THE RIGHT TO HEALTH

The *Convention on the Rights of Persons with Disabilities*

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In the absence of federal human rights legislation, Australia's legal obligation to respect and protect human rights derives from its adherence to core human rights treaties.[1] Australia's recent ratification of the *Convention on the Rights of Persons with Disabilities* ('the *Convention*') provides fresh and persuasive guidance on the application of the core human rights treaties to people with disabilities.[2] It provides an opportunity to re-evaluate the human rights content of Australian law.

In mental health law, current debate about the significance of the *Convention* has largely been concerned with the meaning of Article 17 (Protecting the integrity of the person)[3] on the right to respect for physical and mental integrity on an equal basis with others, and Article 12 (Equal recognition before the law) on the right to recognition everywhere as persons before the law.[4]

Pivotal to the interpretation of these Articles is the question of capacity, the structures and systems that are necessary to support a person with diminished legal capacity, and the mechanisms that may be deployed if a person lacks capacity to make decisions. These important issues tend to be overshadowed by a persistent debate about the right to refuse medical treatment. Approaching the right to health and mental health solely from a 'right to refuse treatment' perspective underestimates the importance of the right to health and mental health and the force and impact of the *Convention*.

This article argues that the development of the right to health and mental health in international human rights law, coupled with the recognition of human rights as interdependent, indivisible and interrelated, critically informs the structure and orientation of the *Convention*. In particular, the continuity and complementarity between civil and political rights on the one hand, and economic, social, and cultural rights on the other, underscores the *Convention's* injunction to provide a comprehensive range of health, mental health and social services that are acceptable to the person, culturally appropriate, and provided on a voluntary basis.

A *Convention* perspective subsumes the refusal of treatment debate within a broader and more significant discussion about the provision of appropriate health care.

An active consideration of the right to health as it is developing in international human right law assists in illuminating both the *Convention* as a whole as well as highlighting the particular importance of Article 25 (Health) on the right to the enjoyment of the highest attainable standard of health. This article outlines the developing content of the right to health, the nature of state obligations in health matters, the adoption of a social model of disability in the *Convention*, the special content of Article 25 (Health), and the principle of accountability as it applies in the health context. It concludes that the right to health requires the adoption of a human rights approach in the provision of a comprehensive range of health and social services.

The content of the right to health

The right of everyone to enjoy the highest attainable standard of physical and mental health was first articulated in the *Constitution of the World Health Organization* in 1946.[5] Article 25 of the *Universal Declaration of Human Rights* (1948) includes the right to an adequate standard of living for the health and well-being of every person and their family.[6] The *International Covenant on Economic, Social and Cultural Rights* ('ICESCR') expands that right in Article 12.[7] References to the right to health, or elements of it, appear in other core documents,[8] in regional human rights instruments,[9] and in 121 State constitutions.[10]

The right to health complements and extends the right to be free from torture and other cruel, inhuman or degrading treatment or punishment, which encompasses the right to be free from non-consensual medical treatment and experimentation as expressed in Article 7 of the *International Covenant on Civil and Political Rights* ('ICCPR')[11] It is an inclusive right that provides for the freedom to control one's own body, and extends to access to timely and appropriate health care, the prevention, treatment and control of diseases, a system of health protection, and provision of the underlying and social determinants of health.[12] Specific elements of the right include access to safe and potable water, adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[13] Non-discrimination, gender equality and the right to essential medicines are also recognised.[14] The continuous development of knowledge about health and its determinants underpins the articulation of the right to health.

The content of the right to health is guided by the principles of accessibility and availability: availability refers to quantity, distribution and functioning of public health, health care and health related facilities, goods and services,[15] and accessibility refers to physical

REFERENCES

1. See also *Human Rights Acts 2004* (ACT); *Charter of Human Rights and Responsibilities Act 2006* (Vic)

2. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 46 ILM 443 (entered into force 12 May 2008). Australia signed on 30 March 2007 and ratified on 17 July 2008. It entered into force in Australia on 16 August 2008. Australia acceded to the CRPD Optional Protocol on 21 August 2009.

3. The CRPD titles each Article to enhance accessibility. Here, each CRPD title appears in brackets following the Article number.

4. See Bernadette McSherry (ed), 'International Trends in Mental Health Laws' (2008) 26(2) *Law in Context Special Issue*; and Bernadette McSherry & Penny Weller (eds), *Rethinking Rights-Based Mental Health Law* (forthcoming).

5. 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' *Constitution of the World Health Organisation*. See <who.int/governance/eb/who_constitution_en.pdf> at 12 May 2010. The preamble adds that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'

6. *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 1st plen mtg, 71, UN Doc A/810 (1948).

7. *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), ratified by Australia on 13 November 1980.

8. *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 21 December 1965, 660 UNTS 195 art 5 (entered into force 4 January 1964); *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 1 March 1980, 1249 UNTS 13 art 12 (entered into force 3 September 1981); *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 art 24 (entered into force 16 January 1991);

Pivotal to the interpretation ... [of Convention Articles] is the question of capacity, the structures and systems that are necessary to support a person with diminished legal capacity, and the mechanisms that may be deployed if a person lacks capacity to make decisions.

accessibility in terms of location, safety and disability access and economic accessibility in terms of cost, equitable funding and insurance structures.

Health and health-related services must be provided in a culturally appropriate manner. They must be mindful of gender and life cycle issues,[16] and utilise appropriate scientific and medical technology. Health care information must also be accessible and available. All people must have the right to seek, receive and impart information and ideas concerning health information. Services must also be available on a non-discriminatory basis, with health facilities and services available and accessible to all members of the community including the most vulnerable and marginalised.[17]

The nature of state obligations

As a social, economic and cultural right, it has been assumed that the right to health is subject to the principle of progressive realisation.[18] It is now recognised that the principle of discrimination requires immediate application in order to redress inequality. The recognition that all human rights are interdependent, indivisible and interrelated further reinforces the obligation to attend to the right to health.

The concrete rights that are expressed in the right to health coalesce at the intersection of the three planes of individual autonomy, health and public health governance, and the expertise of health professionals. Applying the right to health requires consideration of each of these dimensions and the interaction between them.

Beyond the text of the international treaties, authoritative comment on their scope and meaning is provided by the committees established by the United Nations to monitor the implementation of international conventions.

The Committee on Economic, Social and Cultural Rights ('CESCR') monitors implementation of the ICESCR (1966). General Comment 14 outlines the scope of Article 12 of the ICESCR on the right to the highest attainable standard of health, and indicates that the right to health imposes positive obligations on the State to respect, protect and fulfil the right to health. The obligation to **respect** requires States to refrain from denying or limiting equal service access for all persons. The obligation to **protect** requires States to ensure that there is equal access to health care and health-related services. The obligation to **fulfil** requires States to take positive measures that enable and assist individuals and communities to enjoy the right to health. This means that people with mental disabilities must be provided with services for their health needs, including services specific to their condition of the same standard as are provided to other members of the community.

While the principle of progressive realisation tailors these obligations to accord with available resources, States have immediately applicable core obligations to ensure equal treatment, and take deliberate, concrete and targeted steps towards the full realisation of the right to health. The basic standards of a rights-based approach to health encompassed in the latter obligation includes the development of a transparent plan with clear benchmarks and indicators, the meaningful engagement of communities, and the establishment of mechanisms for monitoring and accountability.[19] In mental health, the profound effects of stigma give particular significance to the principles of non-discrimination, participation and accountability.

A social model of disability

The developing appreciation of the right to health finds expression in the *Convention*. The principle that human rights are interdependent, indivisible and interrelated[20] construes the right to health as a fundamental precondition for the exercise of other human rights. The *Convention* gives substance to the complex nature of the right by adopting a social, rather than a medical, model of disability.[21] The social model of disability addresses the environmental constraints that limit the ability of people with disabilities to engage in community life. It draws attention to the relationship between stigma, discrimination, structural inequalities, inadequate service provision and deficits in health. With regard to mental disabilities, the marginalisation produced by these interrelationships may be extreme.

Considered together, the articles in the *Convention* lay out a comprehensive program for a social model of health protection. The guiding framework for the Convention is found in Article 3 (General principles), expressed as:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
(b) Non-discrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
(e) Equality of opportunity;
(f) Accessibility;
(g) Equality between men and women;

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families opened for signature 2 May 1991, 30 ILM 1517 arts 28, 43(e) and 45(*c*) (entered into force on 1 July 2003); *Convention on the Rights of Persons with Disabilities*, above n 3.

9. *European Social Charter*, opened for signature 18 October 1961, 529 UNTS 89 arts 11, 13, 15 (entered into force 26 February 1965); *Additional Protocol to the American Convention of Human Rights in the Area of Economic, Social and Cultural Rights*, opened for signature 17 November 1988, OASTS 69 art 10 (entered into force 16 November 1999); *African Charter on Human and Peoples' Rights*, opened for signature 27 June 1981, 1520 UNTS 217 arts 16, 18 (entered into force 21 October 1986).

10. WHO, Fact Sheet 31, UN GE.08-41061, June 2008, 10.

11. *International Covenant on Civil and Political Rights*, opened for signature 16 December 1996, 999 UNTS 171 art 7 (entered into force 23 March 1976) ratified by Australia 13 November 1980.

12. See also *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978; the *United Nations Millennium Declaration*, GA Res 55/2, UN GAOR, 55th sess, UN Doc A/Res/55/2 (2000); the *Declaration of Commitment on HIV/AIDS*, GA Res S-26/2, UN GAOR, 26th sess, UN Doc A/Res/S-26/2 (2001).

13. *General Comment 14 — The Right to the Highest Attainable Standard of Health*, UN ESCOR, 22nd sess, [9] UN Doc E/C.12/2000/4 (2000). See also *General Comment 3* on the nature of States parties' obligations, Article 2 of the ICESCR.

14. WHO above n 9, 3.

15. *General Comment 14*, above n 14.

16. Ibid [12(c)].

17. Ibid [12(b)].

18. Progressive realisation means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of the right to health. See www.un.org.au.

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Considered in the context of the rights of people with mental disability the guiding principles give shape to the provisions that relate to non-discrimination, equality before the law, and the provision of health services, rehabilitation, housing, education, and communication and employment services.

Of particular relevance for people living with psychosocial disability is the obligation to provide appropriate accommodation and support in the community. For example, Article 19 (Living independently and being included in the community) requires states parties to ensure that:

> Persons with disabilities have access to a range of ... residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community ...

Similarly, Article 26 (Habilitation and rehabilitation) requires states to attend to social frameworks that:

> maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

The obligation extends to the comprehensive provision of services that precede and extend beyond acute service intervention. States are obliged to:

> organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services.

These services and programs are expected to be tailored to individual needs and based on the principle of early intervention. They must:

> begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths.

They must also support community participation and be provided on a voluntary basis.

> [Services and programmes shall be organised, strengthened and extended in such a way that they] support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

Importantly, Article 27 (Work and employment) protects the right of persons with disabilities to work on an equal basis with others. It seeks to safeguard and promote the realisation of the right to work by prohibiting discrimination on the basis of disability with regard to conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions.

Article 28 (Adequate standard of living and social protection) includes the most explicit description of the expected health and social protection measures. States parties must:

> recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.
>
> 2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:
>
> (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
>
> (b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
>
> (c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;
>
> (d) To ensure access by persons with disabilities to public housing programmes;
>
> (e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

These Articles leave no doubt that the *Convention* requires the comprehensive provision of health and health-related services. In developed western jurisdictions the chronic under-resourcing of mental health systems that followed the global movement of de-institutionalisation has resulted in (ongoing) breaches of the entitlement to health protection and health care.[22] For example, there has been a widespread failure to provide appropriate community services, a failure to provide responsive acute services, and a propensity to discharge patients from institutional care for inappropriate administrative reasons rather than for sound therapeutic purposes.[23] In Australia, the repeated observations that people with mental disabilities are overrepresented in both the homeless[24] and criminal justice populations suggest profound system failure.

The content of Article 25

Recognising the *Convention* as a document which sets out a comprehensive system of health protection allows a contextual reading of Article 25 (Health). The Article highlights the principle of non-discrimination and provides detailed requirements for the provision of health services. It emphasises the importance of providing equitable, non-discriminatory, accessible, gender-sensitive health services to all members of the disability community, including people with mental disabilities. Services must address both the general and disability-specific health needs of people with disability. People with disability must be included in sexual and reproductive health and population-based public health programs. Services are to be provided 'as close as possible to people's own communities'. Non-discriminatory obligations also extend to the provision of health and life insurance, and food and fluid. People with mental disabilities are often not provided with

19. *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc E/CN.4/2005/51 (2005).

20. *Vienna Declaration and Programme of Action Report of the World Conference on Human Rights*, UN Doc/A/CONF.157/23 (1993).

21. Gerard Quinn & Theresia Degener, *Human Rights and Disability: the Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability* (2002).

22. Lawrence Gostin, ' "Old" and "new" institutions for persons with mental illness: treatment, punishment or preventive confinement?' (2008) 122(9) *Public Health* 906, 908.

23. Terry Carney, 'The mental health service crisis of neo-liberalism — An antipodean perspective' (2008) 31(2) *International Journal of Law and Psychiatry* 101; Pauline Savy, 'Outcry and silence: the social implications of asylum closure in Australia' (2005) 14(3) *Health Sociology Review* 205.

24. Brian Burdekin, *Human rights and mental illness. Report of the National Inquiry into human rights of people with mental illness'* (1993); Mental Health Council of Australia & Brain and Mind Research Institute, *Not for Service: Experiences of injustice and despair in mental health care in Australia* (2005).

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appropriate general health services, even when they are in institutional care.[25]

The most important aspect of Article 25 (Health) for people with psychosocial disability is the requirement that health care be provided 'on the basis of free and informed consent'. This expression echoes Article 7 of the ICCPR.[26] The habit of treating people with psychosocial disabilities without their free and informed consent, often on the misplaced assumption that they lack the requisite capacity, constitutes a violation of the right to health, and is regarded as unethical conduct on the part of the health professional.[27] The *Convention* requires the development of systems that maximise the ability of people with mental disabilities to be recognised as self determining agents who are afforded a real opportunity to give free and informed consent. [28]

If a person lacks the ability to provide free and informed consent, as is contemplated in Article 12 (Equal recognition before the law), the *Convention* requires that substitute decision-making processes are guided by the 'will and preferences' of the person. The text indicates that the reference point for decision-making must rest with the person with the mental disability. This does not mean that other points of view are irrelevant. Rather, the *Convention* framework orders the weight and significance that is accorded to different perspectives.

Importantly, it displaces an objective, medically determined, 'best interests' standard as the primary measure. In *Convention* terms 'best interests' rests on a subjective determination of what the person has chosen, or would have chosen were they able to do so. While any health decision should take expert medical advice into account, and will be heavily influenced by medical wisdom, the *Convention* requires that people with disabilities, including people with mental disabilities, are afforded real decision-making opportunities, including maximum participation in decision-making at times when they have diminished legal capacity. The *Convention's* emphasis on autonomy and participation acknowledges that the question of whether the balance of social, practical and/or health related advantages and deficits that attach to any treatment decision (or treatment refusal) is acceptable, best determined by the person who is the subject of the decision. This means that objectively determined 'best interest' principle — whether it is expressed in law or influences decision-making as a professional ethical principle — must be modified to include and respect, where possible, a person's subjective determination of their own best interest. How those expressed choices impact on third parties, such as family and carers, is an additional and separate question that must also be included in the decision-making process.

Emphasising the primacy of the principle of free and informed consent also adds substance to the debate about the right to respect for physical and mental integrity in Article 17 (Protecting the integrity of the person). Whether or not a person has the opportunity to express a preference for one form of treatment or intervention over another is likely to have relevance in determining if medical treatment constitutes a violation of the Article. This may arise, for example, in instances where a person may prefer to be detained rather than receive medication. The *Convention* indicates that the determination of whether there has been a violation of physical and mental integrity should take account of the preferences of the person. Both the principle of free and informed consent and the principle of participation are grounded in the recognition that engaging with the views and ideas of people who are the subjects of an exercise of power is an essential element of a human rights approach.

Article 25 (Health) urges that the subtle, but profound, shift which must take place in health care decision-making can be achieved, at least in part, by raising awareness among health professionals of the 'human rights, dignity, autonomy and needs of persons with disabilities'. This is to be achieved by providing human rights training and supporting the 'development and promulgation of ethical standards in both public and private health care'. In *Convention* terms, the ethical standards of relevance are those that are human rights compliant.

Accountability

In addition to human rights training and support to supplement the efforts of health professionals to articulate human rights-based ethical standards, the right to health requires that systems of formal accountability are established to ensure that health, mental health and social support systems give full weight to human rights.

Article 33 (National implementation and monitoring) of the *Convention* imposes obligations on states parties to designate one or more focal points within government to monitor and coordinate the implementation of the *Convention*. It requires, moreover, that:

25. *Universal Declaration of Human Rights*, above n 7.

26. *International Covenant on Civil and Political Rights*, above n 12.

27. WHO, above n 11, 17.

28. Penny Weller, 'The Convention on the Rights of Persons with Disabilities: Developing Law and Ethics' 35(1) *Alternative Law Journal* 8.

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

The *Convention* also addresses accountability and the desirability of evidence-based program and policy planning by requiring the collection of relevant statistics in Article 31 (Statistics and data collection). These strategies complement the obligation in the right to health to establish formal mechanism of accountability, such as systems of complaint, review and judicial oversight. Accountability mechanisms contribute to an effective matrix of social and health protection.

The *Convention* in Australia

International law provides some latitude to states parties to devise appropriate responses to human rights obligations.[29] As a well-resourced nation with a history of active participation the international community, Australia is well placed to engage with the 'new era' of human rights offered by the *Convention*.[30] To do so will require a *Convention*-based evaluation of standard practices and legal frameworks, including gaps and omissions in service provision. Of particular importance in this regard will be the assessment of strategies which reduce the impact of stigma and discrimination, evaluation of service systems that facilitate prevention and early intervention, and evaluation of treatment responses that facilitate the full and sustainable integration of people with mental illness in the community on an equal basis with others. The development of integrated social service systems will provide an important counter to the crisis focus of current service provision.

The human rights sensibility of health professionals will remain an important aspect of the development of a *Convention*-based response to mental illness. Following a recent mission to Australia, the United Nations Special Rapporteur on Health Mr Anand Grover, released a statement of preliminary observations and recommendations.[31] Mr Grover noted the relationship between standards of practice and the human rights sensibility of health professionals, and urged improvement in human rights education for health professionals:

> Although ethics training is a component of current programmes, regrettably, human rights training is not included in the curricula for health professionals in Australia. The practice of health professionals has a bearing upon the various aspects of the enjoyment of the right to health such as confidentiality, consent and access to treatment. Lack of human rights training may result in violations of patients' human rights. I therefore call upon the Government to include obligatory human rights training in the curricula for health professionals.

Mr Grover also noted that people with mental illnesses in Australia are overrepresented in all types of custody, particularly in the criminal justice system.

He concluded that:

> Guaranteeing human rights protections through supportive legal and policy frameworks alongside practical, targeted interventions that place empowerment and meaningful community engagement at their centre are necessary to ensure the right to health for all Australians.

As Mr Grover's comments indicate, the *Convention* challenges elements of the structural organisation of health care.

The *Convention* also challenges some of the core assumptions underpinning Australian mental health laws. Australia lodged an interpretive declaration when it ratified the CRPD. Interpretative declarations indicate a State's understanding or interpretation of a treaty provision, but do not purport to exclude or modify the legal effect of a treaty. The declaration reads as follows:

> Australia recognises that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards;
>
> Australia recognises 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 ...[32]

While it is acknowledged that crisis intervention in mental illness may be necessary to protect a person's life and health, some disability organisations challenge the basis on which substituted decision-making arrangements and medical treatments are deemed to be necessary, challenge the operation of the principle of last resort, and query whether treatment decision-making is subject to adequate legal safeguards.[33]

Civil commitment criteria in the mental health laws in Australia generally apply to people whose mental illness is of sufficient severity to warrant intervention because the person is, or will become, a danger to themselves or others. The laws are triggered by medical assessments, and generally empower the designated psychiatrist to make treatment decisions. The uncertainty consistently attributed to predications of 'dangerousness'[34] undermines the apparent sureness of civil commitment criteria. If the prediction of dangerous is uncertain or even meaningless, the statutory ground operates as an arbitrary criterion. Similarly, doubts about the efficacy of medical treatment weaken the health-based justifications for compulsory medical intervention. This leaves open the possibility that, counter to human rights principles, mental health laws operate in an arbitrary and disproportionate manner. Furthermore, the provisions may in practice offend the requirement in Article 14 (Liberty and security of the person) of the *Convention* 'that the existence of a disability shall in no case justify a deprivation of liberty'.[35]

This analysis indicates that the statutory criteria for civil commitment warrant careful consideration. The implementation of supported and substituted decision-making strategies for treatment decisions, which are currently unrecognised in mental health laws, in conjunction with recognition of psychiatric advance directives could also bring Australian law and practice in closer alignment with *Convention* principles by enabling

29. René Provost, *International human rights and humanitarian law* (2002) 277.

30. Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: new era or false dawn?' (2007) 34(2) *Syracuse Journal of International Law & Commerce* 563.

31. Anand Grover, 'Preliminary observations and recommendations' (Press statement, 4 December 2009). < http://www2.ohchr.org/english/issues/health/right/docs/PressStatementAustralia041209.doc > at 12 May 2010. Mr Anand Grover was appointed UN Special Rapporteur for Health in August 2008. He will present his final report on the mission to Australia to the UN Human Rights Council in June 2010.

32. UN Enable — Declarations and Reservations <un.org/disabilities/default.asp/documents/convention/documents/toolaction/www.disstudies.org/default.asp?id=475> at 12 May 2010.

33. Report No 95, Joint Standing Committee on Treaties (JSCOT), 16 October 2008, Chapter 2: CRPD, para 2.7.

34. Patrick Keyzer & Bernadette McSherry, *Sex offenders and preventive detention* (2009).

35. Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law' (2009) 8(12) *Psychiatry* 496.

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the participation of the person and provide substantive safeguards to the decision-making process itself.

Conclusion

Mental health laws in Australia have been developed without reference to the *Convention*. As illustrated above, the *Convention* can provide fresh guidance in the articulation of laws, policy and standards which will give substance to the right to enjoyment of the highest attainable standard of health and mental health for people with disability, including people with mental disability. The commitment to do so must spring from a concerted engagement with human rights.

The right to health in the *Convention* imposes the obligation to develop a human rights sensibility in the provision of mental health care, improve the health protection matrix, provide services in the community, and develop legal and policy frameworks that support the right to health. The challenge in mental health is to address the need for comprehensive services and to create legal frameworks and service standards that support human rights protections. These tasks will be assisted by the incorporation of international human rights standards into federal legislation.

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