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# Freedom of Opinion and Expression: From the Perspective of Psychosocial Disability and Madness

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**Abstract:** This article argues that civil mental health laws operate to constrict how people think, understand, and speak about psychosocial disability, madness, and mental distress. It does so with reference to views and experiences of mental health service users and psychiatric survivors (users and survivors) and their/our accounts of disability, madness, and distress, such as those articulated by the emerging field of Mad studies. The analysis considers the application of the rights to freedom of opinion and expression that are enshrined in the *International Covenant on Civil and Political Rights* and other international human rights instruments to the mental health context. The article explores the suppression of freedom of opinion and expression that is effected through the symbolic violence of psychiatry and the mental health paradigm. Focusing on Australian legal frameworks, the article discusses how the material violence and coercion characterising mental health laws compound this process. It is further argued that civil mental health laws, by codifying the tenets of psychiatry and the mental health paradigm so as to render them largely unassailable, validate the ontological nullification of users and survivors. The foregoing analysis exposes dangers of adopting a functional test of mental capacity as the pre-eminent legal standard for authorising involuntary mental health interventions. It is suggested that considering freedom of opinion and expression from the perspective of psychosocial disability and madness reinforces the Committee on the Rights of Persons with Disabilities' interpretation that such interventions are incompatible with international human rights standards.

**Keywords:** mental health law; Convention on the Rights of Persons with Disabilities; International Covenant on Civil and Political Rights; psychosocial disability; Mad studies; freedom of expression; freedom of opinion; coercion; symbolic violence; capacity

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## 1. Introduction

This article examines the suppression of freedom of opinion and expression by mental health (law). The international human rights to freedom of opinion and expression are understood to act as 'enablers' for a range of civil and political rights and 'the good working of the entire human rights system' (O'Flaherty 2012, pp. 629–31). International human rights bodies have long acknowledged the importance of these rights for political participation and the democratic process, in addition to the enjoyment of the rights to freedom of assembly and association (Human Rights Committee 2011, p. 1). Further, the value of freedom of opinion and expression for the protection of social, economic, and cultural interests is increasingly recognised (O'Flaherty 2012, p. 631), including the development of societies (Sen 1999, pp. 152–54), education, and women's ability to make informed decisions of particular relevance to them (Commission on Human Rights 2000). Their application in the specific context of disabled people, including people with psychosocial disabilities, has not been a focus in international human rights discourse. The new era of disability rights heralded by the advent of the

Convention on the Rights of Persons with Disabilities (CRPD),<sup>1</sup> which embodies the indivisibility and interdependence of civil and political rights and economic, social, and cultural rights (Degener 2016, p. 5), provides an opportune moment in which to reconsider these foundational human rights.

Sections 2 and 3 explain key concepts and terms that are used throughout this article, including symbolic violence, madness, and psychosocial disability. In Section 4, I outline components of the international human rights to freedom of opinion and expression and the relevance of these rights to disability. In Section 5, I consider how the views and experiences of mental health service users, survivors of psychiatry, and other people with psychosocial disability (users and survivors) demonstrate that denial of freedom of opinion and expression is implicated in psychiatry and the mental health paradigm at multiple levels. This extends to forms of colonial and cultural oppression operating at the global level. I also discuss the growing body of knowledge of users and survivors about madness, distress and psychosocial disability. The discussion shows how the symbolic power of psychiatry and the mental health paradigm operates to constrain and silence ways of knowing, expressing, opining, and being that may be vital to a person's sense of self, a process of symbolic violence that cultivates the ontological nullification of users and survivors.<sup>2</sup>

Australian civil mental health laws<sup>3</sup> provide for an individual to be detained, or made subject to a community treatment order, in order to force mental health interventions upon them. As a federation, Australia is comprised of states and territories, each of which has its own mental health statute. Focusing on Australian legal frameworks, Section 6 provides an overview of mental health laws and reflects on debates about their compatibility with international human rights standards, paying particular attention to the concept of (in)capacity.

Section 7 describes the coercive project of mental health law and the interrelationship between the material violence and symbolic violence that are inherent in this body of law. It is argued that mental health laws solidify restrictions on the freedom of opinion and expression of users and survivors. It is further argued that, by codifying certain tenets of psychiatry and the mental health paradigm so as to render them largely unassailable, mental health laws validate the ontological nullification of users and survivors. It is suggested that these suppressive processes radically diminish opportunities for individual self-expression and for the epistemologies of users and survivors to exert influence on societal systems and structures.

## 2. Symbolic Violence

An analysis of freedom of opinion and expression from the perspective of psychosocial disability and madness illuminates the 'symbolic violence' that is perpetrated by psychiatry and the mental health paradigm and reified by mental health laws.

Symbolic violence is perpetrated where an actor, usually the State, dominates symbolic struggles in a particular social sphere—struggles over the making of meanings and construction of social realities—and thus monopolises associated symbolic power (Bourdieu 1990, pp. 135–37). The processes by which psychiatry and the mental health paradigm push aside, diminish and nullify other understandings of experiences and interactions that are labelled as 'mental illness', are increasingly recognised as involving symbolic violence (Crossley 2004, p. 172; Lee 2013). The symbolic power thereby exerted is founded on a dominant ideology, including 'fundamental precepts, such as the existence of mental 'illnesses', the pathologisation of certain behaviours/beliefs deemed socially

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<sup>1</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) (CRPD).

<sup>2</sup> 'Ontological violence' or nullification occurs when a dominant ideology delivers an interpretation that 'determines the very being and social existence of the interpreted subjects' (Žižek 2008, p. 62).

<sup>3</sup> Although similar issues are raised by forensic mental health and disability laws, my focus here is on civil mental health laws. The term 'mental health laws' is used throughout this article when referring to civil mental health laws, which are termed 'civil commitment laws' in some countries.

unacceptable and the location and the causes of mental distress' (Kinouani 2015). Flick Grey has spoken of how this ideology comprises a 'specific biomedical, diagnosis-driven universe of meaning' which silences and marginalises 'the lived truth of those in contact with the mental health system' (Coopes 2017).

In referring to the 'mental health paradigm' and the 'medical model', I am referring to systems of meaning that derive substantially from the discipline of psychiatry as a subset of medicine.<sup>4</sup> These systems of meaning, which dominate mental health service delivery, presuppose and privilege psychiatric understandings of madness and distress as involving 'illness' and 'disorder', which must be cured, fixed, and managed. The Special Rapporteur on the Right to Health has recently made recommendations aimed at addressing 'the imbalance of the biomedical approach in mental health services' (Human Rights Council 2017, p. 20). Aspects of psychiatry and mental health services may temper the excesses of this approach. For example, psychiatrists may be sensitive to their patients' social relationships and circumstances in making diagnoses, providing advice, and recommending treatment, and may attend most closely to experiences that actually seem to bother their patients. Clinicians in mental health services will reach different views, informed by their various disciplinary backgrounds and a range of ideas, which will influence real world decisions and outcomes. Certain critical strains within psychiatry emphasise 'the dangers of simply suppressing' madness 'with drugs or other means' (Critical Psychiatry 2017). Yet these forces would be hard-pressed to alter the tenets forming the very roots of these systems of meaning.

### 3. On Terminology

The CRPD was formulated after extensive deliberations, and, uniquely, input from a number of disabled people's organisations, including the World Network of Users and Survivors of Psychiatry.<sup>5</sup> The application of the CRPD to psychosocial disability is made clear in Article 1, in which it is stated that persons with disabilities include 'those who have long-term physical, mental, intellectual or sensory impairments'. Although the term 'mental impairments' is used in the CRPD, the associated disability is recognised in Article 1 as involving the interaction of such actual or perceived 'impairments'<sup>6</sup> with 'various barriers' that may hinder a person's 'full and effective participation in society on an equal basis with others'. This part of the CRPD is understood to incorporate the 'social model' of disability (see Degener 2016, p. 2).<sup>7</sup> The term 'psychosocial disability' is now commonly used by activists, advocates, and scholars applying the CRPD framework and provisions to protect the rights of users and survivors.

Madness and mental distress are in the process of being re-imagined as distinct from, and part of, disability. The choice of particular words to name and categorise a person, experience, or encounter in this context is a political choice that may operate tacitly to either preserve or resist the dominant paradigm (Burstow 2013, p. 82) and be indicative of heated conceptual battles (Diamond 2013, p. 64). Whilst 'mental health service user' and 'consumer' are terms commonly employed in government and public discourse, people on the receiving end of mental health services frequently use a variety of different terms to describe themselves. The term 'consumer', implying an acceptance of psychiatry's medical model by someone who has real choices in the marketplace, may be considered misleading given the reality of involuntary mental health interventions, and is insulting to those who have suffered psychiatric abuse (see Weitz 2003, p. 71).

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<sup>4</sup> On the hegemonic nature of psychiatric discourse see Burstow (2013, pp. 80–81).

<sup>5</sup> For the list of non-governmental organisations representing disabled people that participated in the CRPD negotiations, see United Nations Enable (2007).

<sup>6</sup> The role of the concept of 'impairment' within the social model of disability has been subject to criticism by disability theorists (for example Hughes and Paterson 1997) and doubt has been cast on the applicability of this concept to psychosocial disability (Penson 2015).

<sup>7</sup> The origins and development of the social model of disability are addressed in Barnes (2012).

Two terms that embody resistance to psychiatric discourse are ‘Mad’ and ‘psychiatric survivor’. The term ‘psychiatric survivor’ has been embraced by many to show

pride in our history of surviving discrimination and abuse inside and outside the psychiatric system, in advocating for our rights and in our personal and collective accomplishments—that psychiatric survivors are much more than a diagnostic label (Reaume 2008).

The term ‘madness’, which has in recent history been used in derogatory fashion, has been reclaimed since the emergence of the antipsychiatry movement and is used by some individuals and constituencies to affirm emotional, spiritual, and neuro-diversity (Menzies et al. 2013, pp. 10–11; Costa 2008). Rejecting the very categories of madness and sanity, Erick Fabris proposes the upper-case, proper noun ‘Mad’, to encompass people *considered* ‘mentally ill’, ‘for political action and discussion’ (Fabris 2013, p. 139).

‘Madness’ and its derivatives are controversial terms that may be considered offensive, including by many mental health service users. ‘Disability’, however, is far from achieving universal acceptance amongst users and survivors when it comes to self-identification (for example Beresford et al. 2010, pp 19–20). Jana Russo and Debra Shulkes, writing about the European user/survivor movement, have expressed concern about ‘an implicit, and sometimes openly stated, demand that we all adopt the disability framework’, particularly given that people’s ability to self-define is often already diminished by the application of psychiatric labels and diagnoses (Russo and Shulkes 2015, p. 33).

‘Mental illness’ and ‘mental disorder’ are products of the diagnostic medical model, whereas ‘psychosocial disability’ aligns with the social model of disability and acknowledges the socially constructed nature of disability. ‘Person with psychosocial disability’ is a term that can be used to refer to people who may define themselves in various ways vis-à-vis their interaction with mental health services, including people ‘who do not identify as persons with disability but have been treated as such, e.g., by being labeled as mentally ill or with any specific psychiatric diagnosis’ (World Network of Users and Survivors of Psychiatry 2008). The political value of this term is captured by Tina Minkowitz who sees it ‘as a bracketed space’, allowing for individuals to identify needs for support and assert rights-claims when necessary (Minkowitz 2014, p. 461).

My choice to use the terms ‘madness’, ‘mental distress’ and ‘psychosocial disability’ in this article represents an attempt to heed the calls of Russo and Shulkes for ‘an open-ended exploration of what different terms and concepts mean to different people’ (Russo and Shulkes 2015, p. 34), and of Alice Hall that ‘language is necessary in order to critique, challenge and re-write the stories and structures through which disabilities have been traditionally understood (Hall 2016, p. 8).’

#### 4. The International Human Rights to Freedom of Opinion and Expression

The stifling of political dissent, workers’ rights, media communications, artistic expression, and religious freedom are some of the areas that have been central to the development of domestic and international jurisprudence concerning the rights to freedom of opinion and expression. A number of international instruments have addressed threats posed to freedom of expression by expanded laws directed at combating terrorism and protecting national security and public order, such as offences of ‘encouraging’, ‘praising’ and ‘justifying’ terrorism, or engaging in ‘extremist activity’ (see Parmar 2015). A 2016 report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression stressed the potential for such measures to undermine the media, critical voices and activists (United Nations General Assembly 2016). Scholarship has taken up issues such as challenges that are associated with new information technologies, including internet governance (Benedek and Ketteman 2014), and the suppression of diverse gender identities (Nunan 2010).

The growing body of commentary about sharing and receiving ideas and information via digital technologies is particularly relevant when considering how to promote freedom of opinion and expression for people with disability (see Goggin 2017, p. 2). Yet, turning attention to disability in this sphere may yield valuable insights for theorising and implementing the rights

to freedom of opinion and expression for all people, such as by destabilising assumptions about what constitutes ‘normal’ communications and expanding possibilities for activating communication rights (Goggin 2017). Confronting the meaning of the rights to freedom of opinion and expression specifically from the perspective of psychosocial disability and madness within disability human rights law may similarly enrich wider understandings of these rights. To date, there has been little consideration of the application of these rights to the mental health context, although concerns surrounding gross limitations on freedom of opinion and expression are implicit in much activism, advocacy, and research by users and survivors and their/our allies, as will be discussed in Section 5.

The first appearance of the rights to freedom of opinion and expression in an international human rights instrument was in Article 19 of the *Universal Declaration of Human Rights* (UDHR),<sup>8</sup> which states:

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 19 of the *International Covenant on Civil and Political Rights* (ICCPR)<sup>9</sup> encompasses the right to hold opinions without interference and the right to freedom of expression, with the right to freedom of expression further enfolding

freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of [a person’s] choice.<sup>10</sup>

A notable difference between the UDHR and ICCPR formulations is that the UDHR treats freedom of opinion and expression as belonging to a single right, whereas the ICCPR demarcates two distinct rights and groups the subsidiary right to ‘freedom of information’, together with the right to freedom of expression. Whilst the term ‘freedom of expression’ dominates international legal discourse, assuming the subsumption of freedom of information within its parent right, there is a complex relationship between what may be seen as two ‘contiguous’ rights—to freedom of expression and to freedom of (access to) information (McGonagle and Donders 2015, pp. 2–6). In this article, I refer to the ‘rights to freedom of opinion and expression’ to refer to the body of rights and obligations enshrined in Article 19 of the ICCPR, which contains the ‘principal global expression of the right’ (O’Flaherty 2012, p. 633).

The Human Rights Committee, which oversees the implementation of the ICCPR, published a new General Comment on Article 19 in 2011, *General Comment No. 34: Article 19: Freedoms of opinion and expression* (General Comment No. 34). This instrument notes the interdependence of the rights to freedom of opinion and expression, ‘with freedom of expression providing the vehicle for the exchange and development of opinions’ (Human Rights Committee 2011, p. 1). The only reference to disability is in the section on ‘freedom of expression’, which makes clear that ‘all forms of expression and the means of their dissemination’ are protected by Art 19(2), and mentions sign languages in the associated list (Human Rights Committee 2011, p. 3).

The re-articulation of the rights to freedom of opinion and expression in Article 21 of the CRPD displays a much-needed focus on freedom of information and communication rights. It supplements Article 19 of the ICCPR primarily by enumerating elements concerning seeking, receiving, and imparting information and ideas through diverse technologies, modes, and communication styles. Article 21 provides the following non-exhaustive list of actions States Parties must take to realise the rights to freedom of opinion and expression:

<sup>8</sup> *Universal Declaration of Human Rights*, GA Res 217A, UN Doc A/810 91 (10 December 1948).

<sup>9</sup> *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 172 (entered into force 23 March 1976) (ICCPR).

<sup>10</sup> ICCPR, Art 19(2).

- (a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;
- (b) Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;
- (c) Urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;
- (d) Encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;
- (e) Recognizing and promoting the use of sign languages.

Article 21, which includes a requirement for States Parties to take measures to ensure that people with disability can exchange information and ideas through all forms of communication of the person's choice, can thus be seen as vital to securing the participation of people with disability in all aspects of life. The emphasis seems to have been placed upon the technical and mechanical aspects of communication. This article is primarily concerned with the openness of the substance of communications and their epistemic underpinnings.

In the wake of the CRPD's entry into force, much of the debate about protecting the human rights of people with disability, including people with psychosocial disability, has focused on the right to equal recognition before the law contained in Article 12 and the requirements for States Parties:

- to recognise that people with disability 'enjoy legal capacity on an equal basis with others in all aspects of life';<sup>11</sup> and
- to take measures 'to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.<sup>12</sup>

This debate has been substantially preoccupied with whether the CRPD permits substitute decision-making, such as guardianship and involuntary mental health interventions, and how States Parties can comply with the requirement to provide support in the exercise of legal capacity, as required by Article 12(3) (often termed 'supported decision-making'). The paradigm shift in the approach to legal capacity embodied in Article 12 of the CRPD (Beaupert and Steele 2015), as discussed in Section 6, has generated a vast body of commentary. A pivotal strand in the gradual broadening in scholarship to engage in more holistic fashion with the CRPD (for example, Arstein-Kerslake 2017; Beaupert et al. 2017) concerns the lawful material violence perpetrated against people with disability, violence that would not be tolerated in other contexts and against non-disabled bodies (Steele 2014; Steele and Dowse 2016; Spivakovsky, forthcoming).

Turning attention to the rights to freedom of opinion and expression offers promise for enhancing and complementing these enquiries in a number of respects. Applying these rights to mental health laws specifically may give additional insight into harms that are caused by the legal reification of the symbolic power of psychiatry and the mental health paradigm, including the lawful material violence constituted by involuntary mental health interventions. The Committee on the Rights of Persons with Disabilities (CRPD Committee), which is the body charged with monitoring the CRPD, has released a General Comment dealing with Article 12 of the CRPD, *General Comment No. 1: Article 12: Equal Recognition before the Law* (General Comment No. 1), concluding that substitute decision-making arrangements, including detention and other involuntary interventions pursuant to mental health laws, contravene Art 12 in addition to other provisions of the CRPD, and must therefore be abolished

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<sup>11</sup> CRPD, Art 12(2).

<sup>12</sup> CRPD, Art 12(3).

(Committee on the Rights of Persons with Disabilities 2014). One question that follows is whether an additional consideration supporting the abolition of mental health laws lies in the need to protect the ‘negative’ aspects of the rights to freedom of opinion and expression (i.e., non-intervention by the State). Given the manner in which the ‘lives, experiences and opinions’ of people with disability are fundamentally devalued and invalidated (Spivakovsky, forthcoming), the scope of States’ ‘positive’ obligations to establish legal, policy, and administrative machinery to support freedom of opinion and expression (Kenyon et al. 2017) is equally relevant.

Freedom of opinion and freedom of expression are valuable concepts because they are not limited to speech, and are therefore well-suited to encompassing the diverse modes of communication and expression that people with disability may use to interact with other people and the world. Crucially, the notion of rights to freedom of opinion and expression holds potential for disrupting the symbolic power and epistemic authority of psychiatry by validating opinions and expressions of users and survivors that conflict with the mental health paradigm. Further, an approach from this standpoint may assist in preventing the (further) pathologisation of both their/our resistance to this dominant paradigm (see Hamilton and Roper 2006, pp. 420–21; Spivakovsky, forthcoming) and their/our wider socio-political dissents (for example Metz 2009). In fact, struggles over the creation of ‘truths’ across Mad and disability activism and scholarship share groundings in resistance against assignments of impairment and illness through dominant medical epistemologies (Lewis 2013, p. 117). Karen O’Connell has interrogated the ambivalent position that eccentricity occupies in (disability) law, and the increasing tendency to pathologise eccentric behaviour, with a view to destabilising the categories of disability and normalcy (O’Connell 2017). Similarly, asserting the importance of ‘freeing’ the opinions and expressions of people with disability about their/our actual or perceived ‘impairments’ or ‘illness’—whether regarding idiosyncracies, spiritual beliefs, unusual experiences, altered states of consciousness, distress, pain, discomfort, social needs, oppression, health, or desire to be left alone—may work to dislodge, enrich, and connect apparently fixed social and legal categories.

Freedom of opinion, according to General Comment No. 34, covers ‘all forms of opinion’, ‘including opinions of a political, scientific, historic, moral or religious nature’ (Human Rights Committee 2011, p. 2). Article 19(2) of the ICCPR on the right to freedom of expression protects the exchange of ‘information and ideas of all kinds, regardless of frontiers’. In emphasising the inexhaustible nature of the forms of protected information and ideas, General Comment No. 34 lists political discourse, commentary on personal and public affairs, canvassing, discussion of human rights, journalism, cultural and artistic expression, teaching and religious discourse as being included amongst the expressions protected by Article 19 (Human Rights Committee 2011, p. 3). There is nothing to suggest that a person’s opinions and expressions about their experiences of psychosocial disability or interactions with mental health services would be excluded. In light of growing concern about the questionable evidence base for mental health interventions (see Human Rights Council 2017, pp. 7–8; Whitaker 2010) and serious physical harms and lower life expectancies that are associated with these interventions (The Royal Australian & New Zealand College of Psychiatrists 2016; Lawrence et al. 2013), the imperative to protect an individual’s ability to form their own opinions about what is happening, and should happen, to their mind and body—and to act on those opinions—is heightened.

The right to freedom of expression is subject to the restrictions set out in Article 19(3) of the ICCPR, specifically ‘restrictions as are provided by law and are necessary’:

- (a) For respect of the rights or reputations of others;
- (b) For the protection of national security or of public order (ordre public), or of public health or morals.

The circumstances in which freedom of expression will be protected under international law are circumscribed. The above restrictions do not apply to the right to freedom of opinion, which, according to General Comment No. 34, may not be infringed even during a state of emergency (Human Rights Committee 2011, pp. 1–2). I am primarily interested in exploring the nature and

implications of denial of freedom of opinion and expression for users and survivors; this article does not undertake legal analysis of whether mental health laws contravene Article 19 of the ICCPR and/or Article 21 of the CRPD. In particular, I do not examine whether restrictions that are imposed by mental health laws on the freedom of expression of people falling within their jurisdiction would come under the legally permissible restrictions.

The following section addresses the suppression of freedom of expression and opinion in the mental health context with reference to the views, experiences, and epistemologies of users and survivors and the symbolic violence that operates to marginalise these perspectives.

## 5. Unravelling the Symbolic Violence of Psychiatry and the Mental Health Paradigm

The symbolic violence of psychiatry and the mental health paradigm perpetrates diverse, sometimes blatant, and sometimes very subtle harms, by categorising the distress that people experience and facilitating a range of mental health interventions across institutional and community settings (Lee 2013). The deeply stifling and suppressive effects of psychiatry and the mental health industry have long been theorised.<sup>13</sup> Erving Goffman's work on mental asylums tracked the career of inmates and suggested that the asylum's structures, regimes, and rules imposed a status beyond the patient's control, whilst discrediting their story (Goffman [1961] 2007). Goffman's observations led him to describe asylums as 'total institutions', which radically altered inmates' personal identity (Goffman [1961] 2007). The following accounts of users and survivors confirm the thesis that psychiatry and the mental health paradigm can set in motion processes that destroy a person's sense of self.

Cath Roper has described the outcome of being psychiatrised, and co-opted into medical ways of making meaning of one's madness, and distress as follows: 'Our sense of self crumbles, our way of being in the world, what we know, how we make meaning, is disparaged and wrong' (Roper, forthcoming). Patricia Deegan, sharing her experience of being diagnosed with 'mental illness' at a young age, has said:

Our personhood and sense of self continued to atrophy as we were coached by professionals to learn to say, "I am a schizophrenic"; "I am a bi-polar"; "I am a multiple". And each time we repeated this dehumanizing litany our sense of being a person was diminished as "the disease" loomed as an all powerful "It", a wholly Other entity, an "in-itself" that we were taught we were powerless over (Deegan 1996).

The notion that an institution or worldview can radically alter someone's identity implies that there is a reprogramming of thoughts and opinions about one's self and one's place in the world. The symbolic violence of psychiatry and the mental health paradigm can stifle thoughts, foreclosing possibilities for understanding and conceptualising one's own experiences. This process can preclude the forming and expressing of other opinions and understandings about what is happening, understandings that may be vital for a person to make sense of, work through, or embrace their experiences. Instead, it can instil a complete lack of self-confidence and faith in oneself, as elucidated by Ji-Eun Lee relying on descriptions by users and survivors of how they internalised the reality offered by clinicians of their 'resistance to treatment' and 'incompetence' (Lee 2013, p. 116).

Jana Russo has encapsulated the causal connection between the symbolic violence of psychiatry and the denial of the freedom of opinion and expression of users and survivors in describing how 'finding the right words', and even thinking through one's experiences, are challenging processes when 'we constantly meet psychiatry as a point of reference' (Russo 2016, p. 76). Katie Aubrecht's description of coercion in mental health treatment demonstrates how this encounter can destroy one's sense of self to the point of being completely uncertain about one's thoughts and opinions, or feeling almost possessed by the text of 'illness':

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<sup>13</sup> Scholarship in this tradition includes the following, among many others: (Szasz [1960] 1997; Goffman [1961] 2007; Foucault [1964] 2001; Chamberlin [1997] 2012); Fabris (2011); Rappley et al. (2011); Arrigo (2012); Newnes (2016).

Under the watchful gaze of a physician, I was taught to read experiences, red cheeks, heavy hearts, and knots, as symptoms of mental illness and as tests of my character. I was constantly quizzed about how well I knew the experiences I had were actually true experiences. I couldn't be sure what I felt, liked, or wanted anymore. I did, however, become ever more familiar with what doctors felt, liked, and wanted, and that those would be the right things to feel, like, and want (Fabris and Aubrecht 2014, p. 191).

The impression that is created by such accounts is that when medical systems of meaning about madness and distress are imposed upon an individual this may actually suffocate thoughts and opinions that will enable them to express how they are feeling, what they are experiencing, and their views on what should happen and what supports—if any—they would find useful. Constructions of psychiatrised people<sup>14</sup> as 'disordered', 'incompetent' and 'dangerous' can entail epistemic disqualification of an individual as a legitimate 'knower' who can speak on their own behalf (Liegghio 2013). Further, supplanting an individual's thoughts and opinions with a system of meaning that destroys their very sense of self goes to the core of being and human dignity (see Liegghio 2013; Roper, forthcoming). This is a manifestation of 'ontological violence', described by Slavoj Žižek as occurring when a dominant ideology delivers an interpretation that 'determines the very being and social existence of the interpreted subjects' (Žižek 2008, p. 62).

Decades of resistance by ex-patients, psychiatric and mental health system survivors, consumers, mental health service users, advocates, practitioners, academics, and other allies have cultivated epistemologies grounded in experiential knowledge that challenge psy-based<sup>15</sup> understandings about 'mental illness' (Menzies et al. 2013, pp. 3–9). Whilst such dissents are often co-opted and manipulated to reinforce mental health industry agendas (Penney and Prescott 2016), different constituencies of users and survivors continue to work strategically to engage their/our own knowledge, histories and identities to build distinct visions and realities of healing, social justice, and political change (for example, Costa et al. 2012; Russo and Sweeney 2016). One spearhead of these initiatives is the emerging field of enquiry, Mad studies.

Mad studies operates as a praxis within which divergent perspectives and disciplines can connect as part of a collective project aiming to

engage and transform oppressive languages, practices, ideals, laws and systems, along with their human practitioners, in the realms of mental 'health' and the psy sciences, as in the wider culture (Menzies et al. 2013, p. 13).

Mad studies is particularly relevant when considering freedom of opinion and expression from the perspective of psychosocial disability and madness because of its explicit focus on deploying the opinions and experiences of Mad constituencies, and celebrating their expression, in order to 'contest regimes of truth' (Menzies et al. 2013, pp. 14–15). In working to transform and transcend dominant medical approaches to madness, Mad studies does not deny that users and survivors may experience 'psychic, spiritual and material pains and privations' and want help in dealing with these experiences:

To the contrary, it is to acknowledge and validate these experiences as being authentically human, while at the same time rejecting clinical labels that pathologize and degrade; challenging the reductionist assumptions and effects of the medical model; locating psychiatry and its human subjects within wider historical, institutional and cultural contexts; and advancing the position that mental health research, writing, and advocacy are primarily about opposing oppression and promoting human justice (Menzies et al. 2013, p. 10).

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<sup>14</sup> The term 'psychiatrisation', which refers to processes that construct and produce people as 'mentally ill', subverts understandings of madness and mental distress as individualised pathologies (LeFrançois and Coppock 2017, p. 165).

<sup>15</sup> Rose (1998) contends that the psy sciences (psychology, psychiatry, and other disciplines that designate themselves with the prefix psy) constitute techniques for the disciplining of human difference.

In discussing possibilities for harnessing the individual and collective experiences and knowledge of users and survivors, Peter Beresford emphasises that users and survivors have different and diverse *knowledges* and that experiential knowledge takes many forms (Beresford 2016, p. 42). Some of these knowledges are comparatively well-established (see Mills 2014, p. 144), such as the hearing voices movement, which positions the experience of hearing voices, and other unusual beliefs and experiences, as something real and meaningful (Intervoice The International Hearing Voices Network), thereby subverting explanations of such experiences as symptoms of ‘mental illness’ or ‘psychosis’. Others are emerging, such as the ‘Mad approach to grief’, which Jennifer Poole and Jennifer Ward offer up to ‘start a conversation’ about ‘getting under’, ‘feeling’, and ‘claiming’ grief, in part to challenge the increasing medicalisation of grief through the development of a broadening array of psychiatric diagnostic categories (Poole and Ward 2013). Research conducted on mental health service users’ views about their experiences of mental health issues and interactions with mental health services revealed limitations the medical model places upon people’s ability to truly make sense of the wider social context of madness and distress (Beresford et al. 2010).

Whilst such knowledges diverge in important ways, many of them share in common a dissatisfaction with the dominant medical model and the constraints that it imposes on their/our abilities and opportunities to name and make meaning of our experiences. Some users and survivors consider certain experiences labelled as symptoms of ‘mental illness’ to be meaningful processes that they wish to explore rather than numb through the use of medication (Spandler and Calton 2009, p. 245). Thus, Poole and Ward speak of ‘grief liberation practices’ run by people who have been constructed as disordered ‘because of how they expressed and communicated the pain’ and who ‘know what it is to break open the bone of grief and story it from down deep’ (Poole and Ward 2013, p. 103). These knowledges indicate that experiences that are frequently classified as symptoms of ‘mental illness’ are for some users and survivors forms of expression in and of themselves, which need to be felt, voiced, and lived through on one’s own terms. Helen Spandler and Tim Calton posit the ‘right to *experience* psychosis . . . without *forced* treatment/medication . . . but with maximum *support*’ in response to this need (Spandler and Calton 2009, p. 246), throwing into sharp relief the denial of freedom of opinion and expression that can accompany an approach which predominantly seeks to eliminate or dull such ‘symptoms’.

Article 21 of the CRPD does not explicitly direct itself to this outlook on expression and the interconnection between expression and the different epistemologies and ways of being of people with disability. On one level, the exploration in this article points to the potential limitations of the CRPD in addressing fundamental injustices connected to deference to medical epistemologies that enact ‘mental illness’ as a negative attribute residing in the mind and body in framing the social needs and political demands of people with psychosocial disability. On another level, I am using the concept of freedom of opinion and expression as a springboard to interrogate concerns which underlie and give further content to articulations and theories of rights under the banner of the CRPD. Degener writes that the CRPD provides for a new concept of ‘transformative equality’, which goes beyond combating discriminatory behaviour, structures, and systems to require positive measures that change the offending structures and address hierarchical power relations (Degener 2016, p. 24). Further engaging the substantive dimensions of the concept of freedom of opinion and expression for disabled people—in addition to procedural aspects relating to modes of, and technologies for, expression and communication—may enliven this project.

Whilst there are unifying threads in the experiences and histories of users and survivors, the potential for the Mad movement—particularly through (sometimes unwitting) attempts to universalise experiences of madness and mental distress—to itself subjugate the knowledges of marginalised individuals, communities, and identities (Gorman 2013) should be acknowledged as part of the complexity of denial of freedom of opinion and expression at work in this context. Within different constituencies of users and survivors, hierarchies that privilege and centre certain experiences can trivialise the process of meaning-making for people for whom there is no well-established knowledge

base (Grey 2017). Every person's experience of seeking access to, using, or being abused by, mental health services, and how this experience interacts with their identities, relationships, and social positionings, is unique. Yet, allowing for the expression of unique experiences may require a conscious broadening in outlook to address certain commonalities within marginalised communities. Colin King, for example, explains how the invisibility of whiteness within European psychiatry serves to obscure the neo-colonial processes underpinning diagnoses of 'psychosis' and 'schizophrenia' assigned to African and black men (King 2016). In cautioning against 'the solidification of an 'essential' Mad identity', Rachel Gorman exposes a troubling lack of engagement by the Mad movement and disability studies with analyses of race, poverty, migration, and the global (Gorman 2013).

With the onset of the Movement for Global Mental Health (Movement for Global Mental Health 2017), and the World Health Organization's prioritisation of global mental health promotion (Wildeman 2013), considerations of freedom of opinion and expression expand beyond individual and collective expressions and experiences of user and survivor constituencies towards ethno-cultural expression and freedom. In her exploration of how global mental health policy can be read as a form of colonial discourse, China Mills uncovers how psychiatric practice can become an instrument of rights violations masked as benevolent health interventions in parts of the global South (Mills 2014, pp. 4–6). Mills concerns about Global Mental Health lead her to ask: 'as this knowledge is exported as a universal standard, a global norm, what other ways of knowing are lost, or forced to speak in whispers?' (Mills 2014, p. 7). The racism and colonialism that in many respects underpins psy discourses can threaten 'the cultural survival of Indigenous spirituality and healing', impacting ongoing struggles for Indigenous sovereignty (Tam 2013, p. 297). Users and survivors in India are utilising the framework of the CRPD to contest the colonial impositions of the asylum, mental health law, and practices of segregation and exclusion that have become 'inextricably mixed into the project of providing mental health services' (Davar 2005).<sup>16</sup> The next steps in reform of laws and policies relating to mental health and disability in the global North thus have pressing socio-political implications both within and beyond its borders.

The discussion in this section has hinted at the breadth of the denial of freedom of opinion and expression that is effected through the symbolic violence of psychiatry and the mental health paradigm. It has also been suggested that such suppression of different ways of knowing, expressing, and opining cuts to the essence of being and humanness, manifesting as a form of ontological violence against the inherent human dignity that forms the foundation of international human rights.<sup>17</sup> Before considering how these harmful suppressive effects are compounded by civil mental health laws in the final section, Section 6 provides an overview of these legal frameworks and debates surrounding their compliance with the CRPD.

## 6. Civil Mental Health Laws, the Convention on the Rights of Persons with Disabilities and (In)Capacity

The trajectory of law's relationship to madness when it comes to civil confinement and control of people with psychosocial disability is often characterised as involving a central tension between 'rights-based legalism' and paternalism or clinical discretion (McSherry and Weller 2010, pp. 4–5). Mental health law reform in the global North has tended to oscillate between allowing medical professionals substantial discretion over the treatment and detention of people with psychosocial disability and requiring more extensive legal oversight of these processes (Bean 1986, p. 14). A persistent assumption underlying these reforms has been that some level of formal involuntary psychiatric intervention in the lives of individuals with psychosocial disability is necessary in order to

<sup>16</sup> The scope of this article precludes a fuller account of the relationship between freedom of opinion and expression and global mental health promotion and Western medical imperialism (see (Davar 2005; Jayawickrama and Rose 2017; Bayetti and Jain 2017; Mills 2014), for exploration of relevant intersections).

<sup>17</sup> See ICCPR, Preamble: 'Recognizing that these rights derive from the inherent dignity of the human person'.

protect health and safety. The advent of the CRPD has eroded this assumption. At present, however, mental health laws in many jurisdictions typically make provision for two classes of compulsory intervention, which are effected through a legal ‘involuntary order’:<sup>18</sup> (a) inpatient commitment or detention in a mental health facility; and (b) outpatient commitment or a community treatment order (CTO), requiring submission to mental health interventions and compliance with other conditions whilst living in community settings. Another element of formal coercion pursuant to mental health laws is the administration of unwanted drugs and procedures to individuals subject to an involuntary order.

In Australia, the statutory criteria that must be satisfied for a person to be made subject to an involuntary order<sup>19</sup> include core prerequisites that: (a) the person has ‘mental illness’ or ‘mental disorder’ variously defined;<sup>20</sup> and (b) owing to that condition, ‘treatment’ is required in order to protect the person or other people from harm. The immediacy and level of seriousness of the requisite harm varies between jurisdictions and typically extends to a risk of deterioration in the person’s condition or health. An additional requirement, often termed ‘the least restrictive alternative principle’, is that there must be no less restrictive means of providing the ‘treatment’.<sup>21</sup> Secondary statutory criteria relating to the proposed intervention may also apply, such as the need for immediate or efficacious ‘treatment’ to be provided (see Carney et al. 2011, p. 58).

A more recent arrival in four Australian jurisdictions—Western Australia, Tasmania, South Australia, and Queensland—is a requirement that the person lacks ‘decision-making ability’ in relation to, or the capacity to consent to, the proposed intervention.<sup>22</sup> Although a lack of decision-making ability is not a prerequisite to making an involuntary order in the other jurisdictions, the relevant mental health statutes do now incorporate important provisions and requirements regarding obtaining consent and consideration of decision-making ability that limit the circumstances in which involuntary mental health interventions can occur.<sup>23</sup> The closely related concepts of mental capacity and decision-making ability discussed further below, which have become pivotal in disability human rights discourse, go to the heart of the rights to freedom of opinion and expression. This is because their formulation in and through mental health, disability, and capacity laws implies that the opinions and expressions of people considered to lack mental capacity or decision-making ability are so unworthy of being taken seriously that they can be overridden.

Decision-making about involuntary mental health interventions under Australian mental health laws is primarily shared between clinicians, in particular, psychiatrists and other doctors, and MHTs (or an equivalent body such as a generalist tribunal).<sup>24</sup> MHTs are multi-disciplinary quasi-judicial bodies that are established in each state and territory, sitting at the apex of the primary decision-making

<sup>18</sup> I adopt this term to refer to the various orders that authorise involuntary mental health interventions pursuant to civil mental health or commitment laws throughout this article.

<sup>19</sup> *Mental Health Act 2014* (Vic), s. 5; *Mental Health Act 2007* (NSW), ss. 12–15 (detention) and 53–54 (community treatment order); *Mental Health Act 2015* (ACT), ss. 58 (psychiatric treatment order) and 66 (community care order); *Mental Health and Related Services Act* (NT), ss. 14–15A (involuntary admission) and 16 (involuntary treatment in the community); *Mental Health Act 2016* (Qld), s. 12; *Mental Health Act 2009* (SA), ss. 10, 16 (community treatment orders), 21, 25, 29 (inpatient treatment orders); *Mental Health Act 2013* (Tas), ss. 39 and 40; *Mental Health Act 2014* (WA), s. 25.

<sup>20</sup> Some Australian mental health statutes broaden the scope of involuntary intervention beyond people considered to have a ‘mental illness’ to cover other people with disability, such as people who are considered to be ‘mentally disordered’ or to have a ‘mentally disturbance’ or ‘cognitive impairment’ in certain circumstances: see, for example, *Mental Health and Related Services Act* (NT), ss. 15–15A; *Mental Health Act 2007* (NSW), s. 15.

<sup>21</sup> This principle does not form part of the statutory criteria that must be satisfied in order for an involuntary order to be made by the MHT in Tasmania, although it should be factored into decision making under the *Mental Health Act 2013* (Tas) by virtue of ss. 12(d) and 62(a).

<sup>22</sup> The terminology and formulations used for this criterion vary: see *Mental Health Act 2016* (Qld), ss. 12(1)(b), 14; *Mental Health Act 2009* (SA), ss. 5A, 10(1)(c), 16(1)(c), 21(ba), 25(ba), 29(ba); *Mental Health Act 2013* (Tas), ss. 7, 40(e); *Mental Health Act 2014* (WA), ss. 18, 25(1)(c).

<sup>23</sup> See *Mental Health Act 2014* (Vic), ss. 68–76; *Mental Health Act 2007* (NSW), ss. 68(h1); *Mental Health Act 2015* (ACT), ss. 78, 56. In the Northern Territory and the Australian Capital Territory one of the prerequisites is that the person lacks decision-making ability, or has refused, treatment; in the Northern Territory the standard lifts to unreasonable refusal: *Mental Health and Related Services Act* (NT), s. 14(b)(iii); *Mental Health Act 2015* (ACT), ss. 58(2)(b), 66(2)(b).

<sup>24</sup> The term mental health tribunal (MHT) will be used to refer to the MHT or equivalent body in each jurisdiction.

hierarchy (Carney et al. 2011). MHT decisions may be appealed to the courts, although appeals are not a frequent occurrence in most jurisdictions. Typically, an interim period of involuntary detention for assessment purposes can lead to a longer formal period of involuntary intervention. The MHT is in most cases responsible for making the initial involuntary order and conducting further hearings to determine if the person continues to satisfy the relevant statutory criteria on the order's expiry or the next review date. Similar criteria apply for authorising detention and making a CTO. Uniquely, in NSW, a separate lower threshold test is prescribed for making a CTO in some situations,<sup>25</sup> comparable to the standard applying to preventive outpatient commitment regimes in place in some United States jurisdictions (Player 2015, pp. 175–81).

One distinct trend in recent mental health law reform in the global North has been towards a stronger due process model, or increased procedural protections, such that laws provide for more stringent and frequent oversight by courts or quasi-judicial bodies (Carney et al. 2011, p. 5). However, recent reforms have expanded the situations in which involuntary psychiatric interventions may be authorised in several respects (Gooding 2017, p. 31). The introduction of CTOs, for example, has extended the locus of involuntary mental health interventions into the community. Whilst CTOs are now well-embedded in the Australian mental health law landscape, they have sparked controversy in other jurisdictions where they have been only relatively recently established, such as Scotland (Taylor 2016) and many parts of the United States (Player 2015, pp. 162–63). Outpatient commitment has far-reaching coercive implications, intruding into many aspects of a person's life (Fabris 2011, pp. 136–49), and the presumption that CTOs are a less restrictive alternative to detention has been called into question (Callaghan and Newton-Howes 2017, pp. 908–10). The situational context in which involuntary mental health interventions can be authorised has also broadened in some jurisdictions through changes to the relevant statutory criteria (Appelbaum 2006).

Given this trend towards *expansion*, it is imperative to continue grappling with questions surrounding the compatibility of mental health laws with human rights standards and the wider ethics of involuntary mental health interventions.

#### *The Convention on the Rights of Persons with Disabilities and Involuntary Mental Health Interventions*

Historically, mental health laws largely grounded the authority for their involuntary interventions in 'mental illness' and 'dangerousness' criteria. The shift towards 'incapacity' or 'lack of decision-making ability' as an additional or alternative rationale has commonly been viewed as a progressive development (Fistein et al. 2009). The entry into force of the CRPD has destabilised this perspective.

There is now a sharp divergence between mental health laws depending upon whether they incorporate a prerequisite that the person lacks the capacity to consent to the proposed intervention. Many commentators have pointed to the seemingly anomalous nature of mental health laws that do not include such a criterion. It has frequently been argued that this position discriminates unjustifiably against people with psychosocial disability, since informed consent is foundational to laws governing health care generally (Large et al. 2008, p. 878; Callaghan et al. 2013). Long before the entry into force of the CRPD, similar reasoning led commentators to propose the abandonment of separate mental health legislation in favour of generic health care or incapacity legislation applying to anyone lacking the capacity to consent to proposed medical treatment (Gordon 1993; Szmukler and Holloway 1998; Wand and Chiarella 2006). Thus the creep into mental health laws of incapacity-related prerequisites to involuntary interventions is often understood to be a delimiting, rights-respecting measure (Fistein et al. 2009).

The CRPD prescribes a regenerated outlook on (in)capacity, as epitomised in Article 12 (Equal recognition before the law). Article 12(1) states the underlying principle that 'persons with disabilities have the right to recognition everywhere as persons before the law'. The remaining provisions expose

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<sup>25</sup> *Mental Health Act 2007* (NSW), s. 53(3), (5).

how domestic formulations of legal capacity have undermined this principle in its application to people with disability. Article 12(2) demands recognition of the 'legal capacity' of people with disability on an equal basis with others. Legal capacity is a constitutive concept in numerous legal systems, encompassing an individual's ability to hold rights and duties (legal standing); and their ability to exercise those rights and duties (legal agency) ([Committee on the Rights of Persons with Disabilities 2014](#), p. 3). Article 12(3) provides that States Parties 'shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. The short-hand term 'supported decision-making' is often used to describe measures contemplated by Art 12(3), although this term does not appear in the CRPD's text. Different understandings of this term indicate that 'supported decision-making' 'refers to a collection of various demands . . . [which] centre upon boosting the agency of persons with disabilities, offering them resources for making choices among good options about how to live' ([Gooding 2017](#), p. 11).

Denial of the legal capacity of people with disability on the basis that they lack the mental capacity to make decisions about their/our own lives, or to participate in various private and public processes, has been endemic throughout history. People with disability who are considered to lack mental capacity have been legally prevented, for example, from getting married, voting, entering into contracts, and deciding what happens to their/our bodies and minds ([Committee on the Rights of Persons with Disabilities 2014](#), p. 2). Laws in numerous countries continue to effect deprivations of liberty and denials of legal personhood on the basis of distinct approaches to mental capacity, known as the 'status approach', the 'outcome approach' and the 'functional approach' ([Committee on the Rights of Persons with Disabilities 2014](#), p. 4). The status approach to mental capacity denies legal capacity purely on the basis of a person's status as a person with disability, or a medical diagnosis, whereas the 'outcome approach' attributes incompetence on the basis that a person has made a decision that is considered to have negative consequences ([Committee on the Rights of Persons with Disabilities 2014](#), p. 4). A third, highly-contested approach, is the 'functional approach', which denies legal capacity where a person is considered to lack mental capacity on the basis of a specified assessment process, which often involves attempting to determine 'whether a person can understand the nature and consequences of a decision and/or . . . can use or weigh the relevant information' ([Committee on the Rights of Persons with Disabilities 2014](#), p. 4).

In General Comment No. 1 on the right to equal recognition before the law, the CRPD Committee interpreted Article 12 of the CRPD as requiring the abolition of substitute decision-making regimes, such as guardianship and mental health laws ([Committee on the Rights of Persons with Disabilities 2014](#), p. 6). The Committee's view is that Article 12 is contravened when people with disability are denied legal capacity on the basis of mental capacity tests, including tests adopting a functional approach to mental capacity. This interpretation therefore inverts the long-standing view that various disability-specific regimes providing for substitute decision-making grounded in an incapacity rationale are protective, and instead casts them as discriminatory measures ([Beaupert and Steele 2015](#), p. 162). Historically, as Linda Steele explains, 'through the division of human rights subjects on the basis of mental capacity and incapacity, human rights *accommodated*, and, in fact, were *premised upon* the differential and discriminatory treatment of people with mental incapacity' ([Steele 2016](#), p. 1014). Further, General Comment No 1 ascribes multiple violations of the rights of people with psychosocial disability to mental health laws and other substitute decision-making regimes applying to people with disability, including contravention not only of Art 12 of the CRPD, but also Art 14 (Liberty and security of person), Art 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment), Art 16 (Freedom from exploitation, violence and abuse), Art 17 (Protecting the integrity of the person), and Art 25 (Health) ([Committee on the Rights of Persons with Disabilities 2014](#)).

The CRPD Committee's interpretation has precipitated candid debate about whether States Parties are under an obligation pursuant to international human rights law to absolutely prohibit involuntary mental health interventions and other substitute decision-making regimes that regulate the lives of disabled people. However, much academic and public policy discussion in the wake of General

Comment No 1 proceeds on the assumption (or reaches the conclusion) that substitute decision-making for people with disability is warranted in some circumstances, and rather considers the bases on which such arrangements are permissible in light of the CRPD's provisions. Indeed, a number of States Parties to the CRPD have entered interpretive declarations, indicating their understanding that substitute decision-making regimes do not breach the provisions of the CRPD.<sup>26</sup> A prominent interpretation of Article 12 is that a functional approach to mental capacity is the dividing line between laws that are consistent with, and those that infringe, the CRPD (for example Dawson 2015). This position corresponds in many respects with earlier analyses that general incapacity or health care laws, rather than mental health laws, should govern the situations when others can make decisions about the lives and bodies of people with psychosocial disability with a view to providing health care.

In 2014, the Australian Law Reform Commission (ALRC) completed a landmark review of equal recognition before the law and legal capacity for people with disability, which considered the implications of the CRPD for domestic law reform (Australian Law Reform Commission ALRC). The Commission noted the interchangeable nature of a functional approach to mental capacity and a test of 'decision-making ability' (see Australian Law Reform Commission ALRC, pp. 71–72), variations of which now form part of the prerequisites for making an involuntary order in the mental health statutes in four Australian jurisdictions, alongside various combinations of the core and secondary criteria, as noted above.<sup>27</sup> A test of 'decision-making ability' assesses a person's mental capacity based on factors such as their ability to understand, retain, and weigh information that is relevant to a specific decision and to communicate that decision (Australian Law Reform Commission ALRC, pp. 200–1). The ALRC considered that an assessment of 'decision-making ability' that delinks this concept from diagnosis or disability and focuses on assessing the support a person needs to exercise legal agency avoids the pitfalls of a status approach to mental capacity (Australian Law Reform Commission ALRC, pp. 70–73). According to the CRPD Committee, a functional approach to assessing mental capacity (or decision-making ability) is flawed, firstly, because it is discriminatorily applied to people with disability, and, secondly, because it 'presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment . . . denies . . . [them] a core human right' (Committee on the Rights of Persons with Disabilities 2014, p. 4).

Functional abilities in the mental health context are determined with reference to medical and psy-based epistemologies that defer to psychiatry, via a process turning in large measure on a person's 'mental illness' diagnosis and status as a person with a psychosocial disability that judges their views about interventions proposed by psychiatrists and other clinicians. For example, the first requirement of the Queensland incapacity criterion is that the person must be 'capable of understanding . . . that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing'.<sup>28</sup> This formulation demands that a person, to be considered as having mental capacity, must form and express opinions about their experiences that align substantially with medical conceptions of 'mental illness'. It is unlikely that delinking decision-making ability from diagnosis or disability in the wording of a mental health statute would disturb these mechanisms. Accordingly, Steele and I contend that a test of 'decision-making ability' to determine whether involuntary mental health interventions are warranted is a veiled status approach to mental capacity (Beaupert and Steele 2015, 2017).

As discussed in the following section, the gradual encroachment of an incapacity or 'lack of decision-making ability' prerequisite to involuntary mental health interventions carries with it significant risks associated with codifying the notion that there is an intrinsic association between incompetence and psychosocial disability.

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<sup>26</sup> For example, Australia, Ratification (with Declarations), registered with the Secretariat of the United Nations 17 July 2008, 2527 UNTS 289 (date of effect 16 August 2008).

<sup>27</sup> *Mental Health Act 2016* (Qld), ss. 12(1)(b), 14; *Mental Health Act 2009* (SA), ss. 5A, 10(1)(c), 16(1)(c), 21(ba), 25(ba), 29(ba); *Mental Health Act 2013* (Tas), ss. 7, 40(e); *Mental Health Act 2014* (WA), ss. 18, 25(1)(c).

<sup>28</sup> *Mental Health Act 2016* (Qld), s. 14(1)(a)(i).

## 7. Juridical Denial of Freedom of Opinion and Expression: Interlocking Material and Symbolic Violence

Whilst much of this article is concerned with symbolic violence, the denial of freedom of opinion and expression that occurs in the mental health context is deeply bound up in material violence. As Steele has written, non-consensual medical treatment, detention, and physical and chemical restraint are exceptionally legally permissible when applied to people with disability under particular legal frameworks, comprising forms of ‘disability-specific lawful violence’ (Steele 2014). Mental health laws form one such legal framework, which legalises acts that would amount to civil and/or criminal wrongs, such as the crimes of battery and assault, if perpetrated in other contexts and against nondisabled people (see Steele 2014). This section, firstly, considers how the (threat of) material violence produced by involuntary mental health interventions intensifies the denial of freedom of opinion and expression that is effected through the symbolic violence of psychiatry and the mental health paradigm. Secondly, it is argued that the medico-legal discourse of mental health laws, by consecrating this symbolic violence, operates to manipulate and nullify individual ways of knowing and being, and to radically diminish opportunities for the epistemologies of users and survivors to exert influence on societal systems and structures. Constructions of people with psychosocial disability as lacking capacity and ‘insight’ are central to these processes of dehumanisation.

### 7.1. *The Suppressive Effects of Mental Health Law’s (Threat of) Material Violence*

The coercion, control, and force effected upon users and survivors through Australian mental health laws operate at multiple levels. A formal involuntary order provides the overarching mandate for the forced administration of specific drugs and procedures to an individual. On a day to day basis, clinicians are for the most part responsible for authorising the administration of drugs and other interventions.<sup>29</sup> MHT or other independent authorisation is typically only mandated for the performance of more exceptional procedures, such as electroshock and neurosurgery, in specified circumstances.<sup>30</sup> Even where clinicians are obliged to consult individuals who have involuntary status before providing or administering drugs or undertaking procedures, or to seek their informed consent in the first instance,<sup>31</sup> there is an expectation that ‘treatment’ will be provided. Drugs and procedures may be forced upon a person against their will, and even if they are considered to have the capacity to give informed consent, with the exception of electroshock and neurosurgery in some jurisdictions.

Many users and survivors characterise their interactions with mental health services and detention in mental health facilities as involving violent, torturous assaults on their bodies and minds (for example Lee 2013, p. 110). The experience of being in a psychiatric ward, which may include being placed in seclusion and administered with unwanted drugs, can be physically, psychologically, and emotionally harmful and oppressive. Being forcibly administered with drugs or procedures has been described by users and survivors as a terrifying and degrading experience that ‘breaks the spirit’ (Lee 2013, p. 112). Forced administration of drugs also produces painful and damaging physical effects. Fabris uses the term ‘chemical incarceration’ to describe the prolonged imposition of drug treatment without a person’s consent, regardless of whether the treatment is administered pursuant to mental health laws or in other contexts such as schools, prisons and hospitals (Fabris 2011, pp. 114–31). Drugging of individuals in nursing homes or of people with cognitive disability or intellectual disability in residential homes, for example, would equally be covered.

<sup>29</sup> In the Northern Territory and Tasmania, the MHT is responsible for pre-approving treatment to be provided to a person subject to involuntary treatment, although clinicians can administer treatment outside this authority in specified circumstances: *Mental Health and Related Services Act* (NT), s. 55; *Mental Health Act 2013* (Tas), s. 41(2)(c).

<sup>30</sup> *Mental Health Act 2014* (Vic), s. 96 (electroshock), s. 102 (neurosurgery); *Mental Health Act 2007* (NSW), s. 96 (electroshock); *Mental Health Act 2015* (ACT), s. 157 (electroshock); *Mental Health Act 2016* (Qld), s. 236 (electroshock), s. 239 (non-ablative neurosurgery); *Mental Health Act 2009* (SA), s. 42 (electroshock), s. 43; *Mental Health Act* (WA), Pt 21, Div 6 (ECT), Pt 21, Div 7 (neurosurgery).

<sup>31</sup> For example, *Mental Health Act 2014* (Vic), s. 70.

The process of chemical incarceration, which is an embodied, visceral, physically violent process induces physical effects, such as numbing, fatigue, and cognitive restriction, which render an individual malleable and weaken their ability to resist; the chemical impact of the drug on the brain 'leads to pacification' (Fabris 2011, p. 115). It appears that the physical effects of drugging can reinforce the oppression involved in the 'textual' diagnostic and 'treatment' process, through suppressing abilities to form opinions and to 'seek, receive and impart information and ideas'.<sup>32</sup> Thus one's own body can become an alien place of interlocking material and symbolic imprisonment, as evidenced by Aubrecht's description of coercion in mental health treatment:

What you describe as chemical incarceration, for me, meant being restrained in what felt like someone else's body. Pharmaceutical reason confined me within a glass bubble that separated me from my body and my body from the world. Voices were muffled, and responses were delayed and over determined. Within a biomedicalized world of one, I was encouraged to imagine the medication as a guide that would lead me to adjust to the timelines of respectable 'reality' (Fabris and Aubrecht 2014, p. 191).

Not everyone who is subject to involuntary mental health interventions is administered with drugs through the use of physical force. Some people 'consent' or 'acquiesce'. Yet, the coercive project of mental health law manifests in pernicious fashion at this point, where a person may be faced with a 'choice' of refusing proposed interventions and being detained or subject to a CTO for even longer, or 'agreeing' and being returned to a situation that more closely resembles their daily life.

Choice is limited in the mental health context, where medication is presumed necessary and service provision is predicated on the ability to use physical force to ensure compliance. Sjöström's work has shown how the 'coercion context' of the mental health paradigm can be leveraged so as to secure individuals' 'consent' to mental health interventions across both involuntary and voluntary settings, blurring the boundary 'between coercive measures and patients' voluntary acceptance of treatment' (Sjöström 2006, p. 37). A study of patient perceptions of 'leverage' in community mental health settings showed that the pressures experienced by users and survivors come not only from within mental health services, but also beyond, and extend beyond pressure to comply with 'treatment' as an end in itself, to pressures to maintain 'treatment' and 'stay well' in order to secure other 'gains' (Canvin et al. 2013); access to critical social services, such as housing support or social security, may effectively be contingent upon individuals' compliance with psychiatric interventions in some cases. Even where clinicians do not actively use informal coercion to secure their patients' compliance, knowledge that formal coercion is a possibility can lead people to 'internalise' the notion that drugs and medical procedures are necessary (Rogers 1998). The nature of 'informed consent' becomes particularly tenuous where formal coercion is legally permissible (Carney et al. 2007).

Mental health laws embed coercive forces throughout numerous aspects of the lives of users and survivors. These forces extend to lawful violence prior to the making of an involuntary order, such as where police are empowered to apprehend a person and transport them to a mental health facility. Social and relational pressures and informal coercion may be overlaid upon the numbing effects of medication, which are sometimes administered deliberately to induce compliance with other drugs (Minkowitz 2007, p. 424). Further, methods of inducing compliance can extend to coercing individuals to adopt particular behaviours to demonstrate their recovery, such as women being 'pressured to put on makeup and present a more feminine appearance as a sign of 'getting better' (Minkowitz 2007, p. 424). Guilaine Kinouani concisely captures the catch-22 situation users and survivors who seek to resist hegemonic forces within mental health services can find themselves in:

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<sup>32</sup> See ICCPR, Art 19(2) (enshrining the right to freedom of expression).

I can choose to accept a diagnosis of psychosis and find it useful. However, the fact remains that not doing so may well mean that I cannot access services, that I am deemed to lack insight and thus subjected to more oppressive forms of ‘treatment’ (Kinouani 2015).

The domination of lawful violence in the mental health context can thus wear down an individual’s will to resist, constraining the ability to express one’s opinions and potentially ‘changing the personality’ by destroying ‘identity, self-concept, relationship to the world, and inner subjective experience’ (see Minkowitz 2007, p. 421) through an elaborate interplay of formal and informal coercion.<sup>33</sup>

## 7.2. Medico-Legal Incapacitation of the Expressions, Opinions and Epistemologies of Users and Survivors

Fiona Campbell’s work on the relationship between law and disability explains how law partners with medicine in rendering disability within ‘official’ realities that reinforce negative attitudes and stereotypes about disability, for example, through narratives of tragedy, suffering, and catastrophe (Campbell 2009, pp. 34–37). The dialectic relation between law and psychiatry similarly encodes medico-legal expressions which invalidate people ‘for their articulated and lived difference’ (Arrigo 2012, p. xxii); for people with psychosocial disability oppressive medico-legal narratives frequently revolve around ‘risk’ and ‘incompetence’ (Liegghio 2013). Legal rendering of disability can impose official definitions and categories of ‘deficiency’ based on medical categorisations which deny the private realities, opinions and expressions of people with disability (Campbell 2009, p. 37). Mental health laws providing for involuntary mental health interventions operate to embed psychiatry’s configurations of madness and mental distress, to the exclusion of other understandings.

MHTs have been observed to ‘mould’ the information presented to them by the parties to their proceedings into a form that satisfies the prerequisites for involuntary intervention, frequently deferring to clinical opinion. Jill Peay’s study of MHTs operating under the *Mental Health Act 1983* (Eng and Wales), concentrating primarily on ‘restricted’ or forensic patients, found that the tribunals routinely endorsed clinical recommendations, ‘almost irrespective of the content of the recommendation’ (Peay 1989, p. 209). The study observed the misapplication of the relevant statutory criteria via a ‘back-to-front’ process, whereby some MHT panels reasoned backwards to a pre-determined outcome, heavily influenced by pragmatic considerations, such as subjective assessments of risk (even very low level risk) and available support options (Peay 1989). According to a later study conducted in the same jurisdiction by Elizabeth Perkins, clinical judgments about a person’s ‘insight’ into their alleged condition and compliance with proposed interventions tended to be uncritically accepted by MHT panels operating under civil mental health laws, and witnesses and narratives were placed on a ‘credibility’ spectrum, which positioned patients’ narratives as least credible when weighing up the evidence (Perkins 2003).

Turning to Australian MHTs applying civil mental health laws, research on the use of the concept of ‘insight’ by Victorian MHT panels found that this concept allowed panels to ‘medicalize arguments put forth by persons subjected to mental health review board hearings, thereby framing the person’s self-perceptions and choices as evidence of pathology’ (Diesfeld and Sjöström 2007, p. 98). Observations of MHT hearings conducted by Carney et al.’s comparative study of Australian MHT operations found that even where the opinions of the person at the centre of proceedings were sought by panels, they were ‘sometimes ... treated as an exhibit, in that their performance and behaviour at the hearing [was] judged as evidence pertaining to their mental illness’ (Carney et al. 2011, p. 215). In these situations, the person’s opinions and expressions were largely used as a means of establishing evidence of mental illness, lack of insight, and non-compliance with clinical advice. Constructions of people with psychosocial disability as ‘incompetent’ are a primary mechanism by which they/we are marginalised, silenced, and, ultimately, ‘disqualified as legitimate knowers’ (Liegghio 2013, p. 126). Maria Liegghio has described how such ‘epistemic disqualification’ effectively

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<sup>33</sup> On law’s violence, and the violence and coercion that inhere in judicial interpretive acts, see Cover (1986).

renders individuals out of existence (Liegghio 2013, p. 124). Further embedding a functional approach to mental capacity in mental health laws as a pivotal prerequisite to involuntary mental health interventions, by codifying the association between psychosocial disability and incompetence that is already implicit in these laws, risks exacerbating this invalidation of the ways of knowing and being of people with psychosocial disability.

General Comment No 34 states that the rights to freedom of opinion and expression in the ICCPR prohibit ‘any form of effort to coerce the holding or not holding of any opinion’, and that ‘freedom to express one’s opinion necessarily includes freedom not to express one’s opinion’ (Human Rights Committee 2011, p. 3). In maintaining that involuntary mental health interventions contravene the universal prohibition of torture, Minkowitz has comprehensively described the abusive nature of the process of obtaining information and a ‘confession’ from people who resist psychiatric diagnosis and treatment (Minkowitz 2007, pp. 421–25). MHT processes can entail a further element of coercion of individuals into particular admissions and understandings of their situation, and the consolidation of these admissions and understandings as the official version of events that justifies making an involuntary order. For example, a process of intense questioning in pursuit of a certain response was observed by Perkins’ study where MHT panels felt that clients were hiding something. Perkins termed this approach a “catching out’ technique’: leading questions were asked to lure patients into revealing the presumed truth regarding their condition and their understanding of their condition (Perkins 2003, p. 72). Some MHT panels go to great lengths to establish whether a person *accepts* that they have a mental illness and need medication to alleviate their condition. If a person does not succumb completely to the medico-legal understanding of the compliant, ‘insightful’ patient, mental health law may re-invent them as ‘incompetent’, and therefore eligible for involuntary mental health interventions.

Historically, users and survivors who seek to resist the medical model and the mental health paradigm have frequently been denied the symbolic capital that is necessary to make their/our own meanings about psychosocial disability, experiences of madness and mental distress, and encounters with mental health services.<sup>34</sup> Mental health laws reinforce this process of epistemic invalidation, which is so deeply embedded within laws and cultural practices that it is largely invisible. This legal interpretive process causes a kind of ‘overlock’, that strengthens and prevents fraying of the symbolic power of psychiatry. Official discourses can stabilise and compound the appearance of ‘lawful violence’ in the disability sector as therapeutic and necessary at the structural level (Spivakovsky, forthcoming). I suggest that one consequence of the denial of freedom of opinion and expression that is effected through mental health laws is to systematically wrest symbolic power from people with psychosocial disability by conferring an ‘absolute, universal value’ on the symbolic capital that is possessed by psychiatry (see Bourdieu 1990, p. 136).

Dinesh Wadiwel has analysed how systems of violence against people with disability both ‘materially produce disability’ and constitute an ‘epistemic problem’, where regularised violence and torture are simultaneously concealed and reconstructed as benevolent and necessary (Wadiwel 2017; see Steele 2014). Wadiwel suggests a connection between the failure to name material acts of violence against people with disability and the epistemological construction of people with disability as ‘not having a dignity to violate’ (Wadiwel 2017, p. 389). The epistemological struggle that is demarcated in this article similarly implicates a denial not only of legal personhood, but also an ontological nullification of humanness—the designation of a border between who is and is not considered a human to be treated with dignity and whose experiences, opinions, thoughts and feelings should be respected and acted on (see Roper, forthcoming). Further, the legal codification of people with psychosocial disability as lacking capacity, through mental health laws, may materially construct

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<sup>34</sup> See Bourdieu regarding the situations in which people are denied the ability to imprint meaning upon the structure of social space through the operation of symbolic violence (Bourdieu 1990, pp. 134–35).

individuals as not having a dignity to violate, weaving these negative constructions into both a person's sense of self and the official records that will influence future legal and administrative decision-making about that person.

In affirming that people with disability are rights-holders who enjoy legal capacity on an equal basis with others in all aspects of life, the CRPD arguably strives towards contestation of the symbolic violence that has pervaded society's relationship with disability and madness. This is evident from the statement of the Committee on the Rights of Persons with Disabilities in General Comment No. 1 on Article 12 of the CRPD that mental capacity is 'contingent on social and political contexts, as are the disciplines, professions, and practices, which play a dominant role in assessing mental capacity' rather than being 'as is commonly presented, an objective scientific and naturally occurring phenomenon' (Committee on the Rights of Persons with Disabilities 2014, p. 4). Acknowledging the contingent nature of 'mental capacity' not only exposes as discriminatory the historical denial of the legal capacity of people with disability, but also disrupts the very categories of mental capacity and incapacity and any attempts to define legal capacity with reference to these categories.

It is unsurprising that reflection on denial of freedom of opinion and expression in this context animates the debate about the right to equal recognition before the law enshrined in Article 12 of the CRPD. The demand of Article 12 targets the coercion underpinning and effected through mental health (law) at the points of convergence between the material violence and symbolic violence of this body of law. The analysis in this article suggests that allowing the State to inflict material violence upon its citizens, and other people within its territory, in the form of involuntary mental health interventions systematically stifles attempts to think, feel, opine, express, and imagine outside of psychiatry's schema. This may hinder recognition and further development of the epistemologies of users and survivors, as well as stifling individual self-expression. Ending involuntary mental health interventions may significantly expand possibilities for the lived truths of users and survivors to shape the responses and support options that are available to people with psychosocial disability at individual and structural levels. These considerations add weight to the interpretation of the Committee on the Rights of Persons with Disabilities that substitute decision-making pursuant to mental health laws contravenes Article 12, and other provisions, of the CRPD.

## 8. Conclusions

This article has examined aspects of the relationship between the rights to freedom of opinion and expression and madness and psychosocial disability. I explored how the symbolic violence of psychiatry and the mental health paradigm operates to suppress the opinions and expressions of people with psychosocial disability. This enquiry was in part guided by experiences and epistemologies of mental health service users and survivors of psychiatry. I discussed how the denial of freedom of opinion and expression that is effected through the symbolic violence of psychiatry and the mental health paradigm is compounded and consecrated when wielded as part of the coercive project of mental health law. I argued that codifying 'incapacity' as a prerequisite to involuntary mental health interventions may further amplify this process. I also argued that mental health (law) may produce a form of ontological violence, fundamentally altering the opinions, expressions, and ways of being of people with psychosocial disability. Finally, I suggested that these combined considerations reinforce the interpretation of the Committee on the Rights of Persons with Disabilities that Article 12 and other provisions of the CRPD require the absolute prohibition of involuntary mental health interventions.

My exploration of the rights to freedom of opinion and expression from the perspective of psychosocial disability and madness ultimately folded back into mental health law's problematic of coercion. This problematic entails a mutually reinforcing relationship between the material violence that is immanent in denial of legal personhood under civil mental health laws and the symbolic violence of psychiatry and the mental health paradigm. It also connects to scholarship and debates about the deployment of medico-legal and psychiatric epistemologies in ways that silence the political resistance and claims of marginalised groups at the intersections of different coercive legal frameworks,

such as people in immigration detention (Joseph 2016) and incarcerated people labelled as ‘mad Muslim terrorists’ (Patel 2014).

Probing the contours of the denial of freedom of opinion and expression that permeates involuntary mental health interventions holds value, for people with psychosocial disability and beyond, because it demands, in the first instance, a ‘stripping bare’ to the immediate wishes, feelings, concerns, and communications (or attempts to communicate) of individuals and constituencies. This may assist in delineating physical, psychical, social and political aspects of these opinions and expressions and their connections to different political and historical struggles. Giving effect to the requirement in Article 4(3) of the CRPD to ‘closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations’ in developing and implementing laws and policies to implement the CRPD calls for direct and genuine engagement with the opinions and expressions of disabled people.

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