# Forced Medication of People with Disabilities: Breach of OPCAT

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*'It was scary. At one point, one of the nurses came over and said I was going to have an injection. I said, 'No I'm not'. She said, 'Yes you are'. This went back and forth until I realised there were two extra security guards standing behind her. Next thing I knew they had come over and forced the injection on me.'*[1]

[1] Your story, your say Final Report, 'Consumers' priority issues and solutions for the Royal Commission into Victoria's Mental Health System' (June 2020) *Victorian Legal Aid,* 19. https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-your-story-your-say-report.pdf

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# 1. Executive Summary

Forced medication inflicts unnecessary mental and physical suffering on individuals and disproportionately impacts persons with a disability or mental illness. The United Nations Special Rapporteur on Torture, Juan Mendez, found that medical treatments 'may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person,' particularly when performed on marginalised groups, such as people with disabilities.[2]

Forced medication violates an individual's right to physical and mental integrity and breaches the limits of legal interference that the state is permitted to inflict on an individual.[3] This undermines the entitlement to personal autonomy and has detrimental and, at times, life-threatening repercussions.[4] This report highlights that the use of forced medication, other than in crisis situations, constitutes a breach of the *Optional Protocol to the Convention Against Torture* (*OPCAT*).

The use of forced medication as a standard form of mental health intervention is unacceptable. Dainius Pūras, the United Nations Special Rapporteur on the right to health, asserts that everyone has the right to the "enjoyment and highest attainable standard of physical and mental health."[5] He pushes for a "revolution" that will see a shift to a rights-based approach to care and support.[6] The Special Rapporteur states there must be immediate action to reduce and, eventually, cease its use.[7] For Australia to contribute to this action, the Government must remove laws that allow it to occur and offer alternatives to dealing with the situation.

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[2] United Nations Office on Drugs and Crime, *Interim Report of the Special Rapporteur on Torture and other cruel, inhuman, or degrading treatment or punishment*, Juan E. Méndez (Report 1, 2013) 7.
[3] *United Nations the Convention on the Rights of Persons with Disabilities*, adopted by the General Assembly 24 January 2007, https://www.ohchr.org/Documents/Publications/CRPD_TrainingGuide_PTS19_EN%20Accessible.pdf ('*The Convention on the Rights of Persons with Disabilities'*).
[4] Ilias Bantekas et al, *The UN Convention on the Rights of Persons with Disabilities: A Commentary.* (Oxford University Press, 2018) 451.
[5] United Nations Human Rights Office of the High Commissioner, 'World needs "revolution" in mental health care - UN rights experts', (June 6, 2017) https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689&LangID=E
[6] Ibid.
[7] United Nations General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* Dainius Pūras 2017

A mental health diagnosis is not grounds to justify the use of forced medication, nor is it grounds to evaluate the risk a person *may* pose to themselves or the community. Using public order and safety as a justification for the use of forced medication deters individuals from voluntarily seeking medical help. This fear of coercion and loss of autonomy makes mental health care inaccessible, failing to meet the needs of those who need it most.

The presumption of necessity allows the Australian legal system to justify the use of forced medication. However, the damage often being done to the individual being forcibly medicated as a long-term treatment is incompatible with *OPCAT* and the *United Nations Convention on the Rights of Persons with Disabilities* (*UNCRPD*).[8]

It is accepted in a civilised community that families, friends, workers and society are entitled to feel safe around people who display problematic behaviour. However, only in acute crisis situations could a chemical intervention be acceptable, for example, with individuals who are under the influence of drugs and have lost personal control.

Alternatives to forced medication are available and must be offered to neutralise the situation by de-escalating and reassuring the individual rather than injecting substances that the individual does not want and often regards as poison. For instance, when individuals exhibit aggressive behaviour, they should be entitled to choose how they should be handled. In this instance, seclusion may be used as an alternative to forced medication. Alternatively, an advance directive can be used as an empowering option for individuals to decide what intervention and/or what medication may be right for them. In Germany, studies have been done which demonstrate the advantageous nature of considering a patient's individual opinion when choosing the least restrictive and most effective intervention, as individuals have a right to individualized treatment.[9]

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[8] *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* adopted by the General Assembly 18 December 2002; UN General Assembly, *Convention on the Rights of Persons with Disabilities,* adopted by the General Assembly 24 January 2007, A/RES/61/106 (‘*OPCAT*’).

[9] Irina Georgieva et al, *Patient’s Preferences and Experiences of Forced Medication and Seclusion* (Psychiatry Q, 2012) 83(1) 1-13 (24 April 2011).

Problematic decisions about financial matters and dealing with families could be dealt with by restricting some freedoms through guardianship tribunals in a measured way but does not justify the administration of medication with all its disabling effects.

### *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('CAT') and OPCAT

CAT defines torture as any physical or mental act intentionally inflicted upon a person that results in severe pain or suffering.[10] Both the conventions require signatory states to implement effective measures that will end and criminalise all acts of torture in its jurisdiction.

*OPCAT* seeks to implement the principles established by the CAT, introducing an independent National Prevention Mechanism (NPM) to maintain respectful, safe and humane conditions, protecting detainees from unnecessary distress.[11] The NPM inspects detention facilities to ensure no torture occurs. Despite ratifying *OPCAT* in 2017, the Australian Government is significantly behind other signatories, postponing the establishment of an NPM domestically across all jurisdictions until 2022. Furthermore, the Australian Human Rights' Commission, states that the implementation of *OPCAT* in Australia has been slow, since its ratification in late 2017, despite public concern over the treatment of inmates and people with disabilities in detention systems.[12]

### UNCRPD

The *UNCRPD* explicitly prohibits forced institutionalisation and medication of persons with disabilities, requiring healthcare providers to deliver treatment with free and informed consent.[13] This is because persons with disabilities are particularly vulnerable to the distressing effects of torture and ill-treatment and are more susceptible to experiencing distress from medical

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[10] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment https://www.ohchr.org/Documents/ProfessionalInterest/cat.pdf*

[11] Preventing Torture: The Role of National Preventive Mechanisms. (2018). [online] New York and Geneva: United Nations Human Rights Office of the High Commissioner. Available at: https://www.ohchr.org/Documents/HRBodies/OPCAT/NPM/NPM_Guide.pdf.

[12] Australian Human Rights Commission, "Implementing OPCAT in Australia (2020) | Australian Human Rights Commission," *humanrights.gov.au* (June 28, 2020) <https://humanrights.gov.au/our-work/rights-and-freedoms/publications/implementing-opcat-australia-2020>.

[13] Ibid.

intervention. Special Rapporteur Juan Mendez stated that a deprivation of liberty on the grounds of mental illness is unjustified.[14] Yet Australia continues to forcibly medicate individuals with disabilities through the use of *Community Treatment Orders (CTO)*.[15] With patient consent and legal capacity not being afforded, Australia violates articles 15, 16, and 17 of the *UNCRPD*.

In line with article 33 of the *UNCRPD*, the Australian Government must integrate stronger independent monitoring mechanisms to ensure greater conformity to the Convention.[16] These include an Office of Disability Strategy within the Department of Prime Minister and Cabinet (The Australian Human Rights Commission agreed with this recommendation), amended legislation to ensure that the Australian Human Rights Commission has the power to independently monitor the *UNCRPD* in accordance with article 33(2), formal monitoring mechanisms under the National Disability Scheme, and sufficient resources for Disability Protection Officers to carry out their monitoring functions.

**Relationship between UNCRPD and OPCAT**

The *UNCRPD* and *OPCAT* both advocate for the protection of human rights for vulnerable members of society. The *UNCRPD* aims to ensure all people with a disability have equal access to human rights and fundamental freedoms, while the *OPCAT* seeks to strengthen the protection of the rights of those imprisoned and disabled individuals by establishing monitoring procedures in all detention facilities.

The *UNCRPD* prohibits the use of forced medication, backed by the monitoring mechanisms of *OPCAT*. The Australian government signed the *UNCRPD* in 2007, which prohibits forced medication as it is seen as a violation of an individuals' rights; however, it is still legal within Australia to forcibly medicate the disabled. As Australia has reserved the capacity to engage in forcible medication from a legal standpoint through its restricted acceptance of the *UNCRPD*, no legal recourse is available for victims of this breach. Instead, *OPCAT* provides a remedy to

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[14] *Special Rapporteur On Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment,* Juan E Mendez (22nd sess, Human Rights Council Agenda Item 3) 4 March 2013.
[15] *United Nations Convention on the Rights of Persons with Disabilities*, (entered into force 3 May 2008), declarations and reservations.
[16] McCallum AO, Ron, *The United Nations Convention on the Rights of Persons with Disabilities: An Assessment of Australia's Level of Compliance* (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, October 2020) (See 3.2.1.A of this document)

enforce compliance. Ideally, the implementation of NPM's in 2022 will make this process more accessible to aggrieved parties.

### The Impacts of Forced Medication

The administration of forced medication causes unnecessary distress to individuals, which constitutes an act of torture, particularly for people with a disability or mental illness. Forced medication subjects individuals to a regime of invasive medical treatment to which they do not consent, undermining their autonomy and ability to act in their own best interest. Consequently, patients lose trust in the medical system, and the development of doctor-patient rapport is impaired, reducing the likelihood of patients voluntarily seeking professional help. This reduction in voluntary psychiatric hospital admissions due to fear, confrontation and persecution is often used as justification for forced treatment by authorities. The limits of the law on forced medication is analysed by Justice Action's report here.

Forced medication has numerous adverse effects on those subjected to the practice. These effects can lead to further issues such as mental and physical effects of antipsychotic injections, the formation of serious illnesses including Myocarditis and Type 2 Diabetes; and mental health implications due to a loss of personal autonomy, including Post-Traumatic Stress Disorder ('PTSD') and acute mental suffering such as anxiety, the inability to concentrate and insomnia. The negative impacts of forced medication are unequivocally clear.

### Alternatives to Forced Medication

Treating those with mental illness or disability with coercive methods such as forced medication is unnecessary, especially given the abundance of proven alternatives. A longitudinal study on schizophrenia and affective psychosis patients found that 'the participants not on antipsychotic medication were approximately six times more likely to recover than participants on medication'.[17] These alternatives are necessary to allow people with mental illness and disabilities to access treatments that prioritise rehabilitation rather than forced medication.

[17] Martin Harrow, et al, 'Twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders' (2021) *Cambridge University Press*, 1-11.

Examples of treatment alternatives can be found in Justice Action's report *'Alternatives to Forced Medication'*. These include Cognitive Behaviour Therapy, psychoeducation, music therapy, aerobic exercise, the appointment of an enduring guardian, light therapy, therapeutic communities, social-network based therapies, assisted accommodation and employing workers that can create individualised treatment plans.

# 2. *Optional Protocol to the Convention Against Torture* ('OPCAT')

Torture and degrading treatment is becoming increasingly clarified and defined by international conventions. Previous common practices in social care, disability, health, and mental health settings are now classified as environments where torture and ill-treatment are identified.[18] Established healthcare practices being labelled as torture is an imminent and highly controversial issue. However, an interim report of the Special Rapporteur on '*Torture and other cruel, inhuman or degrading treatment or punishment*' acknowledged that medical treatments which are intrusive, irreversible by nature, lack a therapeutic purpose, or aim to correct or alleviate a disability may constitute torture if administered without free and informed consent.[19] It further states that prolonged use of restraint (i.e., physical and/or chemical) may amount to torture if there is a failure to justify such treatment. By analysing involuntary treatment under this light, this section analyses how forced medication can be justified as a violation of human rights.[20]

United Nations' CAT defines torture as:

> *"...Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person*

[18] Penelope Weller, 'OPCAT monitoring and the Convention on the Rights of Persons with Disabilities' (2019) 25(1) *Australian Journal of Human Rights*.
[19] United Nations General Assembly Human Rights Council, *Interim Report of the Special Rapporteur Torture and other cruel, inhuman, or degrading treatment or punishment, Juan E. Méndez,* (Report, 1 February 2013) ('*Méndez*').
[20] As per Opcat (*Optional Protocol to Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* ('OPCAT'), ratified by the Australian Government in 2017)

*information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."*[21]

The United Nations' OPCAT treaty seeks to reduce the likelihood of mistreatment within detention facilities and institutions, advocating that mechanisms need to be established to maintain 'respectful, safe and humane conditions.'[22] Despite ratifying OPCAT and publicly committing to protecting detainees from treatment that 'causes unnecessary distress', the Australian Government continues to allow forceful medical intervention.[23]

In their 2020 report regarding the implementation of OPCAT in Australia,[24] the Australian Human Rights Commission recommended the immediate creation of a network of inspection bodies known as National Preventive Mechanisms (NPMs). The purpose of these mechanisms is to ensure all detention facilities are overseen in line with the OPCAT guidelines and complement OPCAT and other systems already in place. The Commission stated that the effectiveness of these mechanisms would be critical to the success of OPCAT implementation in Australia.[25] The Australian Government has stated that it intends for a federal model of NPMs to be established by January 2022.[26] However, this will have left a notable gap in the oversight of compliance with the treaty between ratification in 2017 and 2022, without the protection of NPMs during this period.

## Case study: Kerry O'Malley

[21] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) ('*UNCAT*').
[22] Commonwealth Ombudsman, Implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2019) 1 ('*Ombudsman Paper*').
[23] Ombudsman Paper (n 13).
[24] Australian Human Rights Commission, *Implementing OPCAT in Australia* (Report, 29 June 2020) 6[2].
[25] Ibid, 6[4].
[26] Attorney General's Department Senate Standing Committee on Legal and Constitutional Affairs, Supplementary Budget Estimates 2019-20 (LCC-SBE19-141-OPCAT-National Preventive Mechanism) (4 November 2019).

The presence of NPMs may have aided Kerry O'Malley, a victim of unjust CTOs for the past 47 years, from continuous forceful medication.[27] Since 2017, O'Malley has been subjected to CTOs she did not consent to and has been forcibly medicated despite never exhibiting threatening behaviour to herself or to the community. As a result, she has been stripped of her dignity and autonomy, facing countless mental and physical health repercussions. These health implications include anxiety, depression, poor concentration, weight gain, and loss of hair. She is one of 17,000 Australians who are currently forcibly injected under CTOs, and her story represents the mistreatment those in the Australian mental health system and prisons face.[28] O'Malley and other Australians would not have suffered such forceful medical intervention if NPMs existed. We urge the Australian Government to remedy these issues through the establishment of NPMs in 2022.

## 2.1 International compliance

### 2.1.1 New Zealand's mechanisms in dealing with breaches of OPCAT

New Zealand ratified the OPCAT early in 2007. It has been over ten years since New Zealand set up a multi-body national preventive mechanism (NPM) to fulfil its obligation under the treaty.

In March 2017, a report of the Care and Management of at-risk prisoners was released. This exposed an incident where an at-risk prisoner was for restrained sixteen hours a day for thirty-seven consecutive days. The prisoner's hands were cuffed behind their back with their legs, arms, and chest tied down.[29]

The amassed media attention drawn by the report prompted the New Zealand Department of Corrections to acknowledge the concerns, instigating a review.[30] Subsequently, there were

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[27] 'O'Malley update - An urgent plea against forced injections', *Justice Action* (Web Page) <https://justiceaction.org.au/omalley-update-an-urgent-plea-against-forced-injections/>.
[28] 'Responses by Mental Health Authorities and Stakeholders to the Kerry O' Malley Case', *Justice Action* (Web Page) <https://justiceaction.org.au/responses-by-mental-health-authorities-and-stakeholders-to-the-kerry-omalley-case/>.
[29] RNZ, 'Corrections bans tie-down beds two years after critical report', *Newspaper* (online, 11 April 2019).
[30] Michael White, 'The role and scope of OPCAT in protecting those deprived of liberty: a critical analysis of the New Zealand experience', Australian Journal of Human Rights, 16 April 2019.

practice and policy changes, which included extra checks and balances on the use of tie-down beds. However, despite identifying the issue early, action by the New Zealand authorities incurred a two-year delay. Eventually, the removal of tie-down beds was officially declared in 2019. This emphatically implores action to streamline the process of addressing breaches.

Although there were positive changes to practice and policy following this event, criticism and recommendations have been made in order to improve the effectiveness of New Zealand's enforcement of the UNCRPD. The Australian Journal of Human Rights criticised that 'merely identifying inconsistencies without proposing alternatives is of little practical use'. It was suggested that more humane options have to be provided, or else these prima facie breaches of OPCAT would continue to be justified and practiced.[31] Additionally, it was suggested that OPCAT should closely interact with local authorities to enhance institution transparency and visibility of breaches. Overall, this demonstrates that practical changes to medical, bureaucratic and legal cultures are needed to effect change.

The Independent Monitoring Mechanism (IMM) of the CRPD commends the positive progress that has been made in New Zealand in recent years. It additionally commends the efforts of the New Zealand government in improving the participation of persons with disability in the development of government policy. However, they recognise that there is plenty of work left to do to allow persons with a disability to enjoy the full range of human rights they are entitled to and urges the Government to implement improvements faster and to mandate a systemic approach to explicitly integrating the CRPD into domestic law.[32]

[31] Ibid.
[32] *Making Disability Rights Real 2014 to 2019* (Report, June 2020) Making Disability Rights Real - Ombudsman New Zealandhttps://www.ombudsman.parliament.nz › sites › files.

# 3. *United Nations Convention on the Rights of Persons with Disabilities* (‘*UNCRPD*’)

The *UNCRPD* aims to protect the rights and dignity of those with disabilities. The Convention highlights the need to endorse:

- Respect for the inherent dignity and individual autonomy; and
- Full and effective participation and inclusion in society; and
- Equality of opportunity.[33]

The treaty sets out national and international institutions necessary for implementing and monitoring the convention. To guarantee the wellbeing of persons with disabilities, their rights as well as States’ obligations to maintain those rights, must be explicitly outlined.

General comments made in 2014,[34] and Article 12 of the *UNCRPD* affirmed that restrictions on rights and legal capacity must not be biased against persons with disabilities. The UN identifies that laws permitting forced medical treatment deny these rights and ‘must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others’.[35] According to the Committee on the Rights of Persons with Disabilities (‘CRPD Committee’), forced medical treatment is also a violation of articles 15, 16 and 17.[36] Recommendations request for accurate and accessible services option information, non-medical approaches, access to independent support, and that decisions require the free and informed consent of the person concerned.[37]

The *UNCRPD* explicitly prohibits forced institutionalisation and medication of persons with a disability.[38] Such practices are incompatible with the objectives of the *UNCRPD* and beyond the

[33] The Convention on the Rights of Persons with Disabilities (n 2).
[34] General Comment on Article 12: Equal Recognition Before the Law. New York, United Nations, Committee on CRPD, 2014, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>.
[35] Ibid para 7.
[36] Ibid para 42.
[37] Ibid.
[38] *UNCRPD* (n 19), Article 19.

scope of Australia's Reservation to continue the forcible medication of persons with a disability.[39] Healthcare providers must deliver treatment with the free and informed consent of people with a disability to remain compliant with the UNCRPD.[40] In the *Community Treatment Order's* ('*CTO*') current form, patient consent is not being afforded, and the mandatory requirements of the Convention are not being met.

## 3.1 Australian Declarations and Reservations

Australia has ratified *UNCRPD* in 2008 and has made the following declaration:

> *"Australia recognizes that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards;*
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> *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..."*[41]

Australia made an interpretive declaration on articles 12, 17, and 18 of the *UNCRPD*, stating that it understands the Convention to allow for "fully supported or substituted decision-making"[42] within proper safeguards, which has been criticised by some stakeholders and commentators.[43] While the Convention acknowledges the need for supported decision-making in certain circumstances, the *CRPD* Committee in General Comment No. 1 stated that implementation

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[39] Ibid Article 46.
[40] United Nations of Human Rights Office of the High Commissioner, *The Convention on the Rights of Persons with Disabilities Training Guide* (Report No 19, 2014) 69.
[41] *Convention on the Rights of Persons with Disabilities: Declarations and Reservations (Australia),* opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).
[42] Ibid.
[43] 'Legislative and regulatory framework', *Australian Law Reform Commission* (Web Page, 12 November 2013) <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-ip-44/equality-capacity-and-disability-in-commonwealth-laws/legislative-and-regulatory-framework/>.

should work towards abolishing substituted decision-making models.[44] This aims to work towards a supported, rather than substituted, decision-making model that abolishes practices such as forced medical treatment, conservatorships and guardianships.[45] In an Australian context, this could be seen in the abolition of guardianship relationships and instead implementing a model which recognises the legal capacity of persons with disabilities, despite any obstructions to their mental capacity to make such decisions. The state must then provide mechanisms and support to work past any challenges so that their legal capacity can be exercised to the best of their ability. This would also require the abolition of forced medication as a means of substituted decision making, as it is an inherent violation of a person's consent and legal capacity.

General Comment No. 1 also indicates favour towards the use of "best interpretation of will and preferences" rather than "best interests" in the event that the best support is not successful in allowing the person to exercise their legal capacity.[46] Through these sentiments expressed by the General Comments of the CRPD Committee, it is clear that Australia's declaration regarding article 12 contradicts the purposes and implementation of the article and the Convention broadly. This sentiment was echoed by the Australian Human Rights Commission and several Australian Disability Organisations in their Shadow Report in 2019.[47] The CRPD Committee also recommended that Australia withdraw its declaration in the first constructive dialogue between the two parties in 2013, a recommendation which Australia rejected.[48]

Not only does the Convention clearly state that signatories should work towards abolishing practices that give rise to the legal capacity of persons with disabilities being infringed on, it also directly expresses disagreement with forced medication. Forced medication is an infringement on human rights itself, as well as articles 14 and 15 of the Convention (see below). It also contradicts the notion of allowing persons with disabilities with full legal capacity and equal recognition before the law. A declaration stating that the Convention allows for fully substituted

[44] Ron McCallum, *The United Nations Convention on the Rights of Persons with Disabilities: An Assessment of Australia's Level of Compliance* (Report, October 2020) 51-2.
[45] *General Comment No. 1*, 11th Session, CRPD/C/GC/1 (31 March–11 April 2014).
[46] Ibid, 21.
[47] McCallum (n 15) 53-4.
[48] Ibid, 52.

decision-making is both incorrect and inherently contrary to the aim of article 12 and the Convention itself.

Article 17 states that "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others".[49] The compulsory treatment of persons due to a disability undermines the right to respect for their physical and mental integrity on an equal basis with others. The neglect demonstrated by Australian law in protecting these rights on an institutional level undermines the Convention's objectives in protecting the rights and enshrining protections in domestic and international law. Australia's declaration on article 17 narrows this protection which is reflected by compulsory treatment orders permitted by Australian legislation. It states that it understands the Convention allows for "compulsory assistance or treatment of persons" when necessary and subject to safeguards. However, in both 2013 and 2019, the CRPD Committee recommended Australia repeal the legislative measures allowing for involuntary detention in psychiatric hospitals and the use of restrictive practices and medical interventions, as they are contrary to articles 14 and 15 of the Convention.[50] These articles pertain to the right to "liberty and security of person" and "freedom from torture or cruel, inhuman or degrading treatment or punishment", respectively.[51]

The right to be free from non-consensual medical treatment has been recognized by the Committee on Economic, Social and Cultural Rights ('CESCR') as one of the freedoms incorporated in the right to the highest attainable standard of health.[52] Thus, the right to free and informed consent is not merely a function of domestic laws but is one of the human rights and fundamental freedoms that is guaranteed to all persons and that must be applied without discrimination based on disability.[53] Any limitation of the right to free and informed consent that applies only to persons with disabilities, or disproportionately affects persons with disabilities, would constitute discrimination. Typical mental health legislation setting out standards and

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[49] The Convention on the Rights of Persons with Disabilities (n 2) Art 17.
[50] McCallum (n 15) 80.
[51] The Convention on the Rights of Persons with Disabilities (n 2) arts 14-5.
[52] U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc., & Cultural Rights, General Comment No. 14: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights.
[53] Tina Minkowitz, *'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions*' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405.

procedures by which psychiatric interventions can be imposed against a person's will must now be considered unlawful.

### 3.1.1 Statistics

In New South Wales, the *Mental Health Act 2007* (NSW)[54] authorises CTO's made by the Mental Health Review Tribunal. The annual report for 2019-20 by the Tribunal reveals the following:[55]

- An increase in section 44: Appeals against discharge refusals, from 629 to 797.
- An increase in section 51: CTO, from 5519 to 5915.
- An increase in section 96: ECT applications, from 810 to 828.

"In total, the work of the Civil Division under all domains decreased from 17006 to 16,855."

Furthermore, decreasing numbers are explained by the COVID-19 pandemic, which must be acknowledged before considering the fluctuating numbers.

## 3.2 UNCRPD Implementation and Enforcement

As the Convention of UNCRPD celebrates human diversity and human dignity,[56] it sets up the basis for the argument against forced psychiatric interventions. It is developed into a series of steps, initiating with; the recognition of equal legal capacity, free and informed consent of persons with disabilities, and equal right to respect for physical and mental integrity.[57] It then proceeded to the establishment of mechanisms in ensuring the implementation of the recognised rights.

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[54] *Mental Health Act 2007* (NSW), s 51(1)
[55] https://www.mhrt.nsw.gov.au/annual-reports.html
[56] "*The Convention on the Rights of Persons With Disabilities Training Guide*" No.19, United Nations Human Rights Office of the High commissioner, 1.
[57] Tina Minkowitz, '*The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions*' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405, 1.

### 3.2.1 UNCRPD's Suggested Approach

To successfully implement the rights recognised by Article 4(1)(a) of the Convention, States must adopt all appropriate legislative, administrative, and other measures. Article 33 of the Convention sets out three implementation measures, namely; focal points, coordination mechanisms, and independent monitoring mechanisms. Focal points and coordination mechanisms are particularly effective in ensuring there is an authority with ongoing responsibility regarding implementation. Other institutions are needed for successful implementation, including courts and tribunals. These measures are necessary in recognising and upholding the rights of persons with disabilities without discrimination.

#### 3.2.1.A Focal points

Article 33(1) requires a Convention focal point(s) within each or most government departments and ministries, and one overall focal point within the Government with the responsibility of dealing with implementation matters of the Convention. States may also implement focal points at different levels of government. These focal points must promote awareness of the Convention, participation in developing an action plan, and monitoring and reporting on implementation.

#### 3.2.1.B Coordination mechanisms

Article 33(1) requires consideration of establishing or designating a coordination mechanism within the Government of States Parties. It is optional to establish a coordination mechanism at government level; however, it is encouraged as it will facilitate action related to the Convention. It could take the form of an inter-ministerial group, or include representatives of various ministries as well as other organisations, the private sector, and trade unions.

#### 3.2.1.C Independent monitoring mechanisms

Article 33(2) requires States to create a structure whereby they establish or maintain at least one independent mechanism to promote, protect, and monitor the implementation of the Convention. The mechanisms within this structure must meet international standards of independence, plurality, and operating. In addition, civil society, particularly persons with

disabilities and their representative organisation, must be involved and participate in the monitoring process.

### 3.2.1.D Courts and tribunals

Courts play a role in protecting rights within the Convention. Individuals whose rights under the Convention have been breached or violated should have the opportunity to seek a legally enforceable remedy through the court system. National courts can complement the mechanisms of Article 33 and must interpret and apply the Convention nationally. In order to seek enforcement of their rights and obligations on an equal basis with others, people with disability must be recognised as persons before the law with equal standing in courts and tribunals.[58]

### 3.2.1.E Monitoring authorities

In relation to breaching the *Convention on the Rights of Persons with Disabilities*, the CRPD Committee's main role is to monitor the implementation of the *CRPD* in the countries which have ratified this Convention. Therefore, there is an international requirement for Australia to fulfil its obligations. In fact, the Royal Commission into Victoria's Mental Health System's 55th recommendation aims to ensure compulsory treatment is only used as a 'last resort', which indicates a resistance towards abolishing forced medication as a whole.[59]

It is possible to complain to the Committee of the Rights of Persons with Disabilities if rights have been breached. The Optional Protocol to the Convention establishes an individual communications procedure that permits individuals and groups in a State party to the Protocol to complain to the Rights of Persons with Disabilities to the Committee regarding breaches of its obligations under the Convention. The complaint is known as a "communication". The Committee examines the complaint and the observations of the State, and on this basis, formulates its views and recommendations, if any, forwards them to the State, and makes them public.[60]

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[58] United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee), *General Comment No. 1 (2014) on Equal Recognition Before the Law,* UN Doc CRPD/C/GC/1 (19 May 2014) [1], [9], [14]-[15], [38].
[59] *Royal Commission into Victoria's Mental Health System* (Final Report Parl Paper No 202, February 2021) Summary and recommendations, 91.
[60] United Nations, *Frequently Asked Questions regarding the Convention on the Rights of Persons with Disabilities* (Web Page).

### 3.2.2 The Australian Approach

It has become clear that the *UNCRPD* is not being enforced in Australia. This is particularly demonstrated by cases of people with cognitive impairment and mental illness who experience forced medication in Australian justice institutions.[61] Australia is the only signatory to the Convention who has ratified the *UNCRPD* to reserve its right to forcibly medicate persons with a disability under CTOs and is able to do so due to the structure of Australian laws.[62] Thus, the use of that allow the medication of an unconsenting patient is extremely high in Australia by comparison to international standards.[63] We have seen cases of the authorisation of psychosurgery, electroconvulsive therapy, forced sterilisation, and chemical, mechanical, and physical restraint and seclusion.[64] In addition, almost one in five residential mental health care episodes were for patients with an involuntary mental health legal status between 2018 and 2019.[65]

Australia's Interpretative Declaration, in respect of article 17 of the *CRPD,* illustrates Australia's construction that forced treatment complies with international law. Instead of addressing mental health laws as an inherent breach of human rights, States and Territories have focused on reviewing and amending mental health legislation in an effort to increase compliance with human rights.[66] A final report of the Royal Commission into Victoria's Mental Health System, published in February 2021, recognised and called for Victorian mental health laws to be revised, with a focus on promoting and upholding human rights, good mental health and

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https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/frequently-asked-questions-regarding-the-convention-on-the-rights-of-persons-with-disabilities.html

[61] Eileen Baldry, 'Over 1,000 Australians with cognitive disability are detained indefinitely each year. This shameful practice needs to stop', *The Conversation* (online, 17 February 2021) <https://theconversation.com/over-1-000-australians-with-cognitive-disability-are-detained-indefinitely-each-year-this-shameful-practice-needs-to-stop-153724>.

[62] 'Forced Medication in Australia: An International Perspective', *Justice Action* (Web Page) <https://justiceaction.org.au/forced-medication-in-australia-an-international-perspective/>.

[63] Edwina Light et al, 'Community treatment orders in Australia: rates and patterns of use' (2012) 20(6) *Australasian Psychiatry* 478, 479-480.

[64] Bevan, N., and Sands, T., (2016) Australian Cross Disability Alliance (ACDA) Submission to the Senate Inquiry into Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia', Australian Cross Disability Alliance (ACDA); Sydney, Australia, paras 21-26 and 37-44.

[65] Australian Institute of Health and Welfare, *Mental health services in Australia* (Web report) <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices>.

[66] Ibid.

wellbeing.[67] Whilst article 12 of the *CRPD* expresses that people with disabilities have the right to enjoy legal capacity 'on an equal basis with others in all aspects of life', Australia's Interpretative Declaration reflects guardianship and mental health laws that deprive people of liberty on the basis of disability and subject them to forced medical interventions.[68]

Australia has implemented a variety of projects to assist persons with disabilities. This includes the National Disability Strategy which serves to guide government activity regarding the development and implementation of public policy that includes persons with a disability through a high-end policy framework, among other things.[69] This strategy has been in place for over ten years; however, relevant stakeholders assert that it contains limited recognition and no comprehensive actions to address certain areas.[70] Stakeholders are additionally concerned about the absence of monitoring and reporting requirements.[71] This is an example of the inadequate strategies Australia has put in place to combat the issue of forced medication. Ultimately, there has been no proper action to abolish involuntary restraint on the basis of disability or to end forced medical interventions,[72] which has had detrimental consequences for many Australians.

Australia's compliance with article 13(1) of the Convention is also reported to be practically inadequate. Whilst Australian governments fund some legal services specifically for people with disability and Australian courts are introducing disability access schemes,[73] significant barriers are present for those seeking legal assistance, many finding access to justice too difficult, hostile, or ineffectual. As a result, people with disabilities are often left without legal redress.[74]

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[67] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 28.
[68] Australian Law Reform Commission (ALRC), *Equality, Capacity and Disability in Commonwealth Laws* (Report IP 44, November 2013) 19.
[69] Ibid.
[70] Disability Representative, Advocacy, Legal and Human Rights Organisations, *Disability Rights Now: Civil Society Report on the Rights of Persons with Disabilities*, Report (2012).
[71] *ALRC* (n 50).
[72] Disability Representative, Advocacy, Legal and Human Rights Organisations, *Disability Rights Now: Civil Society Report on the Rights of Persons with Disabilities*, Report (2012).
[73] NSW Attorney General's Department, 'Disability Strategic Plan 2006–2008: Summary' (Report, undated) <www.lawlink.nsw.gov.au/Lawlink/DiversityServices/ll_DiversitySrvces.nsf/vwFiles/Summary%20DSP.pdf/$file/Summary%20DSP.pdf> .
[74] Submission by attendee at the CRPD Shadow Report consultation in Sydney, NSW (10 November 2009).

Meanwhile, civil and administrative claims for people with disability receive minimal support, even when such claims contend important human rights issues. Evidently, Community Legal Centres have experienced a redistribution and decrease of funds leading to loss of access and resources[75]. Accordingly, the burden on community legal centres, pro bono services and other community organisations has since increased. Consequently, many people with disabilities are continually referred from one service to another whenever services have inadequate resources or expertise to deal with disability legal issues.[76]

### 3.2.3 An Assessment of Compliance with UNCRPD

In 2010, Australia wrote in its report that the Attorney-General's Department and the Department of Families, Housing, Community Services and Indigenous Affairs had been designated under article 33(1) of the *CRPD* as joint focal points within the Government.[77] However, in its 2013 Concluding Observations, the UNCRPD Committee did not find that persons with disabilities were fully integrated into the monitoring processes pursuant to this article. It was recommended for Australia to bring its monitoring mechanisms in line with article 33.[78]

Article 33 of the *Convention on the Rights of Persons with Disabilities* states:

1. States Parties, in accordance with their system of organization, shall designate one or more focal points within government for matters relating to the implementation of the present Convention, and shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels.
2. States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or

[75] "Community Legal Sector Funding Announcements a Mixed Bag," *Community Legal Centres NSW* <https://www.clcnsw.org.au/community-legal-sector-funding-announcements-mixed-bag>
[76] Nicolas Patrick, Submission to the Senate Legal and Constitutional Affairs Committee, *Inquiry into Access to Justice*, 2009 <https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=fae67931–c2a4–448a–9dc8–0ab803c08780>.
[77] Ron McCallum, "*The United Nations Convention on the Rights of Persons with Disabilities: An Assessment of Australia's Level of Compliance"* (Report, October 2020) 159
[78] Ibid.

more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights.

3. Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process.

Article 33 focuses upon establishing machinery for national monitoring of the Convention in each ratifying country. Shortly after the *CRPD* came into force in May 2008, given the novelty of article 33, the Office of the High Commissioner for Human Rights prepared a thematic study on this provision for the Human Rights Council setting out the monitoring plans of several nations.[79] Now that the *UNCRPD* has been in force for more than a decade, countries are engaging in national monitoring of the Convention.

In 2019, the Australian Human Rights Commission stated that greater coordination, including monitoring mechanisms, were necessary in implementing the convention.

- Australia should establish an Office of Disability Strategy within the Department of Prime Minister and Cabinet (Australian Human Rights Commission agreed with this recommendation);
- Australian parliament should amend legislation to ensure that the Australian Human Rights Commission has the power to independently monitor the *CRPD* in accordance with article 33(2);
- Formal monitoring mechanism be established under the NDS; and
- DPOs be granted sufficient resources to carry out their monitoring functions.

[79] UN. Office of the High Commissioner for Human Rights, “Thematic Study on the Right of Persons with Disabilities to Live Independently and Be Included in the Community : Report of the Office of the United Nations High Commissioner for Human Rights” (December 12, 2014).

## 3.3 International Approach

This subsection explores the inconsistent attempts by states to ratify and enforce the *UNCRPD.* The alternate approaches by states to implement *UNCRPD* has created international complications for the recognition of the document. Many states tend to prioritise some principles depending on their agenda, meaning other key points are not enforced. The case studies of the Czech Republic, Canada and Hungary address the jurisdictional differences, further demonstrating a need for a human rights ombudsman mandate.

### 3.3.1 International Enforcement and Implementation of *UNCRPD*

The manner of the enforcement and implementation of the *UNCRPD* in the global context is not consistent. This is mainly due to the varying interpretations and ways in which signatory parties attempt to ratify and legislate as a response to uphold the values of the *UNCRPD*.

Examples of diverging responses are shown through Northern Ireland, which bases its involuntary admission to a psychiatric institution on the presence of a mental disorder plus serious risk to oneself or others and the necessity of treatment. [80] Italy, Spain, and Sweden, however, are the only countries in which the danger to oneself or others is not considered a criterion for involuntary treatment but do require, in addition to the presence of a mental disorder, “necessity” for treatment.[81]

There is evidence of another response, such as the Italian law regarding “Voluntary and Obligatory Health Checks and Treatments for Mental Illness”. This communicates that involuntary treatment can be implemented as a hospital stay in situations where there is only psychic alterations, such as to require urgent therapeutic interventions that the patient does not accept. This can also only be done in a situation where there are no conditions and circumstances that allow alternative measures to be taken.[82] This view of limiting freedom is with the intention of safeguarding the constitutional right to health, though it seems to be paradoxical.

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[80] Saya et al, Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review (2019) 10 *Frontiers in psychiatry* 271.
[81] Ibid.
[82] Saya, Anna et al, “Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry around the World: A Narrative Review” (2019) 10 *Frontiers in Psychiatry* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6501697/>

However, it is interesting to note that the Italian Court of Cassation and the Italian Constitutional Court hold differing positions regarding the duty of the psychiatrist to ensure public safety.[83] More specifically, this division is discussed in relation to the framework of the psychiatrist being responsible for public safety with regard to their patients and that of the responsibility being within the powers of the police authority. This understanding communicates that any doctor can propose compulsory medical treatment if the conditions are met.[84]

The jurisdictional differences in approaches to implementing the UNCRPD show a common approach of 'taking' some objectives of the Convention and 'leaving' others where they suit the objectives of the jurisdiction. Salient is the potential for a more intensive watchdog across many jurisdictions.[85] The necessity for a human rights ombudsman mandate is evident as the workings of these independent authorities can be necessarily exhaustive in protecting and promoting human rights whilst also reporting, investigating and advocating.

### 3.3.2 International cases examining government's interaction regarding UNCRPD

As established, forced medication and psychiatric intervention violate the universal prohibition of torture in which the UNCRPD provides the basis for this framework.[86] The Convention recognises the equal legal capacity and the free and informed consent of all persons with disabilities, with an equal right to respect for physical and mental integrity. In this way, it is imperative for signatory states to stand by their responsibility and to enforce these standards to protect the rights of those most vulnerable and at-risk, specifically in relation to forced medication as a direct violation. However, this imperative occurs with varying levels of success.

[83] Ibid.
[84] Ibid.
[85] Linda. C .Reif, Enhancing the Role of Ombudsman Institutions in the Protection and Promotion of the Rights of Persons with Disabilities. (2012).
[86] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405.

### 3.3.2.A Czech Republic

In the Czech Republic,[87] the failure to respond to breaches of the *UNCRPD* is evident in 2 complaints from the same applicant as it was argued that the Commissions did not adequately assess the complaint/s. This case exemplifies the necessity to ensure compliance with the *UNCRPD* on both a domestic and international level as the Commission only had general power to interfere with the affairs of Member States if they concerned the EU. Within this framework, the Czech Republic was not held accountable for their actions of evicting the complainant, a person with a disability, and their elderly mother to vacate a flat. Instead, the Commission argued that adopting and enforcing such acts under the *UNCRPD* is the responsibility of the signatory States in accordance "with their respective competences".[88] The inability to find common ground between the UNCRPD and domestic legislation provides avenues for the state to stand by violations of peoples with disabilities, as evident in the Czech Republic, with no real legal duty to prevent the situation from worsening.

Reflecting standards in the Czech Republic and the broader European Union, in 2011 and 2012, the Federal Constitutional Court in Germany ruled on two decisions concerning involuntary medication in forensic psychiatry, changing a decade of precedent.[89] The Federal Constitutional Court ruled that the use of involuntary medication was unconstitutional and, as a result, no longer valid and authoritative.[90] The result of this case was to create a more strict approach to the allowance of forced medication which meant it was no longer a legitimate means of psychiatric treatment. However, the Federal Constitutional Court also disagreed with the Committee's statements that all forms of forced medication, including guardianship and coercive measures, should be abolished.[91] This, similar to that of the rhetoric of the EU, believed it to be

[87] Decision in cases 1418/2016/JN and 101/2017/JN on the Commission's handling of complaints concerning the United Nations Convention on the Rights of Persons with Disabilities (2015) <https://www.ombudsman.europa.eu/en/decision/en/79080>
[88] Decision in cases 1418/2016/JN and 101/2017/JN on the Commission's handling of complaints concerning the United Nations Convention on the Rights of Persons with Disabilities (2015) s10 <https://www.ombudsman.europa.eu/en/decision/en/79080>
[89] Erich Flammer,. and Tilman Steinert., 2015. Involuntary Medication, Seclusion, and Restraint in German Psychiatric Hospitals after the Adoption of Legislation in 2013. *Frontiers in Psychiatry*, 6.
[90] Ibid.
[91] Sabine Müller., 2018. Einfluss der UN-Behindertenrechtskonvention auf die deutsche Rechtsprechung und Gesetzgebung zu Zwangsmaßnahmen. *Fortschritte der Neurologie · Psychiatrie*, 86(08), pp.485-492.

not legally binding under public international law, neither for national and/or international courts.[92]

### 3.3.2.B Canada

Evidence of arrangements that seem to be closer to *UNCRPD* compliance is reflected in Ontario, Canada.[93] Regarding treatment, including medication, an individual's capacity is determinative, in which treatments cannot be provided in circumstances where consent is refused.[94] There is no exception for compulsory psychiatric care; no individual can be forcefully medicated.[95] The interaction with the *UNCRPD* by the Canadian government shows domestic legislation that reflects the standards set out in the Convention. These standards communicate a necessity to emphasise the detriments of forced medication on the human rights of individuals, specifically those with disabilities.

### 3.3.2.C Hungary

Forced treatment to prevent deterioration of health was not justified in the case of the mandatory institutional treatment of Mr. Tamás Plesó.[96] A medical opinion claimed that he suffered from schizophrenia with grandiose delusions.[97] The European Court of Human Rights held there had been a violation of article 5(1) the right to liberty and security, of the European Convention on Human Rights.[98] This forced treatment was ordered based on the relevant sections of the Act on Health Care and the jurisprudence of the Supreme Court. Further, it was satisfied that appropriate medical treatment would improve his condition and nonparticipation in this treatment would pose a threat to his health.[99]

Plesó, however, was unwilling to voluntarily undergo this treatment, complaining that an unjustified deprivation of his liberty had ensued from his mandatory confinement, a violation of

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[92] Ibid.
[93] *The Mental Health Act,* RSO 1990, c M.7.
[94] John Dawson, 2015. A realistic approach to assessing mental health laws' compliance with the UNCRPD. *International Journal of Law and Psychiatry*, 40, pp.70-79. p76.
[95] Ibid.
[96] European Court of Human Rights (41242/08) - Court (Second Section) - Decision - PLESO v. HUNGARY.
[97] "Forced Committal to a Psychiatric Hospital to Prevent Deterioration of Health Was Not Justified," *European Court of Human Rights* (October 2, 2012)
[98] Ibid.
[99] Ibid.

Article 5(1). The application of his complaint was lodged with the European Court of Human Rights, who held that the Hungarian courts had failed to take into account that Plesó did not represent an imminent danger to himself or others, and the fact that he does not have a criminal record. In particular, the court identified that there was a lack of consideration to the reasons for Plesó's refusal to hospitalisation, the actual nature of the envisaged involuntary treatment or the medical benefits, and the possibilities of applying a period of observation. In addition, the court asserted that mandatory treatment and confinement would pose a significant danger to his health. Therefore, the Court's statements evidenced that forced treatment to prevent deterioration of health was not justified. The Court highlighted that involuntary hospitalisation may only be utilised as a last resort, considering less invasive treatments are refused, and the person would gain true health benefits without the imposition of a disproportionate burden.[100]

# 4. Relationship between *UNCRPD* and *OPCAT*

*OPCAT and UNCRPD*, both ratified by Australia, focus on similar principles against torture. With *OPCAT* as a supplement to the 1984 UN Convention against Torture, *UNCRPD* concentrates on human rights for people with disabilities.

Monitoring within *OPCAT* involves regular visits to facilities in which people with disabilities may be in detention to prevent torture and other cruel, inhuman, or degrading treatment or punishment. The inclusion of article 16 in OPCAT acknowledges that persons with a disability are a distinct category to which *OPCAT* applies, and as such, they should be afforded additional protections.[101] This is because they are particularly vulnerable to the distressing effects of torture and ill-treatment and susceptible to experiencing exacerbated distress from medical intervention, which abolishes their self-autonomy.

While *OPCAT* imposes an obligation to protect people with disabilities from exploitation, violence and abuse, the *UNCRPD* addresses these additional protections in greater detail and

[100] *Plesó v Hungary* (App. No. 41242/08) [2012] ECHR 41242/08.
[101] OPCAT (n 4) Art 16.

with respect to the specific needs of vulnerable persons with a disability.[102] State parties and signatories utilise the framework set out in OPCAT as well as the UNCRPD to facilitate acceptable standards of protection of individuals with disabilities.[103]

With respect to complaints about breaches of these international conventions, *OPCAT* involves a Committee against Torture that consists of a panel with ten independent experts who meet twice a year to consider complaints.[104] Contrastingly, the *UNCRPD's* Committee has a panel of eighteen independent experts.[105] As Australia has reserved the capacity to engage in forcible medication from a legal standpoint through its interpretation of the *UNCRPD*, this convention provides no legal recourse for those who suffer from breaches. Instead, recourse should be sought with respect to *OPCAT*. Ideally, the implementation of NPM's in 2022 will make this process much more accessible to aggrieved parties.

# 5. Forced Medication as Torture

It has been recognised that degrading and/or inhuman treatment, which is congruent with the definition of torture pertaining to these conventions, includes psychological anguish, which is intense and serious.[106] As the distress caused by forcible medication is, in fact, intense and serious, it is consistent with the definition of torture. It is important to understand that these interventions constitute torture and are unnecessary unless an imminent and acute crisis occurs, wherein an individual poses a severe danger to themselves or others. In the case of an individual having lost personal control or being under the influence of drugs, it is defensible for a chemical intervention to take place. In the report by the United Nations General Assembly, Special Rapporteur for Torture, it was stated that involuntary psychiatric interventions violate the prohibition of torture and cruel, inhuman or degrading treatment or punishment to the extent they inflict severe pain and suffering.[107]

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[102] *Convention of the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008).
[103] Ibid.
[104] Ibid 14.
[105] Ibid 18.
[106] Mental Distress (n 6).
[107] Méndez (n 10).

On this basis, when a person experiences suffering related to involuntary treatment such as forced medication, it would be considered a form of torture.[108] Additionally, past traumatic experience such as experiences of powerlessness and loss of control must be considered in determining whether an intervention should be regarded as torture, as these past experiences may amplify the trauma.[109] This is particularly important for individuals in prisons and mental health facilities. The increased distress experienced by persons with a disability through forced medication is unnecessary as there are many alternatives to this approach.

A mental health diagnosis is not grounds to justify the use of forced medication, nor is it sufficient to evaluate the risk a person may pose to themselves or the community. It is ultimately unnecessary for mentally-ill persons to have coercive methods used against them given the abundance of non-coercive measures available to treat mental illness. It should be the primary objective of any treatment that the person is able to recover in a way that is personally productive and meaningful. They must only be guided, not coerced, by outside forces, as they navigate their recovery with support where necessary.

As such, all efforts should be afforded to an individual suffering mental health issues to work with the person in their own recovery rather than causing them to feel reduced or damaged from forcible medication which, may perpetuate their mental health issues. There are a variety of methods which take this approach and are more effective in treating mental illness than forcible medication. In addition, there are a number of negative impacts of coercive means that are overcome by substituting them for non-coercive means, which will be addressed in detail below.

See Justice Actions's report 'Limits of the Power to Forcibly Medicate' for the full report on the information below.

[108] Weller (n 9).

[109] Ibid, 98.

## 5.1. Impacts of Forced Medication

The effects of forced medication are widespread. These include detrimental physical and mental health repercussions with potentially life-threatening effects.[110] Forced medication violates medical processes and deprives the agency of persons with disabilities, as it strips people of their rights and freedoms. The impacts of forced medication, as outlined below, conflict with the perceived benefits and show it is a clear breach of OPCAT.

### 5.1.1 Injection Effects

There are various negative effects of the injection of traditional first-generation and second-generation antipsychotic medication. Professor Stroup and Grey, both of whom specialise in psychiatry and psychiatric medication, report the effects following an injection of antipsychotic medication,[111] including:

- Minor effects, including mild sedation and dry mouth
- Unpleasant effects, including constipation, akathisia, and sexual dysfunction
- Painful effects, including acute dystonic reactions
- Disfiguring effects, including weight gain and tardive dyskinesia
- Life-threatening effects, including myocarditis, agranulocytosis, neuroleptic malignant syndrome and Parkinsons.[112]

Another report from the United Nations General Assembly Human Rights Council by Special Rapporteur Nowak noted that antipsychotic medications would also make the subject apathetic, as well as dull intelligence.[113]

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[110] Ilias Bantekas et al, *The UN Convention on the Rights of Persons with Disabilities: A Commentary.* (Oxford University Press, 2018) 451.
[111] T. Scott Stroup and Neil Gray, 'Management of Common Adverse Effects of Antipsychotic Medications' (2018) 17(3) *World Psychiatry* 341.
[112] Ibid; Ilias Bantekas et al, *The UN Convention on the Rights of Persons with Disabilities: A Commentary.* (Oxford University Press, 2018) 451.
[113] United Nations General Assembly, *Torture and other cruel, inhuman or degrading treatment or punishment,* (Interim Report, 28 July 2008) 16, 63.

### 5.1.2 Mental Health Effects

Forced medication has detrimental effects on mental health. It leads to disenfranchisement which is associated with a loss of self-determination, agency and violation of bodily autonomy, which can result in acute mental suffering, anguish, and distress. This severe mental distress can be worsened if an individual has prior traumatic experiences with loss of control.[114]

Moreover, the experience of these harmful mental health effects is synonymous with mental torture and control. Evidently, the physical side effects of forced medication occur in unison with detrimental mental health effects; "I experienced forced neuroleptics as torture. The harder I tried to think, the harder it was to think… I could feel how the chemical affected my vision, my movements, my thoughts."[115]

### 5.1.3 Patient Mistrust

Forced medication, forced treatment, and coercive measures are closely correlated with long-term patient dissatisfaction and disapproval, and mistrust in the medical system. These practices are more detrimental to patient satisfaction than the instances where patients are secluded or restrained. In addition, forced medication violates the medical process and creates a 'toxic' culture when utilised. This was found regardless of national or cultural values of a specific country as researched across ten different nations.[116] The threat of forced medication and coercive treatment can reduce the likelihood of people voluntarily seeking medical help.

### 5.1.4 Agency and Autonomy

In relation to the macro-effects of forced medication, this concerns protecting the agency of persons with disabilities. This works in conjunction with the current societal values and 'norms' surrounding disability and mental illness. As long as forced medication proves to be an easy option for states to administer, the progression of these norms will be stalled. It is important to

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[114] Weller (n 9) 138.
[115] Lavelle, Sandra and Kathleen R Tusaie, "Reflecting on Forced Medication" (2011) 32(5) *Issues in Mental Health Nursing* 274.
[116] McLaughlin, P., Giacco, D. and Priebe, S., 2016. Use of Coercive Measures during Involuntary Psychiatric Admission and Treatment Outcomes: Data from a Prospective Study across 10 European Countries. PLOS ONE, 11(12). p4.

principally recognise persons with disabilities as autonomous agents responsible for their wellbeing with the ability to consent to improve social attitudes. In this way, it is equally important to recognise that violating an individual with a disability's agency and autonomy through forced medication is a form of torture that has serious physical and mental side effects that proves to violate the OPCAT.

## 5.2 Alternatives to Forced Medication

### 5.2.1 Alternative Approaches to Personal Concerns

Given the dangers of forcible medication and its assault on self-autonomy, Australian jurisdictions must implement less restrictive methods so that mental health consumers can choose how to appropriately deal with their difficulties. It is critical for a democratic society such as Australia, to ensure that persons with a disability can access a wide range of non-coercive services and support from their community instead of imposing coercive measures such as forcible medication. Failure to do so would demonstrate an authoritarian approach to mental health care which is unnecessary and unacceptable.

There are a range of different models that demonstrate that adequate mental health care can be provided to individuals with difficult conditions without the need to resort to forced medication. This includes the Trieste Mental Health Model, Soteria and Open Dialogue.

The Trieste Mental Health Model is internationally recognised by WHO as a world standard within psychiatric care. The model is patient-focused and believes patients work best when given their freedoms and the dignity of choice.[117] Trieste fosters mental health through focusing on interpersonal relationships, family engagement, improved living circumstances, and job and play possibilities. It abolished the use of all coercive measures, including; involuntary treatment, closed doors, and seclusion, despite this, it is known to be very effective, cost-efficient, practical, and accepted within the community.[118]

[117] Allen Frances, "Save Trieste's Mental Health System" (2021) 8(9) *The Lancet Psychiatry* 744.
[118] Roberto Mezzina, "Creating Mental Health Services without Exclusion or Restraint but with Open Doors Trieste, Italy" (2016) 92(9) *L'information psychiatrique* 747.

Soteria is an individualised recovery program facility focused on “being with” clients in order to understand their psychosis subjectively, with limited use of antipsychotic medication (taken by choice), driven by predominantly non-medical staff.[119] These facilities are viewed as kinder alternatives to a mental hospital system that is predicated on the routine administration of psychiatric (especially antipsychotic) medications. Early intervention or crisis resolution services are occasionally provided by Soteria.

Open Dialogue (OD) is a mental health social network approach. It empowers people's families and networks to take charge of their own rehabilitation and use their own resources. OD prefers community-based therapy to hospitalisation and emphasises psychological continuity and trust between patient and staff rather than the abuse of medication.[120]

Research has been done on the response by people in hospitals confronted with the choice of forced medication or seclusion. The paper concluded that it was a personal choice depending on the person’s experiences.

A list of non-coercive options appears below. See also Justice Action’s report *‘Alternatives to Forced Medication*’ which similarly discusses a plethora of alternatives to forced medication.

(a) Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application, and scarce financial resources cannot justify postponement of its implementation;

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[119] “Soteria Programme,” *International Mental Health Collaborating Network* <https://imhcn.org/bibliography/recent-innovations-and-good-practices/soteria-programme/>.
[120] UCL, “Open Dialogue,” *UCL Psychology and Language Sciences* (March 2, 2020) <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/oddessi/open-dialogue>.

(b) Any medication must meet the health needs of the patient and must be given to the patient only for therapeutic or diagnostic purposes. Medication must never be administered as a punishment or for the convenience of others.[121]

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;[122]

(d) Employing consumer workers. These workers will be able to empathise with mental health consumers and create better outcomes as they will be able to provide individualised treatment plans, interlaced with the understanding of what an individual is going through and the stigma they often face.

(e) Use of advance directives. This tool will be a written document that allows the consumer to play an active role in their treatment plan once they become incapable of making decisions for themselves. The document will outline a medical treatment plan created by the consumer of what they consent to, by whom and where they are cared for.

(f) The appointment of an enduring guardian. This guardian will be able to make health decisions on behalf of the mental health consumer, once incapable, and have the authority to do so.

(g) The use of Cognitive Behavioural Therapy (CBT), a type of talk therapy that aims to modify undesirable modes of thinking, feeling and behaviour by using a combination of cognitive and behavioural therapy to promote healthy thought and behaviour. CBT has proven effective in improving both positive and negative symptoms of people with schizophrenia. Many schizophrenic symptoms are resistant to pharmacological

[121] *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* GA Res 46/199, UN Doc (adopted 17 December 1991).
[122] Méndez (n 10) 17.

treatment; therefore, CBT is often used in conjunction with antipsychotics. Combining the treatments has shown to be more effective than administering the drugs alone. CBT usually requires anywhere from 5-20 sessions, however, decisions are usually made following a case consultation.

(h) The use of Psychoeducation, an intervention that involves integrating emotional and motivational aspects to enable patients to cope with illness and to improve its treatment adherence and efficacy.

(i) The introduction of aerobic exercise which can help manage symptoms for individuals suffering on the general psychopathology scale, especially those who suffer with a form of schizophrenia.[123]

(j) The use of light therapy, a form of therapy that consists of controlled exposure to intense levels of light (typically emitted by fluorescent bulbs situated behind a diffusing screen). Studies have found this to be particularly advantageous in treating Seasonal Affective Disorder (SAD), as well as depression, eating disorders, bipolar depression, and sleeping disorders.[124]

(k) The introduction of music therapy, a form of therapy beneficial to those with schizophrenia and other mental disorders. The positive effects of music therapy include the improvement of: social and overall functioning, depression and anxiety symptoms, reduction in stress, attention, memory and abstract thinking.[125]

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[123] Peng-Wei Wang et al, 'Effect of Aerobic Exercise on Improving Symptoms of Individuals with Schizophrenia: A Single Blinded Randomized Control Study' (2018) 9(167) *Frontiers in Psychiatry,* 1.
[124] Joseph Woelfel, 'Seasonal Affective Disorder (SAD) Light Therapy' (2005) 21(1) *Pharmacist's Letter & Prescriber's Letter* 4.
[125] Schizophrenia Factsheet, *NeuRA* (June 2019).
<https://library.neura.edu.au/wp-content/uploads/sites/3/2013/05/Factsheet_music-therapy-2.pdf>

(l) The encouragement of sleeping and resting, which is vital in maintaining a high quality of life. There is evidence to suggest sleep disturbances are prevalent in individuals with schizophrenia, thus contributing to the exacerbation of psychotic symptoms.[126]

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[126] Stefan Cohrs, 'Sleep disturbances in patients with schizophrenia', (2008) 22, *CNS Drugs* 939-962.

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