patient, and focusses on the need to repair and strengthen relationships damaged by such behavior ([33], p. 367). This may include exploring options for redress of addictive behaviour, rehabilitation, addressing housing and other problems and psychological support ([47], p. 57). From this perspective, intervention can be viewed as a form of “compassionate interference” ([33], p. 359), a means of attaining autonomy in the sense of restoring the damaged relationships through which our sense of self is defined.

Finally, a theory of relational autonomy highlights the reality of family life and relationships. The majority of people are not in reality self-sufficient individuals, free to live the lives they choose, but are constrained by the responsibilities and relationships which embed their lives ([43], p. 343). In Herring’s evocative language, the question of rights becomes not “is there a good reason to restrict my

freedom”, but rather “is it possible to have some freedom, given the responsibilities of those I am connected to” ([48], p. 16)?

All this is not to deny the value of autonomy and human rights discourse, because the language of rights directs attention to the need to respect the personhood and intrinsic worth of every individual. However, an inflexible adherence to rights as inexorably “trumping” all other considerations ignores the relationships which support the individual person, as well as partially constituting his or her identity. A relational approach to the formulation of mental health laws would direct attention to consideration of the law’s future impact on “the relations they structure” and the core values they either foster or undermine in relationships ([43], pp. 4–5; [49], p. 328). As will be seen below, strategies such as supported decision-making may play a role in supporting the autonomy of patients, in some but not all circumstances.

5. Supported Decision-Making

Supported decision-making, a key recommendation of the CRPD, has the potential to integrate a relational dimension into mental health law, recognising that a person exercises his or her capacity for autonomy in the context of relationships ([41], p. 435). Although supported decision-making has been recommended by the ALRC ([3], para. 10.74), Queensland’s recent review of its mental health laws neither mentioned the CRPD nor recommended the adoption of supported decision-making [4]. This section briefly summarises the potential benefits of supported decision-making, before examining the provisions of the *Mental Health Act 2000* (Qld) dealing with support for an individual suffering from mental illness. Section 5 goes on to consider the limitations of supported decision-making in the context of acute mental illness.

5.1. Potential Benefits of Supported Decision-Making

A supported decision-making approach promises to respect the lived experience, values and goals of people living with mental illness ([11], p. 440; [50], pp. 8–9). It also has the potential to affirm the role of family and circles of support in the lives of people living with mental illness, acknowledging that most adults function through interdependent decision-making using the advice and support of social networks of family and friends ([51], p. 180; [52], p. 141), rather than as isolated, rationalistic individuals ([41], p. 435).

Support in decision-making can take a variety of forms. It may be as simple as the provision of or explanation of information, assistance in communicating a decision (advocacy) ([41], p. 434), or provision of informal support by family and friends. Minkowitz advocates a variety of informal programs of peer support, recovery based networks, community support networks and personal assistance to help people with mental illness exercise their legal capacity ([1], p. 409). Legal models of supported decision-making encompass formalised support for decision-making; shared or co-decision-making; appointing a representative to make decisions ([11], pp. 431–32; [51], pp. 183–89; [52], pp. 147–54); and forms of advance planning such as advance directives ([11], pp. 436–38; [53]) and Ulysses directives⁴⁴. It is not

⁴⁴ “Ulysses directives” are a form of advance directive whereby mentally ill persons give advance permission for treatment to be provided at a later time when they are incompetent, uncooperative, and are refusing care. See [54].

the purpose of this paper to assess and evaluate the different models of supported decision-making which have been adopted in various provinces of Canada ([6], p. 198; [11], p. 434; [50], pp. 149–54), in Sweden ([11], pp. 434–35; [39], p. 444), or the Soteria trials conducted in America ([11], pp. 435–36)⁴⁵, as well as the small-scale trials conducted in some states of Australia ([39], p. 443; [51], p. 134).

5.2. Provisions for Support in the Mental Health Act 2000 (Qld).

None of these models of supported decision-making are currently embodied in the *Mental Health Act 2000* (Qld). The general principles contained in section 8 of the Act explicitly recognise the need to provide support and information to a person with mental illness to exercise the person's rights and express his or her point of view⁴⁶; to support a person with mental illness to “achieve maximum physical, social, psychological and emotional potential, quality of life and self-reliance”⁴⁷; and maintain supportive relationships and participation in community life⁴⁸. However, there is no attempt to formalize these supportive relationships in the legislation.

The *Mental Health Act 2000* (Qld) does permit a person with mental illness who is subject to an involuntary treatment order to appoint an “allied person”, who may be a parent, carer, any adult relative or friend, or the person specified in an advance directive⁴⁹. The allied person's function is to “help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention, treatment and care under this Act”⁵⁰. Although this sounds like an advocacy role, the legislative provisions are restricted to the provision of information relating to orders made and patient's rights⁵¹, with the exception of the entitlement to attend at Mental Health Review Tribunal hearings⁵². The Act contains no provision for the primary carer to receive information about or be involved in the development of a treatment plan, or to fulfil a “supported decision making” role ([55], p. 2).

The remainder of the *Mental Health Act 2000* (Qld) does not establish a legal framework founded on support of people with mental illness, as that concept has been expressed in the literature. The Act in essence contains a substituted decision-making framework where an authorised psychiatrist makes decisions on behalf of a person with mental illness deemed to lack capacity or to have made unreasonable decisions.

6. Problems with Supported Decision-Making

Supported decision-making models seem most appropriate in the context of ageing and dementia-related illness, where there is a gradual decline in capacity, and a person may need support to maintain this capacity ([52], pp. 142–43). It also has potential to increase self-determination for people with intellectual or developmental disabilities, assisting them via the provision of appropriate supports

⁴⁵ Referring to the Soteria project of Loren Mosher.

⁴⁶ *Mental Health Act 2000* (Qld), s 8(c).

⁴⁷ *Mental Health Act 2000* (Qld), s 8(d).

⁴⁸ *Mental Health Act 2000* (Qld), s 8(f).

⁴⁹ *Mental Health Act 2000* (Qld), s 342.

⁵⁰ *Mental Health Act 2000* (Qld), s 340.

⁵¹ *Mental Health Act 2000* (Qld), ss 113 and 345.

⁵² *Mental Health Act 2000* (Qld), ss 332 and 455.

to make autonomous decisions ([56], pp. 27–28; [57]). Perhaps this is why the majority of the literature on supported decision-making has focussed on guardianship laws (which apply to the elderly or people with intellectual disabilities) rather than mental health laws.

Supported decision-making may already occur informally in relation to many matters faced by people with mental illness, including treatment decisions, decisions relating to housing, care of children, and other matters. Mental health laws do not address these topics, but are limited to the involuntary treatment of people with severe mental illness, and provisions governing forensic orders in cases where people with mental illness are charged with or convicted of crimes. Supported decision-making in the context of acute mental illness, particularly psychotic states, raises different issues to support in decision-making generally.

A number of cautions have been expressed in the context of guardianship about the adoption of various models of supported decision-making. These include concerns that supported decision-making is “conceptually ill-defined” ([51], p. 178); ought to be empirically tested prior to adoption, to assess which model is optimal ([51], pp. 179, 191); may expose family members or supporters to legal liability for the consequences of actions, especially under co-decision making models ([52], pp. 158–59)⁵³; and will add an additional layer of regulation and complexity to an already heavily regulated area of life ([52], p. 163).

In addition to these noteworthy issues, the possible adoption of supported decision-making in mental health laws raises a number of specific concerns: namely, that there will always be people who lack supporters and will be excluded from this model; that some people with mental illness lack the capacity necessary to make their own decisions, even with total support; that the introduction of supported decision-making may increase the already onerous burden placed on carers; and that there is a lack of services to provide the intensive support required. These issues will be addressed briefly in turn.

6.1. People Who Lack Support

One of the key issues for any model of supported decision-making is that individuals without supportive family or other relationships are particularly vulnerable either to becoming dependent on publicly funded support services (if those are available), or to being subjected to substitute decision-making because they are unable to access support ([51], pp. 195–96; [52], p. 142). This risk is particularly acute for people suffering severe mental illness, as their behaviour often alienates family and friends, resulting in “social isolation” with truncated or non-existent support networks ([58], p. 34). Verkerk notes that “many of them have a desperate need for flourishing, viable relationships. In fact, part of their problem is that they cannot relate very well with other people” ([33], p. 359).

The assumption that support networks can be readily established has been undermined by the South Australian trial of supported decision-making, because, even with a cohort of only 26 people, two supporters “fell by the wayside and were unable to be replaced” and two socially-isolated people could find no volunteer supporter ([51], p. 192). In Queensland alone in 2012–2013, involuntary treatment

⁵³ But note that the legislation itself can protect supporters from legal liability. For example, in British Columbia, legislation exempts representatives from legal liability, including for injury, death or financial loss, if the representative acts honestly and in good faith, and with reasonable care, diligence and skill: sections 16 and 23 of the *Representation Agreement Act 1996* (BC).

orders were made in respect of 4890 people [4]. A larger number of people received in hospital treatment as voluntary patients, and there are approximately 85,000 people in Queensland living with mental illness and receiving services through the public mental health system [4], a proportion of whom would also benefit from support in decision-making. Given the inability to provide appropriate supporters for 4 out of 26 people in South Australia, the ability of the government or a network of volunteers to provide decision-making support even to those people requiring hospitalisation is highly questionable. In light of this, it would be short-sighted to institute a system of supported decision-making without ensuring it is fully resourced ([9], p. 352).

6.2. Lack of Sufficient Government Support Services

A frequent complaint in relation to mental health treatment is the lack of funding available to address the often complex underlying causes of mental health issues, which may prevent situations reaching crisis point and requiring hospitalisation ([30], p. 587). Relatively few people with mental illness have the financial means to pay for the support they require, but are dependent on underdeveloped and inadequately resourced social services ([59], p. 237).

In both the UK and Australia, studies have shown difficulties accessing professional care for mental health issues “during onset and to prevent the deterioration of illness” ([20], pp. 777–78), and inadequate funding and staffing of community care programs ([30], p. 590; [47], p. 62), leading to highly vulnerable people being prematurely discharged from hospital and returning to live in inappropriate conditions and with inadequate treatment facilities ([20], pp. 777–78). Any attempt to address this from a relational perspective will need to grapple with the broader substantive issues, including not only psychiatric treatment, but also addiction, physical health, housing, income and other support needs ([60], p. 6; [61], p. 17; [62], p. 6).

One major issue requiring consideration which centrally affects the availability of support is the role of family or other voluntary carers in providing support services. The de-institutionalisation of care under contemporary mental health policies has placed far greater responsibility on family members, who provide the vast majority of care for those living with mental illness ([47], p. 46). Carers’ obligations to support a person with a mental illness are often extremely onerous, sometimes requiring them to subordinate their own autonomy and needs to the care of the other ([43], p. 45; [47], p. 51; [49], p. 337). Any framework for supported decision-making needs to contain mechanisms to support these voluntary care-givers, as well as protection against family members who take advantage of or ignore the interests of the person they provide care to.

6.3. People Who Lack Capacity to Make Their Own Decisions, Even with Total Support

Notwithstanding the difficulties expressed above in establishing and maintaining support networks for those individuals who lack supportive relationships, there is clearly potential for supported decision-making arrangements to benefit some people with mental illness. Research shows that many people with mental illness, even those with severe disorders such as schizophrenia, are capable of understanding treatment choices and making rational decisions, despite decisional impairments ([50], p. 10; [58], p. 29; [61], p. 17; [63], p. 89). Other studies measuring the ability of patients with schizophrenia found them to be unable to exercise decision-making capacity ([54], p. 44).

The difference between the studies demonstrates that decision-making capacity exists on a spectrum. Variation exists between individuals, and some persons with mental illness may be capable of making treatment decisions, whereas others are not. A further consideration is that some people living with mental illness may prefer that decisions be made on their behalf, or that decision-making be shared, rather than desiring autonomous decision-making ability ([30], p. 205; [58], pp. 31–34; [61], p. 16; [63], p. 92). Psychiatric patients themselves experience varying levels of competence on a weekly, sometimes daily, basis ([54], p. 46). But it must be acknowledged that there will always be some situations, such as during psychotic episodes, or during episodes of acute bipolar disorder, where the nature of individuals' impairments means that they are incapable of reaching a decision about treatment options ([19], p. 561; [50], p. 11; [51], p. 198; [52], p. 163), even with the provision of support.

“Mental illness”, as defined in the *Mental Health Act 2000* (Qld) is “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory”⁵⁴. Zolnierek, writing from a clinical perspective, observes that “the distortion of reality and reason, characteristic of serious mental illness” ([32], p. 101) means that a significant minority of people with mental illness have no insight into their condition. Such individuals do not have the cognitive capacity to recognise the existence of their illness and the need for treatment, they commonly avoid or refuse care, refuse or forget to take prescribed medication, and behave in a manner dangerous to themselves or others ([33], pp. 361–62; [63], p. 98). It is difficult to see how, for example, a person who believes that she is the Virgin Mary ([39], p. 132), or a person who suffers from a delusion of being persecuted by MI5 ([34], p. 69), can demonstrate the level of thought or perception required to weigh information and make relevant decisions, even with appropriate support.

As Gooding recognises, supported decision-making can only be said to occur when, with appropriate assistance and information, individuals can be supported to become aware of the implications of their choices ([41], p. 436). If this awareness does not develop, even with support, there is no scope for the application of the model. Thus, an alternative model is required.

It is noteworthy that the South Australian pilot study of supported decision-making expressly excluded people with mental illness from its scope ([51], p. 192). Additionally, the Canadian legislative models of supported decision-making were never intended to be used in crisis situations such as psychosis or extreme stress, “but rather prior to problems and conflicts developing” ([41], p. 441). Although supported decision-making may be useful in many situations involving people with mental illness (situations which are not subject to mental health laws), during the type of crisis which commonly invokes the involuntary treatment provisions of the *Mental Health Act 2000* (Qld), an individual may be so unwell as to be unable to appreciate and weigh the information necessary to make an informed decision, even with the provision of support. In this situation, advanced directives or Ulysses directives given by patients before the crisis might be of value.

As mentioned above, the CRPD Committee's insistence that persons with mental illness never lose the capacity for agency is based on a flawed, ideological position denying the reality of impairment. In view of the inapplicability of supported decision-making in times of mental health crisis, the *Mental*

⁵⁴ *Mental Health Act 2000* (Qld) s 12.

Health Act 2000 (Qld) should retain provisions for substitute decision-making in order to be able to make decisions for persons who cannot act to protect their own interests ⁵⁵.

6.4. *The Provision of Information to Supporters or Carers*

Another, significant, issue which needs to be addressed when considering the introduction of supported decision-making is the manner in which family or other supporters are involved. Although the CRPD Preamble recites that “the family is the natural and fundamental group unit of society” and family members are entitled to “assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities” ⁵⁶, no other provisions of the CRPD refer to the role played by families in supporting persons with disabilities, including mental illness. The CRPD Committee recognises “the social networks and naturally occurring community support (including friends, family and schools) of persons with disabilities as key to supported decision-making” ([12], para. IV.45). However, it treats family instrumentally and not relationally, as other provisions emphasise that support is provided to enable a person with disabilities to act as an independent individual, not as a member of a family or community, and requires “those providing support...[to] fully respect the right to privacy of persons with disabilities” ([12], para. IV.47). For supported decision-making to become a viable form of promoting and protecting the legal capacity for agency of people with mental illness, reform of the legal concept of privacy will be required. Without the ability of family or carers to access treatment information for those in their care, it is difficult to see how support can be provided in practice ([19], p. 578).

Similarly, under Queensland’s mental health legislation, family members are not informed about a family member’s mental illness, involuntary status, proposed treatments or side effects. Neither are family members legally required to be included in treatment or discharge planning, unless they have been nominated as the “allied person”. This is vital information “they need to provide adequate and appropriate support for the person in their care” ([47], p. 51; [59], p. 238; [64], p. 482).

A number of simple amendments to the *Mental Health Act 2000* (Qld) could facilitate greater involvement by carers in the treatment process. At the very least, confidentiality provisions in the *Mental Health Act 2000* (Qld) should be amended to permit the provision of information about treatment to carers ([59], p. 242), and this has been recommended in the *Review of the Mental Health Act 2000* [65] ⁵⁷. Carney also recommends greater involvement of family members and social supports during the mental health tribunal review pre-hearing and hearing process, to explain the “existing and historic social circumstances” ([60], p. 6). This reflects the wishes of the majority of consumers ([47]; [60], p. 5).

More fundamentally, the *Mental Health Act 2000* (Qld) could be amended to specifically involve carers in assessment for involuntary treatment and in treatment planning. For example, under New Zealand law, a psychiatrist assessing a person for involuntary treatment must consult the family unless it is not reasonably practical or is not in the best interests of the patient ⁵⁸. Similarly, in NSW, the

⁵⁵ See submissions of NSW Council for Intellectual Disability, *Submission 33* in [3], para. 2.99.

⁵⁶ CRPD Preamble, para (x).

⁵⁷ Sections 71–78 of the *Mental Health Act 2007* (NSW) provide a useful model in this regard.

⁵⁸ S 7A *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ).

“primary carer” must be consulted and involved with planning discharge and ongoing care⁵⁹, although not in relation to the assessment process or treatment while in hospital. A fusion of these models could usefully be adopted in Queensland, providing family and supporters with a right to be consulted at every step, unless the person with the mental illness objects. The *Review of the Mental Health Act 2000* has recognised the benefits of family involvement in treatment and care ([65], p. 4), but has not recommended specific legislative reform to consult and involve family or supporters.

It is crucial that consultation procedures and any supported decision-making procedures enhance, rather than damage, the long-term relationship between families and individuals with mental illness, as research ([47], p. 51; [64], p. 482) as well as consumer experience ([62], p. 26) suggests that strong and supportive relationships are key to coping and recovery for individuals with mental illnesses, as well as reducing relapse rates and re-hospitalisation ([47], p. 45).

Supported decision-making has the potential to more fully involve family and other carers in the treatment planning process. However, if too great an emphasis is placed on the privacy and independence of the person with mental illness, supported decision-making will be impractical, if not impossible. In situations such as an acute phase of a mental illness, supported decision-making will be ineffective without a high degree of assistance in explaining treatment options, making choices and communicating a decision. This process will be impossible if privacy concerns prevent the provision of information to carers or supporters.

In situations where the person with mental illness is antagonistic towards his or her carers, or perceives his or her carers as agents of oppression or control, it may be impossible for those carers to provide support at that time. As mentioned above, supported decision-making needs to be confined to those individuals who are capable of making truly autonomous decisions, when provided with appropriate support, and who are willing to acknowledge and accept support. Where insight into illness is lacking (for example during an acute psychotic episode), supported decision-making is unlikely to be viable ([60], p. 5), and other legal mechanisms will need to be employed, such as reliance on the views expressed in an advance directive, or, as a last resort, substituted judgment. If a supported decision-making model is adopted which makes no provision for the case where a person lacks capacity to make decisions even with support, it will have the effect of abandoning persons with mental illness to the consequences of their irrational choices, including the refusal in some instances of restorative treatment, and then requiring whoever is caring for them to “pick up the pieces” ([41], p. 441; [47], pp. 45, 53).

7. Conclusions

The CRPD has provided a new foundation for assessing the standards contained in mental health laws. Relying on the CRPD, many, including the ALRC, have recommended the introduction of supported decision-making into mental health law [9,11,14,41]. Some have gone so far as to assert that involuntary treatment laws may contravene the CRPD [13], and should be abolished [1]. The CRPD Committee itself has strongly recommended the abolition of mental health laws authorising involuntary

⁵⁹ Section 79 of the *Mental Health Act 2007* (NSW).

treatment, replacing it with a system based on supported decision-making and ensuring that all decisions made reflect the “will, preferences and rights” of the individuals concerned.

The CRPD is grounded in notions of individual autonomy and non-discrimination, concepts which this paper has demonstrated represent only a partial conceptualisation of human experience. Although it is clearly discriminatory to involuntarily detain and treat persons with severe mental illness whereas persons without mental illness have a right to refuse medical treatment, this discrimination may be justified if a relevant ground for differential treatment exists. Analogous precedents for preventative detention of individuals on the ground of dangerous behaviour or public health risk exist in Queensland and Commonwealth law. Further, and perhaps more significantly, discrimination on the basis of a lack of legal capacity (in the sense of the capacity for agency) is justifiable on the basis that the treatment provided actually aims at the restoration of the individual’s autonomy or capacity. Hence involuntary treatment, although a short-term interference with a person’s liberty, is actually based on respect for autonomy and has as its goal the restoration of the capacity to make one’s own choices.

A relational understanding of autonomy shows that people with mental illness, like all other people, develop their capacity for autonomy through family and social relationships, and in a real sense, these relationships constitute their sense of self. Measures which foster the development of these constitutive relationships will, in the long-term, assist in the development of individual autonomy in its fullest sense. Offering support in decision-making and access to advance planning directives may avoid the imposition of involuntary medical treatment in many instances, “by providing greater choice and information, establishing support persons, emphasising participatory health care” ([41], p. 439). Whether supported decision-making should be contained in the *Mental Health Act 2000* (Qld) or in separate legislation, what form/s of supported decision-making should be embraced and what safeguards should be imposed are big questions, worthy of fuller exploration elsewhere.

However, the adoption of supported decision-making as the exclusive model for decision-making in the mental health context is complicated by a number of factors. It can be difficult to locate or establish support networks for individuals who are socially isolated, either by virtue of their challenging behaviour, their inability to form functioning relationships or for other reasons. There is a critical lack of social services available to address the root causes of the problems which often underlie mental illness. The adoption of supported decision-making risks overburdening already stressed relationships between family and friends and the individual with mental illness. Finally, the nature of mental illness is such that there will always be some individuals who lack capacity to make independent decisions, even with the benefit of unlimited support.

In view of the concerns expressed above, while supported decision-making holds promise, there will continue to be a role for substituted decision-making in the form of involuntary treatment under mental health laws. The CRPD Committee’s position must be rejected as too extreme. There is no convincing justification for allowing people with mental illness to “suffer awful lives” ([19], p. 565) in the name of respect for their autonomy. This is particularly true given the knowledge that contemporary treatment options, although requiring lifelong commitment, can manage the symptoms of serious mental illnesses and “return many patients to a productive and meaningful life” ([32], p. 101).

Abbreviations

ALRC: Australian Law Reform Commission;

CRPD: United Nations Convention on the Rights of Persons with Disabilities;

CRPD Committee: United Nations Committee on the Rights of Persons with Disabilities.

Conflicts of Interest

The author declares no conflict of interest.

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