SILENCING PROTE(X)T: DISRUPTING THE SCRIPTS OF MENTAL HEALTH LAW

FLEUR BEAUPERT*

This article interrogates how civil mental health law providing for forced mental health interventions defines and produces vulnerability. Drawing on the work of Judith Butler, a concept of 'intercorporeal vulnerability', emphasising ways in which vulnerability may be generated through the interaction between sociopolitical forces and human bodies, is adopted. Vulnerabilities arising in the mental health law context which tend to be unrecognised or disavowed in a manner that reaffirms dominant discourses about madness, disability and normalcy are identified. Based on this analysis, it is argued that formal deployment of 'vulnerability' within disability law and policy may problematically reinscribe disability within a negative vulnerability status. It is further argued that methodological approaches examining intersections between different sites of identity, power and historicity are imperative to ensure that injustice and inequality can be named, exposed and challenged. The productive and transformative potential of the relationship between vulnerability and resistance is also considered.

I INTRODUCTION

The term 'vulnerability' is increasingly used within a range of legal, policy and service contexts. Numerous scholars have been refining and building upon theoretical understandings of vulnerability with a view to better integrating this concept in law, policy and bioethics in order to achieve substantive equality.[1]

* BA, LLB, PhD (University of Sydney); Independent Researcher. I wish to thank the two anonymous reviewers, Dr Shelley Bielefeld, Cath Roper, Dr Claire Spivakovsky and Dr Linda Steele for their comments on an earlier version of this article. The article is based on a paper presented at the 2017 Conference of the Law, Literature and Humanities Association of Australasia on 13 December 2017 (Dispositions of Enabling/Disabling stream). I am grateful to the session participants and attendees for their feedback on the paper.

1 See, eg, Martha Albertson Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 *Yale Journal of Law and Feminism* 1; Martha Albertson Fineman and Anna Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate, 2013); Wendy Rogers, Catriona Mackenzie and Susan Dodds, 'Why Bioethics Needs a Concept of Vulnerability' (2012) 5(2) *International Journal of Feminist Approaches to Bioethics* 11; Catriona

Some have undertaken analyses demonstrating that the political deployment of vulnerability, despite benevolent aims, can reify marginalised groups as essentially vulnerable and produce detrimental consequences.[2] Analysing the impact of compulsory income management regimes upon Indigenous welfare recipients, Shelley Bielefeld has shown how 'vulnerability can operate as a slippery concept, something that can be used and abused at will in political and legal discourse whilst undermining the autonomy and dignity of those to whom it is applied'.[3] These effects may be exacerbated when the goals of protecting the wellbeing of an apparently vulnerable group, and upholding the autonomy of individuals within the group, exist in tension within the text of a particular legal framework. Several disability law regimes, including mental health law, are cases in point.

Focusing on law and policy in New South Wales ('NSW'), this article interrogates how civil mental health law[4] providing for forced mental health interventions defines and produces vulnerability. I draw attention to limitations of conventional understandings of mental health law as operating primarily to shield vulnerability by protecting and treating individuals. I identify ways in which mental health law *generates* vulnerability by establishing biomedical understandings of 'illness' and assessments of 'incapacity' in positions that are extremely difficult to challenge,[5] and facilitating violent and coercive interventions in lives, minds and bodies.

This article begins in Part II by discussing the theorising of vulnerability and its relevance for disability law and policy reform. I discuss the leaning towards 'ontological vulnerability' within much vulnerability scholarship and some of the problems with this approach. Drawing on the work of Judith Butler and

---

Mackenzie, Wendy Rogers and Susan Dodds (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford University Press, 2013); Florencia Luna, 'Elucidating the Concept of Vulnerability: Layers Not Labels' (2009) 2(1) *International Journal of Feminist Approaches to Bioethics* 121; Henk ten Have, *Vulnerability: Challenging Bioethics* (Routledge, 2016); Jonathan Herring, *Vulnerability, Childhood and the Law* (Springer, 2018); Ingrid Nifosi-Sutton, *The Protection of Vulnerable Groups under International Human Rights Law* (Routledge, 2017); Julie Wallbank and Jonathan Herring (eds), *Vulnerabilities, Care and Family Law* (Routledge, 2014); Jonathan Herring, *Vulnerable Adults and the Law* (Oxford University Press, 2016).

2 Andrea Hollomotz, *Learning Difficulties and Sexual Vulnerability: A Social Approach* (Jessica Kingsley Publishers, 2011); Vanessa E Munro and Jane Scoular, 'Abusing Vulnerability? Contemporary Law and Policy Responses to Sex Work in the UK' (2012) 20 *Feminist Legal Studies* 189; Nina A Kohn, 'Vulnerability Theory and the Role of Government' (2014) 26 *Yale Journal of Law and Feminism* 1, 14–15; Shelley Bielefeld, 'Cashless Welfare Transfers for "Vulnerable" Welfare Recipients: Law, Ethics and Vulnerability' (2018) 26(1) *Feminist Legal Studies* 1.

3 Bielefeld, 'Cashless Welfare Transfers for "Vulnerable" Welfare Recipients', above n 2, 15. See also Shelley Bielefeld, 'Compulsory Income Management and Indigenous Peoples – Exploring Counter Narratives amidst Colonial Constructions of "Vulnerability"' (2014) 36 *Sydney Law Review* 695; Shelley Bielefeld, 'Compulsory Income Management and Indigenous Australians: Delivering Social Justice or Furthering Colonial Domination?' (2012) 35 *University of New South Wales Law Journal* 522.

4 Throughout this article, the term 'mental health law' is used to refer primarily to civil mental health law regimes. However, many of the points raised are also relevant to forensic mental health laws and other coercive disability law regimes.

5 This argument relates to the propensity of mental health law to suppress freedom of thought, expression and opinion: see Fleur Beaupert, 'Freedom of Opinion and Expression: From the Perspective of Psychosocial Disability and Madness' (2018) 7(1) *Laws* <https://doi.org/10.3390/laws7010003>.

colleagues, I adopt a concept of 'intercorporeal vulnerability' which emphasises the sociopolitical forces that interact with human bodies so as to generate and exacerbate vulnerabilities. I argue that this perspective on vulnerability is better equipped than the lens of ontological vulnerability to further the goal of achieving disability justice. This concept is then used throughout the article to identify vulnerabilities arising in the mental health law context which tend to be unrecognised or disavowed in a manner that reaffirms dominant discourses about madness,[6] disability and normalcy. Intersecting sites of identity, oppression and power are shown to be constitutive of these processes.

Part III provides an overview of mental health law, the *Convention on the Rights of Persons with Disabilities* ('*CRPD*') and terminology used in this article.[7] Part IV identifies conceptions of vulnerability contained within mental health law. I discuss how this regime is framed as operating primarily to shield vulnerability – in particular an inherent vulnerability residing in individual minds and bodies conforming to the biomedical notion of mental illness. I use the term 'supra-vulnerability' to describe the extraordinary and 'monstrous'[8] figure of vulnerability that emerges through the coercive function of mental health law, owing to the implication that people subject to forced mental health interventions do not know of their/our own 'vulnerability' and require a coercive 'remedy'. I conclude that the multiple and sometimes conflicting approaches to vulnerability identified, and the concomitant ambiguity of 'vulnerability' in this context, point to dangers of using this term as a formal standard within disability law and policy.

---

6 See Part III for discussion of terminology, including 'madness', used throughout this article.

7 Opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). The scope of this article precludes a comprehensive discussion of debates about the *CRPD*'s implications for forced mental health interventions and supported decision-making arrangements in the mental health context. For a few of the different perspectives circulating on this topic, see Tina Minkowitz, 'The United Nations *Convention on the Rights of Persons with Disabilities* and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34 *Syracuse Journal of International Law and Commerce* 405; Bernadette McSherry and Penelope Weller, *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010); George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN *Convention on the Rights of Persons with Disabilities*' (2014) 37 *International Journal of Law and Psychiatry* 245; Piers Gooding and Eilionóir Flynn, 'Querying the Call to Introduce Mental Capacity Testing to Mental Health Law: Does the Doctrine of Necessity Provide an Alternative?' (2015) 4 *Laws* 245 <https://doi.org/10.3390/laws4020245>; Sascha Callaghan and Christopher James Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the *Convention on the Rights of Persons with Disabilities* in Mental Health Law' (2016) 39 *University of New South Wales Law Journal* 596; Peter Bartlett, 'The United Nations *Convention on the Rights of Persons with Disabilities* and Mental Health Law' (2017) 75 *Modern Law Review* 752; Piers Gooding, *A New Era for Mental Health Law and Policy: Supported Decision-Making and the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press, 2017); Lisa Brophy, Christopher James Ryan and Penelope Weller, 'Community Treatment Orders: The Evidence and the Ethical Implications' in Claire Spivakovsky, Kate Seear and Adrian Carter (eds), *Critical Perspectives on Coercive Interventions: Law, Medicine and Society* (Routledge, 2018) 30.

8 I rely upon Margrit Shildrick's work on vulnerability and 'monstrous bodies': Margrit Shildrick, 'Becoming Vulnerable: Contagious Encounters and the Ethics of Risk' (2000) 21 *Journal of Medical Humanities* 215; Margrit Shildrick, *Embodying the Monster: Encounters with the Vulnerable Self* (Sage Publications, 2002).

Parts V and VI explore how intercorporeal vulnerability may be generated by mental health law, policy and services. In Part V I argue that the well-known phenomenon of pathologisation or psychiatrisation of dissent, usually associated with particular historical situations and political moments, operates in a more insidious fashion in the ongoing delivery of mental health services. I tease out the damaging effects of this phenomenon, including the suppressive action of medical and mental health norms upon minds, bodies and communities. This includes consideration of how diverse historically situated forms of discrimination and oppression are implicated in the discursive injuries experienced by Mad[9] and disabled subjects. In Part VI I discuss the central injury of being subjected to violence, control and coercion to which the subjects of forced mental health interventions are exposed.

The final Part considers the relationship between vulnerability and resistance, including the productive and transformative potential of this relationship. Some possibilities for resignifying vulnerability as radical and transgressive are explored.

My analysis draws attention to the incongruity of using the term 'vulnerability' to represent a status that is being positively addressed by laws and policies in a context where severe vulnerabilities are produced by those same laws and policies, in part due to underlying discriminatory structures and ideologies. This use of the term works to obscure the injuries that are caused by mental health law. While commentators frequently caution against approaches which explicitly or implicitly represent groups as inherently vulnerable, there is a tendency to 'look the other way' when it comes to people with disability in particular. This trend replicates, and is partly a product of, the historical devaluing and marginalisation of people with disability.

One example of the use of 'vulnerability' in disability law and policy is the Code of Practice for the *Mental Capacity Act 2005* (UK) c 9, which approves an amorphous definition of 'vulnerable adults' as people who (a) 'need community care services' due to a disability, age or illness and (b) 'may be unable to take care of themselves or protect themselves against serious harm or exploitation', and states that this description 'applies to many people who lack capacity to make decisions for themselves'.[10] Given persistent calls to adopt mental capacity laws in place of other coercive disability law regimes, Australian law and policy makers may be confronted with decisions about using the term 'vulnerability' in similar fashions.

My analysis indicates that incorporating 'vulnerability' as a formal standard within coercive disability laws and policies may be counterproductive, serving to

---

9 See Part III for discussion of terminology, including 'Mad', used throughout this article.

10 Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, 23 April 2007, 246 [14.4] <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>. For consideration of the relationship between vulnerability, autonomy and the *Mental Capacity Act 2005* (UK) c 9, see Lucy Series, 'Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80; Catriona Mackenzie and Wendy Rogers, 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the *Mental Capacity Act*' (2013) 9 *International Journal of Law in Context* 37.

mask and potentially exacerbate the vulnerabilities they produce. I am not arguing that the vulnerabilities I identify in this article are experienced by *all* subjects of mental health law. My point is that the exposure *of a cohort of people* who encounter mental health services to vulnerabilities *of the severity* discussed gives pause for thought about the wisdom of the political deployment of 'vulnerability'.

My intention is not to assert that mental health service users never experience distress or do not require help and support. Many report receiving much needed assistance and treatment from mental health services, including some who have experienced forced mental health interventions. Many others report being neglected by these services and argue that they need to be expanded and better-resourced. The asserted benefits of psychiatry and mental health systems are largely uncritically accepted in public discourse. This article does not seek to elaborate on these benefits or undertake the work of considering how laws and policies can be used to further these benefits, or better protect the rights of people with psychosocial disability[11] through the provision of various supports and services, since this territory is well-traversed elsewhere.[12]

This article is engaged in the work of redressing the imbalance in conventional understandings of mental health law and policy, by drawing attention to the *predisposition* of this regime to generate vulnerabilities. These understandings frequently fail to give due weight to the perspectives of those who report being harmed and abused by mental health services, in particular forced mental health interventions,[13] or who are developing knowledge about alternatives to psychiatry and mental health services.[14] This critical perspective, which aligns with approaches taken by Mad studies,[15] critical mental health

11 See Part III for discussion of terminology, including 'psychosocial disability', used throughout this article.

12 See, eg, National Mental Health Consumer & Carer Forum, 'Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum (NMHCCF) on Psychosocial Disability Associated with Mental Health Conditions' (2011) <https://nmhccf.org.au/sites/default/files/docs/nmhccf_psychosocial_disability_booklet_web_version_27oct11.pdf>; Penny Weller, 'The Right to Health: The *Convention on the Rights of Persons with Disabilities*' (2010) 35 *Alternative Law Journal* 66; Melbourne Social Equity Institute, University of Melbourne, 'Seclusion and Restraint Project' (Report, August 2014) <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>; Gooding, above n 7.

13 For a synthesis of accounts evidencing abuses to which psychiatric survivors are subjected while detained or residing in psychiatric wards, see Ji-Eun Lee, 'Mad as Hell: The Objectifying Experience of Symbolic Violence' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 105. See also Cath Roper, 'Capacity Does Not Reside in Me' in Claire Spivakovsky, Kate Seear and Adrian Carter (eds), *Critical Perspectives on Coercive Interventions: Law, Medicine and Society* (Routledge, 2018) 85, on the dehumanisation and 'existential violence' that can flow from forced mental health interventions.

14 Scholarship exploring service user and psychiatric survivor-led services, supports and bodies of knowledge includes Jasna Russo and Angela Sweeney (eds), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (PCCS Books, 2016); Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (National Empowerment Centre, Inc, 2012).

15 Mad studies is a praxis grounded in local, regional and global communities of Mad and anti-psychiatry activists, survivors of psychiatry, ex-patients, service users, consumers and allies that centres the knowledge of those deemed 'mentally ill' or 'mad': Brenda A LeFrançois, 'Foreword' in Jasna Russo and

scholarship, and critical disability theory, is alert to potential systemic and structural impacts of disability law and services which are not always, or not easily and obviously, referable to individual experiences.

II THEORISING VULNERABILITY FOR DISABILITY LAW

Dominant theories of vulnerability centre upon a conception of 'ontological vulnerability' shared by all humans.[16] This form of vulnerability is understood to be part of the human condition and something which stems from the bodily, socially constituted nature of our being – a continuing propensity to being physically or psychically injured or experiencing violence, becoming sick or disabled, or being deprived of the resources necessary for our survival and wellbeing.[17] Martha Fineman's theory of vulnerability 'rejects identity categories and "intersectionality" in creating a universal "vulnerable subject" defined by its shared and constant vulnerability'.[18] Fineman describes this concept of vulnerability as arising from our embodiment and its consequences, encompassing many forms of harm that are internal and biological.[19]

Fineman and other vulnerability theorists acknowledge that vulnerability can take multiple forms deriving from various internal and external sources.[20] Catriona Mackenzie, Wendy Rogers and Susan Dodds, for example, have developed a taxonomy of vulnerability incorporating several different sources and states of vulnerability, including 'pathogenic vulnerability', which may be generated by measures in fact designed to shield vulnerability.[21] Mackenzie has urged a broadening to account for vulnerabilities arising from 'interpersonal and social relationships or economic, legal, and political structures'.[22] Yet much vulnerability scholarship evinces a concern to present 'vulnerability as being

---

Angela Sweeney (eds), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (PCCS Books, 2016) v. See further Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013); Rachel Gorman and Brenda A LeFrançois, 'Mad Studies' in Bruce M Z Cohen (ed), *Routledge International Handbook of Critical Mental Health* (Routledge, 2018) 107.

16 Alyson Cole, 'All of Us Are Vulnerable, but Some Are More Vulnerable than Others: The Political Ambiguity of Vulnerability Studies, an Ambivalent Critique' (2016) 17 *Critical Horizons* 260, 265–7, 272; see also Noémi Michel, 'Accounts of Injury as Misappropriations of Race: Towards a Critical Black Politics of Vulnerability' (2016) 17 *Critical Horizons* 240, 242.

17 Bryan S Turner, *Vulnerability and Human Rights* (Pennsylvania State University Press, 2006) 25–8; Martha Albertson Fineman, 'Equality, Autonomy, and the Vulnerable Subject in Law and Politics' in Martha Albertson Fineman and Anna Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate, 2013) 13, 20–21.

18 Martha Albertson Fineman and Anna Grear, 'Introduction: Vulnerability as Heuristic – An Invitation to Future Exploration' in Martha Albertson Fineman and Anna Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate, 2013) 1, 2.

19 Fineman, above n 17, 20.

20 Ibid 20–1.

21 Rogers, Mackenzie and Dodds, 'Why Bioethics Needs a Concept of Vulnerability', above n 1, 24–5.

22 Catriona Mackenzie, 'The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability' in Catriona Mackenzie, Wendy Rogers and Susan Dodds (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford University Press, 2013) 33, 38.

foremost universal'.[23] This leaning has compelling justifications associated with the use of minimalist liberal theory to empty human rights of their power to activate ethical responses to human need and suffering,[24] and to support a non-interventionist state.[25] However, ontological vulnerability has a tendency to fold back into models grounded in biological predisposition when applied to disability law and policy.

Some disability scholars have offered compelling criticisms of the use of 'vulnerability' as a political tool, pointing to the prior discursive designation of disability as 'special' vulnerability, or with negative, internalising connotations of vulnerability.[26] Vulnerability scholarship has frequently highlighted the importance of reinscribing vulnerability within a framework that avoids labelling particular groups or populations, including people with disability, as essentially vulnerable.[27] Nonetheless a number of contemporary analyses of vulnerability characterise disability in terms that may operate to affirm reductionist notions of disability as an inherent biological condition.[28] This characterisation is at odds with the human rights model of disability embodied in the *CRPD*,[29] and the resistance of critical disability theory to the marking of disability as deviant through the enforcement of corporeal standards approximating the 'normate'.[30]

Margrit Shildrick's work on vulnerability and embodiment connects to the notion of ontological vulnerability. Shildrick calls for extension beyond binary categories of dis/ability and toward understandings of *all* bodies as 'unstable and vulnerable'.[31] However, her model of vulnerability and embodiment offers a vision of bodies which are constantly 'becoming' through interactions with not

23 Cole, above n 16, 267.

24 Turner, above n 17.

25 Fineman, above n 17, 13–14.

26 Michelle Jarman, 'Resisting "Good Imperialism": Reading Disability as Radical Vulnerability' (2005) 25(1) *Atenea* 107; Barbara Fawcett, 'Vulnerability: Questioning the Certainties in Social Work and Health' (2009) 52 *International Social Work* 473, 474; Gerard Goggin, 'Disability, Media, and the Politics of Vulnerability' (2009) 1(19) *Asia Pacific Media Educator* 1, 2–5; Hollomotz, above n 2; Jackie Leach Scully, 'Disability and Vulnerability: On Bodies, Dependence and Power' in Catriona Mackenzie, Wendy Rogers and Susan Dodds (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford University Press, 2013) 204.

27 Fineman, above n 17, 16; Scully, above n 26; Jaime Lindsey, 'Developing Vulnerability: A Situational Response to the Abuse of Women with Mental Disabilities' (2016) 24 *Feminist Legal Studies* 295, 298–9.

28 'Inherent vulnerability refers to vulnerability that is intrinsic to the person and arises from specific characteristics, such as disability, mental illness, mental capacity or frail old age': Mackenzie and Rogers, above n 10, 40; '[I]n one form, dependency is inevitable; it is developmental and biological in nature. All of us are dependent on others as infants and many will become dependent as we age, are taken ill, or become disabled': Fineman, above n 17, 18.

29 Theresia Degener, 'Disability in a Human Rights Context' (2016) 5(3) *Laws* <http://doi.org/10.3390/laws5030035>.

30 As described by Rosemarie Garland-Thomson, the 'normate' is the 'corporeal incarnation of culture's collective, unmarked, normative characteristics', a conception of the body that renders 'nonconforming' bodies culturally undesirable and operates to flatten out difference: Rosemarie Garland-Thomson, 'Integrating Disability, Transforming Feminist Theory' (2002) 14(3) *NWSA Journal* 1, 10.

31 Margrit Shildrick, 'Critical Disability Studies: Rethinking the Conventions for the Age of Postmodernity' in Nick Watson, Alan Roulstone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge, 2012) 30, 40.

only other human bodies, but also a range of entities including discourses, objects and technologies.[32] This vision appears to bear more resemblance to the concept of 'intercorporeal vulnerability', which I discuss further below. Further, Shildrick conceives of vulnerability in part as the spectre of *ourselves* that emerges when we are confronted by the 'monstrous' Other, something that people thus seek to erase in line with eugenics regimes targeting disabled people and racialised minorities.[33] Instead of ontological *vulnerability*, this model privileges ontological *instability* and *undecidability*, questioning the very boundaries that appear to exist between bodies and therefore positing an embodied vulnerability possessing a liminal quality.[34]

Few would reject the notion of ontological vulnerability. In this article, however, I adopt a concept of '*inter*corporeal vulnerability' drawing on the work of Butler.[35] Butler develops an account of corporeal vulnerability according to which humans are, 'from the start, even prior to individuation itself and, by virtue of bodily requirements, given over to some set of primary others'.[36] She conceives of the body as a 'relation', vulnerable in the sense of being exposed to interpellations that name and constitute people according to social norms, and harms arising from lack of and radical failures in infrastructural support.[37] Butler's model of vulnerability is valuable for an analysis of disability law and policy because it extends beyond vulnerabilities emerging from the situation of bodies within networks of social relations, and towards an understanding of the body as '*defined by* the relations that make its own life and action possible'.[38] Using the example of gender norms, Butler explains how the 'interpellating action' of social norms may cause them to become 'inhabited in one's gestures and actions, even come to be understood to be essential to who we are'.[39]

Applying Butler's analysis within a disability studies framework, Nirmala Erevelles writes that

> the 'impaired' body is interpellated through a chain of incessant (re)iterations that stabilizes our notion of the natural, and this forms the boundary conditions between nondisabled bodies (bodies that matter) and disabled bodies (bodies that do not matter in the same way).[40]

---

32 Margrit Shildrick, '"Why Should Our Bodies End at the Skin?": Embodiment, Boundaries, and Somatechnics' (2015) 30 *Hypatia* 13, 16–17, 19–20, 24–5.

33 Shildrick, *Embodying the Monster: Encounters with the Vulnerable Self*, above n 8, 4–6, 39; Shildrick, 'Becoming Vulnerable: Contagious Encounters and the Ethics of Risk', above n 8, 216.

34 Shildrick, *Embodying the Monster: Encounters with the Vulnerable Self*, above n 8, 1–5, 79; Shildrick, '"Why Should Our Bodies End at the Skin?": Embodiment, Boundaries, and Somatechnics', above n 32.

35 Judith Butler, *Precarious Life: The Powers of Mourning and Violence* (Verso, 2006); Judith Butler, 'Rethinking Vulnerability and Resistance' in Judith Butler, Zeynep Gambetti and Leticia Sabsay (eds), *Vulnerability in Resistance* (Duke University Press, 2016) 12.

36 Butler, *Precarious Life: The Powers of Mourning and Violence*, above n 35, 31; see also Butler, 'Rethinking Vulnerability and Resistance', above n 35, 12.

37 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 12, 18–19.

38 Ibid 16 (emphasis added).

39 Ibid 17.

40 Nirmala Erevelles, *Disability and Difference in Global Contexts: Enabling a Transformative Body Politic* (Palgrave Macmillan, 2011) 162–3.

Jessica Cadwallader has urged a 'rethinking of pathology in relation to embodiment' in order to expose vulnerabilities that 'medical power/knowledge cannot recognize', and which are consequently disavowed more broadly by mainstream discourses.[41] She underscores the tension characterising the relationship between ontological vulnerability and disability when describing a particular vulnerability that people with disability experience when medicine fails to recognise their *absence* of suffering due to the assumption that people with disability are *supposed* to suffer – that suffering is part of the universal experience of disability.[42] A concept of vulnerability that is attuned to all facets of the intercorporeal nature of our existence must attend to *unexpected* vulnerabilities and discursive injuries, and how they can become 'sedimented' in individual and collective embodied histories.[43]

In addition to exposure to interpellating norms that name and constitute people, Butler's model incorporates a vulnerability that is a dependency upon 'infrastructural norms' – those norms that 'constitute the intersubjective and infrastructural conditions of a livable life'.[44] She states:

> We cannot talk about a body without knowing what supports that body and what its relation to that support – or lack of support – might be. In this way, the body is less an entity than a relation, and it cannot be fully dissociated from the infrastructural and environmental conditions of its living.[45]

This notion of the social structures and supports that enable a livable life, Butler suggests, has implications for understanding embodied and social action in addition to the bodily risks that some are expected to take as a matter of course, such as trans people walking on the street or gathering in public assemblies.[46]

Intercorporeal vulnerability lends itself to facilitating exposure of the often invisible discrimination and oppression that is lodged deep within existing power structures and political mechanisms that may come to be harnessed in pursuit of protecting and empowering 'the vulnerable'. It directs attention towards forces that act upon, harm and become enmeshed with bodies and the legal and medical imaginaries that continue to position disabled bodies as Other. For these reasons I suggest that this concept is better attuned than ontological vulnerability to the central concerns of disability studies.[47] Conversely critical accounts of disability,

41 See Jessica Robyn Cadwallader, '(Un)expected Suffering: The Corporeal Specificity of Vulnerability' (2012) 5(2) *International Journal of Feminist Approaches to Bioethics* 105, 121.

42 Ibid 118.

43 See ibid 112–14; Noémi Michel, 'Equality and Postcolonial Claims of Discursive Injury' (2013) 19 *Swiss Political Science Review* 447, 460, 466; Judith Butler, *'Excitable Speech': A Politics of the Performative* (Routledge, 1997) 80; Maurice Merleau-Ponty, *Phenomenology of Perception* (Colin Smith trans, Routledge, 2002) 150 [trans of: *Phénoménologie de la Perception* (first published 1945)]. Cadwallader's analysis draws attention to vulnerabilities that are 'unexpected' in that they do not 'mesh with the expectations of normal bodies': Cadwallader, above n 41, 121.

44 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 19.

45 Ibid.

46 Ibid.

47 Noémi Michel has argued for a shift away from ontological vulnerability in order to illuminate the specific materialisations of injuries of race: Michel, 'Accounts of Injury as Misappropriations of Race', above n 16.

madness and normalcy hold much potential for enriching the 'radical turn in vulnerability'.[48]

My analysis of vulnerabilities generated by mental health law considers certain context-specific positions and conditions experienced by people who encounter mental health services, with a focus on race and ethnicity. In so doing it demonstrates the continuing relevance of intersectional analyses[49] within projects seeking to achieve social justice and substantive equality for all, uncovering how social norms may interlock at different sites of identity, power and historicity with material impacts upon the body.

Enquiring into vulnerabilities generated by disability law has implications for comprehending and responding to concrete injustices. There is an urgency behind this enterprise in light of trends such as the increasing medicalisation of psychological distress including more widespread labelling of children with psychiatric disorders,[50] and expansion of the legal authority for forced mental health interventions in several respects.[51]

III MENTAL HEALTH LAW, THE *CRPD* AND TERMINOLOGY

The *Mental Health Act 2007* (NSW) ('*Mental Health Act*') provides an overarching regulatory framework for both voluntary and involuntary mental health service delivery in NSW. However, its provisions are substantially devoted to establishing forced mental health interventions, or substituted decision-making arrangements,[52] of three key types: detention in a mental health facility; placement under a community treatment order ('CTO'); and administration of specific psychiatric drugs and procedures.[53] CTOs, requiring individuals to take specified drugs and undergo specified procedures whilst living in community settings, were introduced by the former *Mental Health Act 1990* (NSW); earlier statutes provided only for involuntary status in the form of involuntary admission to a hospital.[54] The objects clause of the current *Mental*

48 Goggin, above n 26, 10.

49 Intersectionality was pioneered by scholars including Crenshaw and Collins: Kimberle Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color' (1991) 43 *Stanford Law Review* 1241; Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (Routledge, 2nd ed, 2000).

50 Robert Menzies, Brenda A LeFrançois and Geoffrey Reaume, 'Introducing Mad Studies' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 1, 7–8.

51 Gooding, above n 7, 30–1.

52 'Substituted decision-making' is a term used to refer to an arrangement whereby a third party is authorised to make a decision on behalf of another person.

53 It should be noted that some Australian mental health statutes broaden the scope of involuntary interventions beyond people considered to have a 'mental illness', such as to cover people considered to be 'mentally disordered' or to have a 'mental disturbance' or 'cognitive impairment' in certain circumstances: see, eg, *Mental Health Act* s 15; *Mental Health and Related Services Act* (NT) ss 15–15A.

54 The precursor to the *Mental Health Act 1990* (NSW), the *Mental Health Act 1983* (NSW), limited permissible forced mental health interventions to involuntary admission to hospitals and the carrying out of specific medical treatments without the patient's consent: pts V and X. In the Second Reading Speech for the Mental Health Bill 1990 (NSW) it was stated that a 'scheme for treatment outside hospitals'

Health Act suggests a graduated hierarchy of care, treatment and ultimately control, privileging voluntary community care, followed by voluntary hospitalisation and resorting to forced interventions 'in a limited number of situations'.[55]

As with several other coercive disability law regimes,[56] mental health law substantially represents itself as a mechanism for protection. According to the second reading speech introducing the *Mental Health Act 1990* (NSW), core elements of which remain in the current *Mental Health Act*, the statute's basic function was to 'provide the opportunity for those suffering from mental illness or a mental disorder to get the care and treatment that they need'.[57] The Minister for Family and Community Services stated that the 'primary objective of this treatment' was 'to ensure that the individual can have as normal and satisfying a life as possible', and that the Bill would 'provide a more enlightened, consistent and humane approach to the treatment of mental disorders'.[58]

This narrative of a humane, progressive approach to mental health care has continued with more recent amendments to the *Mental Health Act*.[59] The 2007 amendments included inserting a new section 68 headed '[p]rinciples for care and treatment', which includes principles aimed at better involving people, and giving effect to their wishes, in the development of treatment plans and ensuring that their consent is sought.[60] The most recent amendments in 2015 were intended to give effect to 'recovery focused treatment as a key objective of the Act',[61] expanding beyond 'merely clinical recovery' toward 'a much broader concern with quality of life issues for consumers and their right to make decisions about their care'.[62]

The 2015 amendments included removing the references to '*control* of persons who are mentally ill or mentally disordered'[63] from the legislative objects owing to concerns that the word 'control' was derogatory and contrary to the shift in mental health policy towards patient-centred and recovery-oriented

---

would be established by Chapter 6 to 'provide a real alternative to compulsory hospital treatment': New South Wales, *Parliamentary Debates*, Legislative Assembly, 22 March 1990, 887 (Mr Collins, Minister for Health and Minister for Arts).

55 *Mental Health Act* ss 3(a)–(c). See also *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, 325 (Kirby P), 333–4 (Mahoney JA).

56 See, eg, Claire Spivakovsky, 'From Punishment to Protection: Containing and Controlling the Lives of People with Disabilities in Human Rights' (2014) 16 *Punishment & Society* 560.

57 New South Wales, *Parliamentary Debates*, Legislative Council, 2 May 1990, 2133 (Virginia Chadwick, Minister for Family and Community Services).

58 Ibid.

59 This is evident from the second reading speech introducing the Mental Health Amendment (Statutory Review) Bill 2014 (NSW), which brought in the most recent suite of amendments to the *Mental Health Act*: see New South Wales, *Parliamentary Debates*, Legislative Assembly, 14 October 2014, 1031 (Jai Rowell, Minister for Mental Health, and Assistant Minister for Health).

60 *Mental Health Act* ss 3, 68(e), (h); Maria Bisogni, 'A Person-Centred Approach to Mental Health Care in NSW' (2015) 16 *Law Society Journal* 90, 91.

61 New South Wales, *Parliamentary Debates*, Legislative Assembly, 14 October 2014, 1031 (Jai Rowell, Minister for Mental Health, and Assistant Minister for Health).

62 Bisogni, above n 59. This article contains a thorough overview of the 2015 amendments.

63 *Mental Health Amendment (Statutory Review) Act 2014* (NSW) sch 1 item 3, amending *Mental Health Act* ss 3(b), (e) (emphasis added).

care.[64] This reform belies the historical and ongoing function of mental health law to contain and control individuals. The manner in which mental health law and policy has co-opted the notion of 'recovery' could be seen as one manifestation of this coercive function. This notion grew within movements of mental health service users and survivors of psychiatry[65] and was initially articulated as a process of recovering from the oppressive effects of mental health services and institutionalisation.[66] As Piers Gooding has noted, the concept of 'recovery' is now used in a range of contexts and understood in ways that sometimes conflict with each other.[67]

The coercive mechanisms of the *Mental Health Act* hinge largely upon two sets of civil commitment criteria, contained in provisions headed '[m]entally ill persons' (section 14)[68] and '[m]entally disordered persons' (section 15),[69] either of which must be satisfied before a person can be detained in a mental health facility. These criteria incorporate a mental or behavioural condition criterion, in addition to a dangerousness/risk criterion requiring that 'care, treatment or control' owing to the specified mental or behavioural condition is reasonably considered necessary to protect that person or others from serious harm.[70] A lower threshold test that does not require satisfaction of the dangerousness/risk criterion is prescribed for making a CTO, unless the order is made at the initial tribunal hearing following a person's involuntary admission to a mental health facility.[71] An additional prerequisite to detention in a mental health facility or the making of a CTO, often termed 'the least restrictive alternative principle', is that 'no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available'.[72]

---

64 NSW Health and NSW Ministry of Health, 'Review of the NSW *Mental Health Act 2007* – Report for NSW Parliament: May 2013 – Summary of Consultation Feedback and Advice' (May 2013) 14.

65 See the final two paragraphs in this Part for discussion of terminology, including 'survivor of psychiatry', used throughout this article.

66 Alison Howell and Jijian Voronka, 'Introduction: The Politics of Resilience and Recovery in Mental Health Care' (2012) 6 *Studies in Social Justice* 1, 4.

67 Gooding, above n 7, 207.

68 Section 14 contains the primary standard grounding ongoing detention in mental health facilities. It applies to a person 'suffering from mental illness' and may trigger a period of detention authorised by the Mental Health Review Tribunal ('MHRT') of up to three months initially, followed by regular MHRT review if clinicians seek to extend the length of a person's detention: *Mental Health Act* ss 35(5), 37–8.

69 Section 15, headed '[m]entally disordered persons', contains a secondary standard which clinicians may rely upon to detain a person on a limited basis without MHRT authorisation for up to three days at a time: *Mental Health Act* s 31. This standard requires a person's 'behaviour' to be 'so irrational' as to justify a conclusion 'on reasonable grounds' that they must be detained in order to avoid 'serious physical harm' being caused to themselves or others.

70 The ss 14 and 15 standards differ in respect of the dangerousness/risk criterion in that s 14 incorporates the broader notion of protection from 'serious harm', whereas a person cannot be detained on the basis of the s 15 standard unless detention is considered necessary in order to avoid 'serious *physical* harm' being caused to themselves or others (emphasis added).

71 *Mental Health Act* s 53.

72 *Mental Health Act* ss 12(1)(b), 35(5)(c), 38(4), 53(3)(a). In *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178, application of this principle – as found in s 53(3)(a) – led Brereton J to find that he could not be satisfied that a CTO made by the MHRT was the least restrictive alternative consistent with safe and effective care: at [43]–[44].

A person cannot be detained in a mental health facility for a prolonged period, or made subject to a CTO of up to 12 months in length, unless they are considered to be 'suffering from a mental illness' or likely to 'relapse into an active phase of mental illness', according to the statutory definition of 'mental illness'.[73] 'Mental illness' is defined in section 4 as

> a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions,
> (b) hallucinations,
> (c) serious disorder of thought form,
> (d) a severe disturbance of mood,
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

Aligning with clinical diagnostic standards, this definition forms part of numerous provisions throughout the *Mental Health Act* which ground its biomedical orientation and confer medical professionals with substantial control over decisions about forced mental health interventions. A clinical diagnosis of mental illness will often, but not necessarily, coexist with satisfaction of the statutory definition of 'mental illness'.

Mental health laws attempt to strike a balance between upholding civil rights and protecting health and safety by 'positioning medical professional discretion at [their] heart … while limiting the scope of professional power and providing "safeguard" mechanisms'.[74] Civil commitment criteria such as those outlined above are the core safeguarding mechanisms, intended to limit the use of forced mental health interventions to those cases where risk of harm is greatest and less restrictive options are not available. The NSW Mental Health Review Tribunal ('MHRT') is established by the *Mental Health Act* as the primary legal oversight body with responsibility for authorising or approving forced mental health interventions; all Australian states and territories have a comparable administrative tribunal at the apex of the decision-making framework.[75] Mental health tribunals are multidisciplinary bodies required to operate within an inquisitorial model in reaching decisions that have far-reaching consequences for people's lives.[76] The Deputy President of the MHRT has written of the

73 *Mental Health Act* ss 14, 35(5)(b)–(c), 38(4), 53(3)–(6). However, clinicians may rely upon ss 15 ('[m]entally disordered persons') and 31 of the *Mental Health Act* to detain a person on a strictly limited basis pursuant to civil commitment criteria focused on a behavioural condition of 'irrationality'.

74 Penelope Weller, 'Mental Health Law' in Anne-Maree Farrell et al (eds), *Health Law: Frameworks and Context* (Cambridge University Press, 2017) 305, 307.

75 Reporting on a comparative study of the operation of Australian mental health tribunals, see Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection & Treatment?* (Themis Press, 2011).

76 Penelope Weller, 'Taking a Reflexive Turn: Non-adversarial Justice and Mental Health Review Tribunals' (2011) 37 *Monash University Law Review* 81, 88–9.

importance of tribunal hearings affording procedural fairness, and appearing to be fair, in light of the 'vulnerability of people appearing before the MHRT'.[77]

The Mental Health Advocacy Service is a branch of NSW Legal Aid which provides legal representation in MHRT matters. Lawyers play crucial roles in advising and representing people appearing before mental health tribunals.[78] Most Australian jurisdictions have legal services dedicated to providing representation in mental health law matters. In 2016 Victoria Legal Aid drew attention to the widely varying levels of legal representation before mental health tribunals across Australia, with the rate as low as four per cent in Queensland.[79] Earlier this year Victoria Legal Aid again called for improved legal representation before the Victorian MHRT given the human rights interests at stake, pointing to particularly low representation in regional Victoria.[80] NSW has the highest rate of representation, at 70 per cent across all hearing types in 2016–17.[81]

Eleanore Fritze has comprehensively reported on the possibilities and limitations of mental health lawyering in civil mental health law matters,[82] including the potential for legal representation to ensure that individual capacity and autonomy is better protected within the constraints of mental health law.[83] Fritze has also emphasised the potential for rights-based strategic advocacy, alongside more conventional individual advocacy, to work towards goals such as: seeking protection for a broader range of rights including rights to care and community supports; tackling issues affecting a specific cohort of people with disabilities; and ensuring compliance with international human rights instruments such as the *CRPD*.[84]

The *CRPD*, which entered into force in May 2008 and was ratified by Australia in July of that year,[85] is a revolutionary instrument of international human rights law. Its reformulation of existing rights in their application to the

---

77 Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (2016) 86 *AIAL Forum* 10, 16.

78 Megan Pearson, 'Representing the Mentally Ill: The Critical Role of Advocacy under the *Mental Health Act 1986* (Vic)' (2004) 29 *Alternative Law Journal* 174; Sandra Boulter, 'Involuntary Patients and Legal Representation' (2014) 44 *Brief* 32; Eleanore Fritze, 'Shining a Light behind Closed Doors' (Report, Jack Brockhoff Foundation Churchill Fellowship, December 2015) <https://www.churchilltrust.com.au/media/fellows/Fritze_E_Shining_a_light_behind_closed_doors.pdf>.

79 Sarah Farnsworth, 'Hundreds of Patients Forced to Have ECT in Victoria without Legal Representation', *ABC News* (online), 21 November 2016 <http://www.abc.net.au/news/2016-11-20/patients-forced-to-have-ect-without-legal-representation/8030996>.

80 Stephanie Corsetti, 'Low Mental Health Legal Representation in Regional Victoria Affects Patient Outcomes, Legal Aid Says', *ABC News* (online), 21 March 2017 <www.abc.net.au/news/2018-03-21/mental-health-legal-representation-low-in-regional-victoria/9571696>.

81 Mental Health Review Tribunal, '2016/17 – Annual Report' (Report, 2017) 29.

82 See, eg, Fritze, 'Shining a Light behind Closed Doors', above n 78.

83 Eleanore Fritze, 'The Variable Treatment of (In)capacity in the Practical Operation of Victoria's Key Substituted Decision-Making Regimes: View from the Frontline' in Claire Spivakovsky, Kate Seear and Adrian Carter (eds), *Critical Perspectives on Coercive Interventions: Law, Medicine and Society* (Routledge, 2018) 65.

84 Fritze, 'Shining a Light behind Closed Doors', above n 78, xvi.

85 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, [2008] ATS 12, entered into force 16 August 2008.

disability context exposes how discrimination against people with disability has historically been embedded within international human rights law itself.[86] Several provisions of the *CRPD*, spearheaded by article 12 on equal recognition before the law, make clear that *formal and substantive* equality has been and continues to be denied to people with disability at epidemic levels through paternalistic regimes which have either not recognised, or failed to support, individual capacities for autonomy and self-determination.[87] The *CRPD*'s mandate for states parties to redress this imbalance embodies the indivisibility and interdependence of civil and political rights and economic, social, and cultural rights.[88] Significant emphasis is placed upon the accommodations and supports required for the full and equal participation of people with disability in society and all aspects of our lives.[89]

The potential application of the *CRPD* to mental health service users is made clear in article 1. This provision states that '[p]ersons with disabilities include those who have long-term physical, *mental*, intellectual or sensory impairments' for whom barriers interact with their bodies to hinder 'their full and effective participation in society on an equal basis with others'.[90] The term 'psychosocial disability' aligns with the social model of disability understood to be embodied in article 1, thus positing the socially constructed nature of disability.[91] The term 'psychosocial' reflects unique aspects of the construction of disability in the mental health context. 'Psychosocial disability' is not a term that appears in mental health law, which relies on biomedical notions of mental illness to underpin justifications for coercive mental health interventions as discussed above.

The term 'psychosocial disability' is gaining traction within public discourse. However its meaning is contested, as evident from sometimes conflicting interpretations adopted by mental health service users and survivors of psychiatry.[92] In this article I use this term to refer to people who may define themselves in various ways vis-a-vis their interaction with mental health services, including people 'who do not identify as persons with disability but have been

86 Linda Steele, 'Court Authorised Sterilisation and Human Rights: Inequality, Discrimination and Violence against Women and Girls with Disability' (2016) 39 *University of New South Wales Law Journal* 1002, 1017.

87 Committee on the Rights of Persons with Disabilities, *General Comment No 1 – Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014); Eilionóir Flynn and Anna Arstein-Kerslake, 'State Intervention in the Lives of People with Disabilities: The Case for a Disability-Neutral Framework' (2017) 13 *International Journal of Law in Context* 39.

88 Degener, above n 29, 5.

89 Weller, above n 12, 66.

90 *CRPD* art 1 (emphasis added).

91 The origins and development of the social model of disability are addressed in Colin Barnes, 'Understanding the Social Model of Disability: Past, Present and Future' in Nick Watson, Alan Roulstone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Routledge, 2012) 12.

92 There are significant differences of approach, for example, as between the Australian National Mental Health Consumer & Carer Forum and the World Network of Users and Survivors of Psychiatry: see generally National Mental Health Consumer & Carer Forum, above n 12; World Network of Users and Survivors of Psychiatry, 'Psychosocial Disability' (Position Paper) <http://www.wnusp.net/documents/2012/Psychosocial_disability.docx>.

treated as such, eg by being labeled as mentally ill or with any specific psychiatric diagnosis'.[93] This usage is broader than that of the Australian National Mental Health Consumer & Carer Forum, which understands psychosocial disability as being 'related to impairments associated with usually severe mental health conditions' and thus understands 'people with psychosocial disability' as forming a subset of those who have a mental health condition.[94] The definition I prefer contemplates a range of discriminatory practices which may hinder a person's full and effective participation in society and an expansive notion of the accommodations and supports a person may need to ensure such participation.[95] Psychosocial disability thus forms 'a bracketed space', allowing for individuals to identify needs for support and assert rights claims when necessary.[96]

People who use, seek to access, or are abused by mental health services use a range of terms to describe themselves, which may differ from those commonly employed in government discourse such as mental health consumer and service user. In light of such multiple positionings, I use a number of these terms interchangeably to avoid privileging a singular perspective. Use of the umbrella phrase 'service users and psychiatric survivors' is intended to encompass a spectrum ranging from acceptance through to rejection of psychiatric discourse. 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.[97]

The term 'madness', which has in recent history been used in derogatory fashion, has been reclaimed since the emergence of the anti-psychiatry movement and is used by some individuals and constituencies to affirm emotional, spiritual, and neurodiversity,[98] signalling resistance to dominant understandings of 'mental illness' which inform conceptions of vulnerability identifiable in mental health law.

---

93 World Network of Users and Survivors of Psychiatry, above n 92, 1.

94 National Mental Health Consumer & Carer Forum, above n 12, 9–10.

95 World Network of Users and Survivors of Psychiatry, above n 90.

96 Tina Minkowitz, 'Rethinking Criminal Responsibility from a Critical Disability Perspective: The Abolition of Insanity/Incapacity Acquittals and Unfitness to Plead, and Beyond' (2014) 23 *Griffith Law Review* 434, 461.

97 Geoffrey Reaume, 'A History of Psychiatric Survivor Pride Day during the 1990s' (Bulletin No 374, 14 July 2008) 2 <http://www.csinfo.ca/bulletin/Bulletin_374.pdf>.

98 Menzies, LeFrançois and Reaume, above n 50, 10–11. Erick Fabris proposes the upper-case, proper noun 'Mad', to encompass people deemed 'mentally ill', and be used as 'a historical rather than a descriptive or essential category … for political action and discussion': Erick Fabris, 'Mad Success: What Could Go Wrong When Psychiatry Employs Us as "Peers"?' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 130, 138–9.

IV CONCEPTIONS OF VULNERABILITY IN MENTAL HEALTH LAW

In this Part I identify three connotations of vulnerability that reside within texts of mental health law as found in legislation and judicial decisions. Firstly, individuals are posited as vulnerable due to the effects of 'mental illness' itself and thus in need of the 'protection' offered by this body of law. Secondly, mental health law evinces a concern to shield the vulnerability of this group from abuse of their civil liberties. The third connotation of vulnerability is that of *other people, or society at large*, to harm that may be caused by people with psychosocial disability, owing to alleged mental illness, unless they are subjected to forced mental health interventions. It is further argued that a problematic conception of what I call 'supra-vulnerability' emerges through the coercive function of mental health law. These conflicting conceptions of vulnerability give rise to a level of ambiguity surrounding this term that suggests it is poorly suited for deployment as a formal standard within future reform initiatives in this context.

NSW Supreme Court decisions concerning the operation of the *Mental Health Act* tend to represent the scheme as being a fundamentally 'beneficial' and 'protective' one,[99] facilitating interventions that 'benefit' individuals and advance their 'welfare'[100] and 'best interests'.[101] The wounding or harm these individuals are being protected from (or are vulnerable to) is attributed quite starkly in judicial decisions to 'mental illness' that impairs an individual's judgment and insight[102] and requires control by medication.[103] This is unsurprising given that the statutory criteria for authorising forced mental health interventions are premised upon the individual's alleged mental illness.

The central tension in mental health law between 'freedom', on the one hand, and 'protection' or 'need for treatment', on the other, is expressed in the objects clause of the *Mental Health Act*,[104] and was well-traversed in the NSW Court of Appeal decision of *Harry v Mental Health Review Tribunal*.[105] Some Australian court decisions recognise that forced mental health interventions necessarily entail restrictions on individual freedom and interference with individual autonomy.[106] However, the primary vulnerability produced *by* mental health law that it admits concern about is *exposure to* abuse of civil liberties and associated

99 *Subramaniam v Mental Health Review Tribunal* (2012) 83 NSWLR 171, 176 [13] (Pembroke J); *B v St Vincent's Hospital Sydney Ltd* [2016] NSWSC 392, [31] (Lindsay J); *M v Mental Health Review Tribunal* [2015] NSWSC 1876, [42] (Lindsay J); *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178, [46] (Brereton J).

100 *B v St Vincent's Hospital Sydney Limited* [2016] NSWSC 392, [31] (Lindsay J).

101 *Subramaniam v Mental Health Review Tribunal* (2012) 83 NSWLR 171, 176 [13] (Pembroke J).

102 *M v Mental Health Review Tribunal* [2015] NSWSC 1876, [74] (Lindsay J); *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178, [31] (Brereton J).

103 *Re BC* [2009] NSWSC 835, [2] (Palmer J); *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178, [25]–[27] (Brereton J).

104 *Mental Health Act* ss 3(c)–(d).

105 (1994) 33 NSWLR 315, 321–5 (Kirby P), 335 (Mahoney JA).

106 See, eg, *M v Mental Health Review Tribunal* [2015] NSWSC 1876, [68] (Lindsay J).

harms.[107] By and large, the *Mental Health Act* and associated judicial decisions imply that *there is no abuse*, or at the least that any abuse is regrettable but excusable, if the statutory criteria are stringently applied and the procedural requirements are met.[108] Therefore whilst the possibility of abuse of mental health law's coercive powers is acknowledged, compliance with mental health law is somewhat unevenly offered up as the 'cure'.[109] This second connotation of vulnerability, then, is effectively trumped by the application of a 'balancing' formula privileging the need to shield individual vulnerability apparently caused by mental illness.

The dominant characterisation of mental health law as protective (of the vulnerable) may be called into question in light of other contradictory functions that this body of law is called upon to perform, foremost among these being its concern to protect 'vulnerable others' against harm that may be caused by the person's 'illness'. One of the core criteria for forced mental health interventions, as stated above, is that the individual requires 'care, treatment or control' for the person's own protection from serious harm or, in the alternative, 'for the protection of others from serious harm'.[110] This dual function of mental health law entails an uneasy union of shielding distress and containing risk that ultimately works to perpetuate the still widely-held stereotype that people with psychosocial disability are inherently dangerous.[111] The fact that the response to these risks is detention and interference with bodily integrity also weakens the medico-legal construction of mental health law as a protective regime, as discussed further in Part VI.

Yet it is difficult to escape the conclusion that mental health law foremost represents people with disability as being inherently vulnerable due to individual pathology. The construction of this vulnerability as a predisposition is solidified by virtue of the fact that containment of, and forcible intervention in, individual minds and bodies is uniquely established as the appropriate response for people with psychosocial disability. This response indicates that the vulnerability resides firmly *inside* the bodies and minds of this group. The implication of mental health law, reinforced in judicial decisions,[112] that people subject to forced mental health interventions lack the capacity and insight to recognise their/our own 'illness' pushes the alleged vulnerability even deeper inside individual minds and bodies. These factors paint a picture of people with psychosocial disability as embodying a degree of vulnerability that transcends 'normal' means of help and support. Accordingly I suggest that a conception of 'supra-

107 *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, 322–3 (Kirby P), 335 (Mahoney JA).

108 See *M v Mental Health Review Tribunal* [2015] NSWSC 1876, [68]–[69] (Lindsay J); *Z v Mental Health Review Tribunal* [2015] NSWCA 373, [35] (Basten JA); *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, 325 (Kirby P), 334–5 (Mahoney JA).

109 *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, 322–3 (Kirby P).

110 *Mental Health Act* s 14(1).

111 Tom D Campbell, 'Mental Health Law: Institutionalised Discrimination' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554, 554.

112 See, eg, *M v Mental Health Review Tribunal* [2015] NSWSC 1876, [74] (Lindsay J); *S v South Eastern Sydney & Illawarra Area Health Service* [2010] NSWSC 178, [31] (Brereton J).

vulnerability' – above, over and beyond the limits of vulnerability – emerges through the extraordinary coercive function of mental health law.

This manifestation of 'supra-vulnerability' corresponds to the vulnerability Shildrick proposes is characterised as a 'negative attribute, a failure of self-protection',[113] and which is a 'companion of the monstrous'.[114] Shildrick maintains that the 'incoherence of the monstrous exposes the vulnerability at the heart of all becoming'.[115] When confronted and touched by the monstrous Other – encompassing an array of outsiders and alien figures that vary across time and place – through this corporeal and intercorporeal process of 'becoming', we ultimately seek to eradicate the vulnerability it exposes within our *selves*. We seek to define ourselves in opposition to that which we exclude as the monstrous Other (the 'mentally ill person', the 'mentally disordered person'), yet within that moment of definition the boundaries between self and Other, the asserted binary between madness and sanity, are confused and revealed as permeable.[116]

The coercive function of mental health law facilitates this process of 'becoming', firstly, as between people with psychosocial disability and the public who must be protected from us and, secondly, within our minds and bodies since we must be protected from ourselves. The logic of this function which seeks to eradicate our 'mad' selves – to save us from our selves – implies that these selves, having been supplanted by disorder and unreason, are in fact monstrous Others.[117] This 'splitting of the self' constitutes a supra-vulnerability which may come to be sedimented in and as the minds and bodies of those who resist the imposition of mental health interventions and are forcibly treated.[118]

V INTERPELLATING NORMS AND RECONFIGURATION OF DISSENT AS 'MENTAL ILLNESS'

Examples of dissent being reconfigured as 'mental illness' are often portrayed as belonging to particular historical circumstances or political moments, whereby psychiatry is manipulated by a political or ideological agenda. A critical perspective on mental health law, on the other hand, exposes how similar processes can be embedded within everyday mental health service delivery in the absence of external political pressure. For some service users and survivors of psychiatry their everyday encounters with psychiatry involve the regular labelling of any attempts to resist medical advice, or to assert their needs and wishes, as clinical symptoms. Mental health law may thus render people vulnerable to, and become complicit in the infliction of, discursive injuries which

113 Shildrick, Embodying the Monster: Encounters with the Vulnerable Self, above n 8, 1.
114 Ibid 6.
115 Ibid 8.
116 Ibid 4–6.
117 Thank you to Linda Steele for drawing a link between the 'supra-vulnerability' that relates to alleged lack of self-knowledge and mental health law's response to effectively remove the power of the self.
118 See Minkowitz, 'The United Nations *Convention on the Rights of Persons with Disabilities* and the Right to Be Free from Nonconsensual Psychiatric Interventions', above n 7, 421; Roper, above n 13, 92–3.

become 'written into' embodied histories and have material consequences for the lives of its subjects.

The vulnerabilities I identify in this Part are associated with the impact of medical and mental health norms upon minds, bodies and communities, aligning with the vulnerability conceived of by Butler as 'a way of being exposed to language' and discourse.[119] According to Butler, this exposure to interpellating[120] norms ultimately forms 'the constraining context for whatever forms of agency we ourselves take on in time'.[121] Cadwallader has shown how medical science can miss the specificity of the vulnerabilities that are embodied through our intercorporeal existence.[122] She maintains that this lack of recognition arises precisely because of the dominance of medical norms that constitute the figure of 'the normal body', and that such unrecognised vulnerability can be a source of suffering.[123] Mental health law similarly fails to give due weight to vulnerabilities associated with the interpellating action of mental health norms. The coercive mandate of mental health law both empowers this process and makes it very difficult to challenge.

When mental health law *codifies* the reconfiguration of a person's expressions, opinions and legitimate dissents as psychiatric symptomatology this renders them vulnerable to an extraordinary denial of personhood, sense of self, social existence and *being*.[124] Since they have been redefined as incompetent through formal legal discourses, they are much less likely to be considered deserving of a platform for dissent in future. Such discursive injuries comprise a particularly destructive aspect of the 'largely invisible and largely socially acceptable' form of discrimination known as 'sanism'.[125] Sanism is discrimination directed specifically against people with psychosocial disability based on stereotypes, prejudices and misconceptions surrounding mental illness diagnoses.[126] The injuries identified in this Part, however, extend beyond sanism – and differ from the familiar notion of 'stigma' – in that they are more actively *produced by* interactions with, and actions of, the mental health industry. They therefore also correspond to the term 'psychiatrisation', which 'denotes that

119 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 18.

120 Earlier theorisations of processes of interpellation include those of Louis Althusser and Frantz Fanon: Louis Althusser, *Lenin and Philosophy and Other Essays* (Ben Brewster trans, Monthly Review Press, 2001) [trans of: *Lénine et la Philosophie* (first published 1968)]; Frantz Fanon, *Black Skin, White Masks* (Charles Lam Markmann trans, Pluto Press, 2008) [trans of: *Peau Noire, Masques Blanc* (first published 1952)].

121 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 18.

122 Cadwallader, above n 41, 107.

123 Ibid 118–19.

124 Maria Liegghio, 'A Denial of Being: Psychiatrization as Epistemic Violence' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 122.

125 Michael L Perlin, 'On "Sanism"' (1992) 46 *SMU Law Review* 373, 374; Michael L Perlin, '"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did' (1999) 10 *Journal of Contemporary Legal Issues* 3, 4.

126 Ibid.

something has been done to the [person] rather than seeing their distress as natural and internal'.[127]

The phenomenon whereby the resistance of political dissidents at certain times and in certain places has been pathologised through mental health discourses is widely acknowledged and condemned.[128] For example, media and commentary have addressed the systematic 'abuse' or 'misuse' of psychiatry to label with mental illness, incarcerate and forcibly medicate political dissidents in the Soviet Union in the 1970s,[129] and allegedly in China in waves since the 1950s[130] and persisting into the 2010s.[131] Concerns about the abuses in the Soviet Union played a formative role in the development of the now superseded United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.[132] These prominent instances of repression are often represented as a product of a particular political regime acting upon or through psychiatry.[133] In *Harry v Mental Health Review Tribunal*, examples of this kind were framed as 'misuse, or excessive use, of compulsory mental health powers' that the courts must be vigilant against.[134]

A wider process of the reconfiguration of dissent as 'mental illness' is evident from other historical and present day examples,[135] many of which involve complex interactions between mental health and other social norms. These situations range from the former classification of homosexuality as a mental illness,[136] to the gendered construction of 'hysteria' in the early 20th century as a

127 Brenda A LeFrançois and Vicki Coppock, 'Psychiatrised Children and Their Rights: Starting the Conversation' (2014) 28 *Children & Society* 165, 165.

128 See Robert van Voren, 'Political Abuse of Psychiatry – An Historical Overview' (2010) 36 *Schizophrenia Bulletin* 33.

129 See, eg, Sidney Bloch and Peter Reddaway, *Russia's Political Hospitals: The Abuse of Psychiatry in the Soviet Union* (Littlehampton Book Services, 1977); Anatoly Koryagin, 'The Involvement of Soviet Psychiatry in the Persecution of Dissenters' (1989) 154 *British Journal of Psychiatry* 336; Stephen Faraone, 'Psychiatry and Political Repression in the Soviet Union' (1982) 37 *American Psychologist* 1105.

130 Paul S Appelbaum, 'Law & Psychiatry: Abuses of Law and Psychiatry in China' (2001) 52 *Psychiatric Services* 1297; Robin Munro, 'Judicial Psychiatry in China and Its Political Abuses' (2000) 14 *Columbia Journal of Asian Law* 1.

131 Stanley Lubman, 'Political Psychiatry: How China Uses "Ankang" Hospitals to Silence Dissent', *The Wall Street Journal* (online), 19 April 2016 <https://blogs.wsj.com/chinarealtime/2016/04/19/political-psychiatry-how-china-uses-ankang-hospitals-to-silence-dissent/>.

132 *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 46th sess, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991) annex ('*Principles for the Protection of Persons with Mental Illnesses and for the Improvement of Mental Health Care*'); Munro, above n 130, 11. The UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* has been superseded by the *CRPD*.

133 Richard J Bonnie, 'Political Abuse of Psychiatry in the Soviet Union and in China: Complexities and Controversies' (2002) 30 *Journal of the American Academy of Psychiatry and the Law* 136, 138.

134 (1994) 33 NSWLR 315, 322–3 (Kirby P).

135 I am not claiming that these processes always involve intention or knowledge on the part of clinicians and administrators of mental health services.

136 Shaindl Diamond, 'Trapped in Change: Using Queer Theory to Examine the Progress of Psy-Theories and Interventions with Sexuality and Gender' in Bruce M Z Cohen (ed), *Routledge International Handbook of Critical Mental Health* (Routledge, 2018) 89, 89–90. LeFrançois has recently interrogated the wielding of heterosexism within a child and adolescent mental health service setting: Brenda A

uniquely feminine disease,[137] affecting women or 'unmanly, womanish, or homosexual' men.[138] In these situations the suppressive processes targeted dissent in the sense of divergence from dominant societal discourses and cultural expectations, acting in specific ways upon particular groups. In the case of 'hysteria', feminist critiques have thus broadened beyond analysis of the medical 'disordering' of women to probe how

> [p]sychoanalysis and much later twentieth-century theory generally, in their exclusion of women except as oppositional and always already marginal figures … work to establish patriarchal 'law', to make it invisible … and to pathologize resistance.[139]

The case of hysteria is just one of several aspects of psychiatry's historical and ongoing role in suppressing female protest and pathologising aspects of womanhood.[140]

A more recent example of the pathologisation of dissent by psychiatry is the attribution of a 'protest psychosis' to African American men during the civil rights era, a phenomenon which fundamentally shifted the diagnostic categories of schizophrenia and psychosis and saw African American people increasingly institutionalised in facilities for the 'criminally insane'.[141] Jonathan Metzl's account of this politicised process demonstrates how the group predominantly diagnosed with schizophrenia shifted from middle class 'US-White' women to African American men; this transition saw schizophrenia itself change into a medical category characterised by dangerousness and aggression.[142] Metzl's analysis of numerous medical files of the Ionia State Hospital for the Criminally Insane in Michigan demonstrates how descriptions of the 'symptoms' ascribed to the predominantly African American inmate population in the 1960s and 1970s blurred into subtle and sometimes overt medicalisation of behaviour which challenged the social order of white America.[143]

Metzl's argument that racial tensions and biases are built into the 'DNA' of healthcare systems, and thereby operate at the structural level *prior to* the clinical encounter between the individual doctor and 'patient',[144] has important implications not only for clinical treatment but also for critical approaches to mental health and other laws which call upon the mental health disciplines to

---

LeFrançois, 'Queering Child and Adolescent Mental Health Services: The Subversion of Heteronormativity in Practice' (2013) 27 *Children & Society* 1.

137 Cecily Devereux, 'Hysteria, Feminism, and Gender Revisited: The Case of the Second Wave' (2014) 40 *ESC* 19, 19–20; Carol S North, 'The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations' (2015) 5 *Behavioural Sciences* 496, 500.

138 Elaine Showalter, 'Hysteria, Feminism, and Gender' in Sander L Gilman et al (eds), *Hysteria beyond Freud* (University of California Press, 1993) 286, 289.

139 Devereux, above n 137, 26–7.

140 See Bonnie Burstow, *Radical Feminist Therapy: Working in the Context of Violence* (Sage, 1992) ix–x; Jane M Ussher, 'A Critical Feminist Analysis of Madness: Pathologising Femininity through Psychiatric Discourse' in Bruce M Z Cohen (ed), *Routledge International Handbook of Critical Mental Health* (Routledge, 2018) 72.

141 See Jonathan M Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Beacon Press, 2009).

142 Ibid xii–xvi.

143 Ibid 147–52.

144 Ibid 202.

justify the use of formal coercion. Metzl notes that that the 'protest psychosis' of the American civil rights era is just one of several instances of differential treatment of particular groups by the healthcare system, a number of which are ongoing.[145] Racialised minorities and indigenous people continue to be over-represented within mental health systems in the western world.[146] The Fifth National Mental Health and Suicide Plan draws attention to disproportionately high levels of distress amongst Aboriginal and Torres Strait Islander adults in Australia.[147]

Even though there are likely multiple and complex causes of such disparities, solutions proposed frequently focus on minor adjustments to mental health service systems including cultural competency training, while the causes are attributed to individual cultural biases of clinicians or discrimination and social disadvantage that racialised minorities are more likely to face.[148] Critical perspectives on mental health law and services, on the other hand, highlight the need to probe the extent to which mental health services and discourses may be seen as more actively deployed – in concert with oppressive ideologies which may permeate their very structures – in processes which render people with psychosocial disability vulnerable to physical and psychological harm, rights abuses and political marginalisation.

Ameil Joseph's examination of decisions of the Immigration and Refugee Board of Canada demonstrates how the disproportionate manner in which racialised minorities diagnosed with mental illness are forcibly treated, confined and deported from Canada continues the violent projects of colonialism and imperialism.[149] Alison Howell's examination of madness in international relations includes analysis of the role of the mental health disciplines in the War on Terror as 'technologies of intelligibility', which cast the actions of suicide bombers – including suicide attempts and hunger strikes held by Guantanamo Bay detainees – as a product of damaged psyches.[150] Suicide and self-harm are thus individualised and medicalised in a way which depoliticises these actions, and delegitimises explanations for these actions, as forms of resistance.[151]

Some of the examples raised here may seem far removed from the everyday operation of mental health law. However, every person meets psychiatry and mental health systems at a junction that is enmeshed within social, political, cultural and historical contexts. Approaching mental health law from a critical perspective requires engagement with these intersections. Specific provisions in

145 Ibid 199.

146 Gorman and LeFrançois, above n 15, 110.

147 Department of Health, Commonwealth of Australia, 'The Fifth National Mental Health and Suicide Prevention Plan' (October 2017) 30.

148 Ameil J Joseph, *Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems* (Palgrave Macmillan, 2015) 6–8.

149 Ibid.

150 Alison Howell, *Madness in International Relations: Psychology, Security, and the Global Governance of Mental Health* (Routledge, 2011) 7–8.

151 See, eg, Shaista Patel, 'Racing Madness: The Terrorizing Madness of the Post-9/11 Terrorist Body' in Liat Ben-Moshe, Chris Chapman and Allison C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (Palgrave Macmillan, 2014) 201.

mental health law prohibiting a person's religious and political views, sexuality, antisocial behaviour, socio-economic status or membership of a particular cultural or racial group alone from being used to justify involuntary mental health interventions[152] may operate to exclude the most overt forms of discrimination in its application, but cannot undo the *prior* intertwining of mental health discourses and systems with oppressive ideologies in ways that are not always or immediately apparent.

A 'Everyday' Pathologisation of Dissent

The foregoing discussion has highlighted the unstable nature of the boundary between individual distress and disability on the one hand, and disturbance of the social order on the other. This blurring has implications for everyday mental health service delivery in ways which have been, and continue to be, unravelled by critical Mad, and critical mental health, theories.

Reflecting on suicides by Indian farmers unable to meet their debts during the agrarian crisis in 2008 and government responses which pathologised their actions, China Mills encourages more contextualised understandings of suicides in general rather than demarcation of farmer suicides as 'inherently political'.[153] Similarly, the familiar examples of reconfiguration of dissent as 'mental illness' may be viewed as the pointy end of more diffuse processes to which people may be subjected in their interactions with mental health services. As Erick Fabris and Katie Aubrecht explain, experiences and behaviours that are considered to be madness and labelled as 'mental illness' represent *implicit resistance* to the status quo regardless of whether or not they involve self-conscious protest.[154] Fabris and Aubrecht further maintain that '[p]sychiatric prescriptions make it possible to define social suffering and dissent as signs or symptoms of the existence of personal disorder and moral weakness, rather than embodied responses to inequitable social systems'.[155] I have argued elsewhere that the manner in which such processes suppress freedom of expression and opinion amounts to a form of 'ontological violence',[156] in that an individual's thoughts and opinions may be supplanted with a biomedical system of meaning that destroys their very sense of self.[157]

---

152 See, eg, *Mental Health Act* s 16(1).

153 China Mills, *Decolonizing Global Mental Health: The Psychiatrization of the Majority World* (Routledge, 2014) 38. A number of farmers addressed suicide notes directly to the Prime Minister explaining that their lives were unlivable because of their economic situation.

154 Erick Fabris and Katie Aubrecht, 'Chemical Constraint: Experiences of Psychiatric Coercion, Restraint, and Detention as Carceratory Techniques' in Liat Ben-Moshe, Chris Chapman and Allison C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (Palgrave Macmillan, 2014) 185, 187.

155 Ibid.

156 'Ontological violence' is 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': Slavoj Žižek, *Violence: Six Sideways Reflections* (Profile Books, 2008) 62.

157 Beaupert, above n 5, 9. In relation to forms of symbolic violence, epistemic violence and epistemic injustice perpetrated in this context see, respectively: Lee, above n 13; Liegghio, above n 124; Roper, above n 13.

Consumers, service users, ex-users, psychiatric survivors and Mad commentators have long shared their experiential knowledge of how '[a]ny criticism of the mental health system is viewed as a sign of "serious psychopathology"'.[158] When individuals resist professional opinions and categorisations of their behaviour as symptoms and refuse to comply with proposed mental health interventions, such resistance may be reconfigured as 'lack of insight', 'non-compliance' and further evidence of psychiatric symptomatology.[159] Mental health law solidifies such clinical assessments through its determinations of legal incompetence.[160] Such determinations can have the harmful consequence that practically *all* of a person's commentary is mistrusted, thus making any further position of resistance very difficult to attain.[161] Bridget Hamilton and Cath Roper have explained the implications of this reconfiguration:

> As a consumer, when I do not believe I am sick, and am not convinced by the information or expertise, this contributes to the exercise of laws that take away my civil rights. Responses to this are not structured around the idea of oppression, as they would be if my rights were violated because of political or religious beliefs. Rather the response is: 'You do not see that you are sick, I know you are sick and I have the means to intervene. This is for your own good and I must act on your behalf.' This is an insidious form of oppression, appearing like compassion. My rights are taken away in the interest of my well-being.[162]

The implicit reframing of people labelled 'mentally ill' within this discursive schema as 'vulnerable', combined with the further attribution of 'supra-vulnerability' effectively made through mental health law, renders individuals subject to forced mental health interventions vulnerable to an extraordinary form of delegitimisation.

Some research participants in a project conducted in Victoria on experiences navigating the mental health system[163] discussed how clinicians had reframed their wishes and legitimate concerns as symptoms or evidence of their need for forced mental health interventions. One man said he was placed on a CTO after leaving hospital when mental health practitioners 'had refused to accept he was transgender and told him it was "all in [his] head"' in addition to stopping his

158 Seth Farber, *Madness, Heresy, and the Rumor of Angels: The Revolt against the Mental Health System* (Open Court, 1993) 23 (emphasis altered).

159 Lee, above n 13, see especially 108.

160 The use of the concept of 'insight' in mental health law proceedings has been examined by Kate Diesfeld and Stefan Sjöström: Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health Law' (2011) 10 *Psychiatry, Psychology and Law* 64; Kate Diesfeld and Stefan Sjöström, 'Interpretive Flexibility: Why Doesn't Insight Incite Controversy in Mental Health Law' (2007) 25 *Behavioral Sciences and the Law* 85.

161 Bridget Hamilton and Cath Roper, 'Troubling "Insight": Power and Possibilities in Mental Health Care' (2006) 13 *Journal of Psychiatric and Mental Health Nursing* 416, 420–1.

162 Ibid 420.

163 This research was conducted by researchers based at Monash University and the University of Melbourne led by Associate Professor Renata Kokanovic in collaboration with Professor Bernadette McSherry, Professor Helen Herrman and Dr Lisa Brophy: Options for Supported Decision-Making to Enhance the Recovery of People with Severe Mental Health Problems (SDM) project: Healthtalk Australia, *Credits* <http://research.healthtalkaustralia.org/supported-decision-making/credits>.

hormone treatment.[164] He was successful in having his order revoked by the Mental Health Review Board.[165] A woman recounted her experience of her emotion being 'used … against [her]' by clinicians to justify the ongoing need for the order.[166] She had conveyed her wish to come off a CTO because she was lactating profusely as a side-effect of the drugs she was prescribed. At a later meeting the clinicians said that she had been 'angry' the last time she attended, in her view by way of justifying the ongoing need for the order. The woman said she had to '[fight] hard' to 'make the case to her psychiatrist that she shouldn't be on medication that made her lactate, and should "have a say" in choosing her medication'.[167] She found the support of a mental health organisation crucial to help her to speak calmly and say the 'right things' during subsequent meetings.

These examples underscore the imperative for rigorous advocacy by lawyers representing clients in mental health law and other legal matters where the outcome depends wholly or in part upon assessments of a person's mental health.[168] The above examples indicate that the 'truth' may be buried in long histories of unresolved conflict characterised by the suppression and pathologisation of dissenting views. The lawyer's role in believing and supporting their client and taking seriously any points of disagreement with clinical opinion assumes heightened importance where judges are operating within legal frameworks, such as mental health law regimes, that take a largely uncritical stance on psychiatric diagnostic and treatment processes. This stance stands in stark contrast to a recent report of the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, which states, among other things, that 'many of the concepts supporting the biomedical model in mental health have failed to be confirmed by further research' and that psychotropic medications 'are not as effective as previously thought' and 'produce harmful side effects'.[169] *Forcing* people to submit to treatments which may harm them, but not necessarily help them, is ethically questionable.

These contemporary understandings demand greater efforts to work within the constraints of existing coercive mental health law frameworks to advocate for recognition of the autonomy and capacity of service users as far as possible,[170] and to continue to agitate for full implementation of the *CRPD*'s provisions.

---

164 Healthtalk Australia, *Community Treatment Orders* <http://research.healthtalkaustralia.org/supported-decision-making/community-treatment-orders>.

165 The Board has since been named the Mental Health Tribunal, which was established under s 152 of the *Mental Health Act 2014* (Vic).

166 Healthtalk Australia, *Luana* <http://research.healthtalkaustralia.org/supported-decision-making/peoples-profiles/luana>.

167 Ibid.

168 Michael Perlin has written extensively on the tendency of some mental health lawyers to relax their advocacy role when representing clients labelled with mental illness due to the impact of 'sanism': Perlin, 'On "Sanism"', above n 125; Perlin, '"Half-Wracked Prejudice Leaped Forth"', above n 125.

169 Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN GAOR, 35th sess, Agenda Item 3, UN Doc A/HRC/35/21 (28 March 2017) 6 [19].

170 For discussion of how Victoria Legal Aid has successfully utilised arguments that the person did not lack capacity to make an informed decision about electroconvulsive therapy – or that their ability to consent to

B Intersecting Sites of Oppression and Power

The field of disability studies offers a perspective upon the oppressive processes described in this Part as mechanisms which uphold existing hierarchies of normalcy/(sanity) and disability/(madness) by rendering those who represent a challenge to the 'normate' as deviant and disordered.[171]

Fiona Campbell has shown how people with disability are expected to fit within a medico-legal 'narrative of suffering' in order to gain the law's protection and may internalise the 'tragic scripts' as a consequence,[172] thereby fulfilling the role designated for disability. People who are subject to forced mental health interventions must often assume the role of the 'compliant patient' in order to be 'free' of the involuntary order and survive a system that has worn them/us down.[173] Those who continue to resist, however, risk becoming deeply entrenched in the 'scripts of incompetence' that are written by mental health law, and the consequent 'scripts of dangerousness' that can unravel when disagreements between clinician and 'patient' become heated and charged.[174] Once the 'non-compliant patient' role has been written into a clinical file, it can be difficult to persuade future decision-makers that this is not an accurate representation. Arguing with such assessments once they have been shored up in a legal order is even harder.

The vulnerabilities identified in this Part may remain unrecognised because of the privilege conferred upon the 'sane' mind and 'able' body by medico-legal discourses. Further, this lack of acknowledgment may involve not only silencing of dissent, but also, as discussed, a pernicious reconfiguration of dissent as 'mental illness'. Similar processes of invalidating and manipulating the testimony and accounts of people with disability have been identified by commentators examining other sites of disability oppression.[175] Claire Spivakovsky, for example, has explained how policy responses to challenges that people with disability make to the violence of 'restrictive practices' can work 'perversely to reinforce the apparent need for such mechanisms in the disability

---

this procedure was not adequately assessed – in Mental Health Tribunal proceedings, see Fritze, 'The Variable Treatment of (In)capacity', above n 83, 78–9.

171 Garland-Thomson refers to the 'normate' as the corporeal incarnation of unmarked characteristics signalling the imaginary norm from which the bodies of people with disability and women are assumed to depart: Garland-Thomson, above n 30, 10.

172 Fiona Kumari Campbell, *Contours of Ableism: The Production of Disability and Abledness* (Palgrave Macmillan, 2009) 36–7.

173 Lee, above n 13, 112; Fabris and Aubrecht, above n 154, 186.

174 Liegghio has explored how psychiatrisation disqualifies individuals as legitimate knowers by constructing them as both incompetent and dangerous: Liegghio, above n 124.

175 Claire Spivakovsky, 'Making Risk and Dangerousness Intelligible in Intellectual Disability' (2014) 23 *Griffith Law Review* 389; Claire Spivakovsky, 'The Impossibilities of "Bearing Witness" to the Violence of Coercive Interventions in the Disability Sector' in Claire Spivakovsky, Kate Seear and Adrian Carter (eds), *Critical Perspectives on Coercive Interventions: Law, Medicine and Society* (Routledge, 2018) 97; Josh Dohmen, '"A Little of Her Language": Epistemic Injustice and Mental Disability' (2016) 93 *Res Philosophica* 669. In theorising 'epistemic injustice', Dohmen draws in particular on Fricker's formulation: Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (Oxford University Press, 2007).

services sector'.[176] 'Restrictive practices' is a term commonly used to refer to practices such as physically restraining a person, chemically restraining a person by administering drugs and the use of seclusion.[177]

What can remain deeply buried within the theme of pathologisation of dissent recounted here is the destructive action of repeated sanist assaults (usually discursive but sometimes physical) that a person may encounter in response to what may be termed 'micro-acts' of protest in day-to-day interactions with various services, agencies and organisations.[178] Importantly, the interpellating action of mental health norms has both psychic and material impacts, such that '[b]odily experiences are organized and ordered through diagnoses'.[179] The extent to which such assaults may come to be 'inhabited in one's gestures and actions, even come to be understood to be essential to who we are',[180] demands further reflection. A seemingly isolated 'violent encounter' in this context, assumed to evidence aggression, unreasonableness, 'impulse control' problems, or 'mental illness', may represent the culmination of slow but steady and repeated incidents of suppression.[181]

While this section has switched focus to what may be termed the 'everyday' pathologisation of dissent, this transition does not signal depoliticisation of the construction of normalcy, disability and madness. Rather, recognising this aspect of the phenomenon alongside the more familiar examples associated with particular historical situations and political moments inculpates the ongoing mechanisms which produce subjects and subjectivities through mental health systems and an array of intersecting sites of identity, oppression and power. In contrast, an approach through the lens of ontological vulnerability may, as Alyson Cole suggests, 'unwittingly dilute perceptions of inequality and muddle important distinctions among particular vulnerabilities, as well as differences between those who are injurable and those who are already injured'.[182]

Noémi Michel has called for a shift away from ontological vulnerability to ensure that the multiple injuries and wounds experienced by people marked by racial difference can be articulated and potentially reformulated within a terrain that enables resistance.[183] Her account of 'discursive injury' grounded in postcolonial and critical race studies has implications for all discursive markers of difference including gender, sexuality, ability, age, class and others.[184] The above discussion of how racism, sanism and ableism inform each other in the construction of Mad subjects and subjectivities points to complex entanglements

176 Spivakovsky, 'The Impossibilities of "Bearing Witness" to the Violence of Coercive Interventions in the Disability Sectors', above n 175, 106.

177 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 244 [8.5].

178 See Fabris and Aubrecht, above n 154, 187.

179 Ibid.

180 See Butler, 'Rethinking Vulnerability and Resistance', above n 35, 17.

181 I am grateful to Claire Spivakovsky who helped to shape this contention through several conversations.

182 Cole, above n 16, 262.

183 Michel, 'Accounts of Injury as Misappropriations of Race', above n 16.

184 Michel, 'Equality and Postcolonial Claims of Discursive Injury', above n 43, 466; Michel, 'Accounts of Injury as Misappropriations of Race', above n 16, 241.

between psychiatrisation and other forms of oppression and diverse encounters with madness and distress.[185] It therefore demonstrates the importance of intersectional analyses in order to name, expose and challenge injustice and inequality.

Rachel Gorman and Brenda LeFrançois envision a 'mad theory' that actively engages with, rather than effacing, broader social movements, stating:

> Broader social relations of gender, race, class, sexuality and gender identity play out in Western-based liberal social movements, including mad movements. As mad movements are appropriated into the academic industrial complex as mad studies, radical antipoverty and antipsychiatry movements are both appropriated and de-emphasised. As a result, emergent mad identity tends towards dominant subjectivities.[186]

Interrogating intersecting sites of identity, oppression and violence requires attention to processes by which sanism, racism, classism, heterosexism, ableism and gender-based discrimination may inform, constitute or belie each other. Joseph has proposed moving beyond intersectional or interlocking analyses and towards the notion of 'confluence', examining how historically situated 'processes and technologies of difference' converge (such as in the project of eugenics), in order to avoid (re)-establishing discriminatory hierarchies and reifying problematic identity categories.[187]

As Jijian Voronka has explained, deploying universal service user categories, such as 'people with lived experience' within social justice projects 'risks conflating our conceptual and ideological standpoints as universally shared, and reifying mental illness'.[188] Similarly, the notion that mental health laws shield 'vulnerabilities' shared in common by its subjects implies a universal identity category consistent with the biomedical lens which obfuscates the complex processes through which mental health laws, norms, diagnoses and systems interact with other social norms, systems and historical projects to render individuals vulnerable to harm. The reconfiguration of dissent as 'mental illness' comprises one insidious manifestation of such processes. In the following Part I turn attention to the coercion and material violence that are facilitated and authorised by mental health law.

---

185 Menzies, LeFrançois and Reaume, above n 50, 16–17; Gorman and LeFrançois, above n 15, 111; Rachel Gorman, 'Mad Nation? Thinking through Race, Class, and Mad Identity Politics' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 269; Louise Tam, 'Whither Indigenizing the Mad Movement? Theorizing the Social Relations of Race and Madness through Conviviality' in Brenda A LeFrançois, Robert Menzies and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press, 2013) 281; LeFrançois, above n 136; Emma Tseris, 'A Feminist Critique of Trauma Therapy' in Bruce M Z Cohen (ed), *Routledge International Handbook of Critical Mental Health* (Routledge, 2018) 251.

186 Gorman and LeFrançois, above n 15, 110.

187 Ameil J Joseph, 'Beyond Intersectionalities of Identity or Interlocking Analyses of Difference: Confluence and the Problematic of "Anti"-Oppression' (2015) 4(1) *Intersectionalities*: *A Global Journal of Social Work Analysis, Research, Polity and Practice* 15.

188 Jijian Voronka, 'The Politics of "People with Lived Experience": Experiential Authority and the Risks of Strategic Essentialism' (2016) 23 *Philosophy, Psychiatry, & Psychology* 189, 190.

VI INFRASTRUCTURAL NORMS AND RECONFIGURATION OF VIOLENCE AND COERCION AS SUPPORT

Disability studies has played a pivotal role in building public awareness of the architectural and social supports needed to sustain the body, by demanding recognition of the lack of support inherent in ableist infrastructures.[189] Butler's understanding of the 'infrastructural norms' that enable a livable life and the vulnerability that is produced 'when we find ourselves radically unsupported under conditions of precarity or under explicit conditions of threat'[190] can help to understand the unique forms of violence and deprivations of support that characterise mental health law. This body of law creates a vulnerability that people have when the 'support' offered (imposed) by a legal regime is characterised by physical force and coercion, as outlined in this Part, rather than social relationships and structures that allow individuals to flourish. Such 'support' is in fact a *site* of vulnerability in which we may be 'radically unsupported', constantly threatened with further involuntary interventions in our minds, lives and bodies unless and until we capitulate to dominant mental health norms.

Commentators have drawn attention to the 'lawful violence' to which people with disability are subjected pursuant to laws providing for non-consensual interventions.[191] The Committee on the Rights of Persons with Disabilities[192] has determined that such interventions, which have historically been constructed as therapeutic and therefore lawful within international human rights law, in fact contravene international human rights standards including by denying individual legal capacity.[193] Linda Steele and Leanne Dowse write that this position involves a shift within international human rights 'to a realisation of the vulnerability generated by the very denial of autonomy entailed in removing

189 The development of the social model of disability was integral to this shift: see Barnes, above n 91. This insight has been transformed into several rights enshrined in the *CRPD* including article 9 (accessibility), article 12(3) (access to support required in exercising legal capacity), article 19 (living independently and being included in the community) and article 21 (freedom of expression and opinion, and access to information).

190 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 19.

191 Linda Steele, 'Disability, Abnormality and Criminal Law: Sterilisation as Lawful and "Good" Violence' (2014) 23 *Griffith Law Review* 467; Steele, above n 86; Linda Steele and Leanne Dowse, 'Gender, Disability Rights and Violence against Medical Bodies' (2016) 31 *Australian Feminist Studies* 187; Spivakovsky, 'From Punishment to Protection', above n 56.

192 The Committee on the Rights of Persons with Disabilities is the body charged with monitoring the *CRPD*: *CRPD* arts 34–9. The Committee is also responsible for managing complaints brought by individuals or groups about violation of the *CRPD*'s provisions by a particular state party and conducting inquiries about allegations of 'grave or systematic violations' of *CRPD* rights: *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2518 UNTS 283 (entered into force 3 May 2008) arts 1–7.

193 Committee on the Rights of Persons with Disabilities, *General Comment No 1 – Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) 2 [7], 3 [13], 4–5 [17], 6 [26]–[28], 12–13 [50]. See also Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*, 14th sess (September 2015).

legal capacity and via acts that others authorise in the gap created by this removal of legal capacity'.[194]

Forced mental health interventions place individuals at risk of suffering serious physical, mental and psychic harms. There is mounting concern about the physical harms and lower life expectancies that are associated with being a mental health service user.[195] There is evidence that iatrogenic harms can be caused by psychiatric drugs, and brain damage by neuroleptics specifically.[196] The potential role played by processes of psychiatrisation of dissent, discussed in Part V, in ushering people into a high-risk category is a question deserving careful exploration. Some people with psychosocial disability characterise their interactions with mental health services and detention in mental health facilities as involving violent assaults.[197] The experience of being in a psychiatric ward can involve being physically restrained, placed in seclusion and administered with unwanted drugs.

Forced administration of drugs can produce painful physical effects. Fabris uses the term 'chemical incarceration' to describe the prolonged imposition of drug treatment without a person's consent, a process that 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'.[198] This particular intercorporeal experience, involving the merging of individual bodies with chemical substances, can radically alter and damage a person's body and mind. Yet this suffering is often unrecognised or disavowed.

Even when physical force does not need to be used to ensure that a person submits to psychiatric drugs, informal coercion is frequently utilised to secure compliance.[199] Mental health laws embed coercive forces throughout numerous aspects of the lives of people who are subject to forced interventions,[200] and the coercive shadow cast by these laws over mental health service delivery more broadly operates to create a culture of fear[201] and to suppress resistance to the

194 Steele and Dowse, above n 191, 188.

195 The Royal Australian & New Zealand College of Psychiatrists, 'The Economic Cost of Serious Mental Illness and Comorbidities in Australia and New Zealand' (Report, 2016); David Lawrence, Kirsten J Hancock, and Stephen Kisely, 'The Gap in Life Expectancy from Preventable Physical Illness in Psychiatric Patients in Western Australia: Retrospective Analysis of Population Based Registers' (2013) 346 *BMJ*, 4.

196 Peter R Breggin, *Brain-Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psychopharmaceutical Complex* (Springer, 2nd ed, 2008); Peter C Gøtzsche, *Deadly Psychiatry and Organised Denial* (People's Press, 2015); Robert Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (Broadway Paperbacks, 2010).

197 Lee, above n 13, 112.

198 Erick Fabris, *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders* (University of Toronto Press, 2011) 115.

199 Stefan Sjöström, 'Invocation of Coercion Context in Compliance Communication – Power Dynamics in Psychiatric Care' (2006) 29 *International Journal of Law and Psychiatry* 36, 37; Krysia Canvin et al, 'Leverage and Other Informal Pressures in Community Psychiatry in England' (2013) 36 *International Journal of Law and Psychiatry* 100.

200 Beaupert, above n 5, 17.

201 Lydia Lewis, '"It's People's Whole Lives": Gender, Class and the Emotion Work of User Involvement in Mental Health Services' (2010) 19 *Gender, Work & Organization* 276, 278.

hegemonic nature of mental health discourses.[202] Further, a determination of legal incompetence impacts negatively upon a person's sense of self and can lead to 'learned helplessness' and diminished capacities, as control over their life is taken away from them and vested in substitute decision-makers.[203] This can foster passivity and dependency that (re)-establish 'scripts of incompetency' as ruling texts in individual lives.[204] However, this is not a *mere* matter of words; such legal codifications may have the effect of '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'.[205]

Confinement, control and violence have not ended with the shift in the organisation of mental health and disability services towards 'community care' and the new framework of recovery-oriented services in mental health. Rather, control and surveillance have expanded beyond the physical institution and been dispersed across other institutional and community sites and settings,[206] including through coercive CTOs. Further, refashioned sites of detention and control that have emerged post-deinstitutionalisation are used to manage people with disability across varying contexts, including prisons, group homes and nursing homes.[207]

Linda Steele's exploration of the 'carcerality of the disabled body'[208] raises questions about the intercorporeal nature of embodiment and vulnerability *across* interconnected sites of disability law. Steele suggests that the detention and punishment of people deemed disabled 'is not attached to a particular material architectural space or a particular legal order, but instead attaches to these individuals' bodies via medico-legal designations as disabled'.[209] Her conception exposes an unrecognised vulnerability generated by disability law which lays bare our corporeal instability and permeability. The body deemed disabled is

202 Guilaine Kinouani, 'Neutrality, Power and Psychiatry: Shifting Paradigm through Praxis' on Guilaine Kinouani, *Race Reflections* (13 December 2015) <https://racereflections.co.uk/2015/12/13/neutrality-power-and-psychiatry-shifting-paragdim-through-praxis/>; Lee, above n 13; Beaupert, above n 5, 17–18.

203 Bruce J Winick, 'The Side Effects of Incompetency Labeling and the Implications for Mental Health' (1995) 1 *Psychology, Public Policy and Law* 6, 28; Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 436–7, 462. Winick develops this analysis to argue for a refined approach to the application of laws that deprive people with disability of legal capacity; Dhanda, relying in part on Winick's analysis, argues for recognition of legal capacity as a universal human attribute.

204 See Lee, above n 13, 113–14.

205 Beaupert, above n 5, 20.

206 See Chris Chapman, Allison C Carey and Liat Ben-Moshe, 'Reconsidering Confinement: Interlocking Locations and Logics of Incarceration' in Liat Ben-Moshe, Chris Chapman and Allison C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (Palgrave Macmillan, 2014) 3, 11–12.

207 Spivakosvky, 'From Punishment to Protection', above n 56, 571–2.

208 Linda Steele, 'Disabling Forensic Mental Health Detention: The Carcerality of the Disabled Body' (2017) 19 *Punishment & Society* 327; Linda Steele, 'Temporality, Disability and Institutional Violence: Revisiting *In re F*' (2017) 26 *Griffith Law Review* 378.

209 Steele, 'Disabling Forensic Mental Health Detention: The Carcerality of the Disabled Body', above n 208, 329.

excluded but *intertwined* with legal orders and – painfully – travels 'through time and space' by the force of this attachment.[210]

An associated development with relevance for the relationship between 'vulnerability' and disability law is the creation of new civil law regimes used to manage people with disabilities, which emulate civil mental health laws to an extent and are similarly portrayed as protective mechanisms. Interrogating the Victorian Supervised Treatment Order regime which targets people with disabilities considered to be violent and dangerous, Spivakovsky has shown how this regime, which has in practice predominantly captured offenders – particularly sex offenders – with disabilities post-release, 'claims to protect people with disabilities from a criminal justice system that would capture and contain them'.[211]

Such expansion of disability-specific coercive regimes which mask their coercive and punitive elements within discourses of protection indicates the extent to which disability law and policy continues to be *premised upon* discriminatory and oppressive ideologies and practices. These regimes may be seen in large measure as a means of protecting *ourselves* from vulnerability, by containing and incapacitating monstrous Others who appear to pose a risk.[212] Superimposing vulnerability-focused interventions over coercive disability laws risks further embedding people with disability in these marginalised positions. The severity of the vulnerabilities produced through mental health law means that legal and policy ascriptions of 'vulnerability' to its subjects is highly problematic. Further, discourses representing this regime as a protective mechanism obscure the reality of the vulnerabilities it generates and may distort the publicly accepted 'truth' about its function and impact.

VII VULNERABILITY AS RESISTANCE AND TRANSGRESSION

Dominant biomedical constructions of 'mental illness', despite their suppressive effects, also 'create opportunities for resistance by offering openings to construct counteridentities against this defining norm'.[213] Given the hegemony of psychiatric discourses, the individual and collective actions of service users and psychiatric survivors in asserting unique identities and building diverse knowledges necessarily entail dissent, protest and resistance. There is a growing body of user and survivor knowledges about madness, distress and alternative visions of healing, social justice and political change,[214] building upon the work

210 Ibid.

211 Spivakovsky, 'From Punishment to Protection', above n 56, 565.

212 Alyson Cole has noted similar trends in societal responses to others deemed unsafe – 'criminals, terrorists, raced and ethnicized populations' – where 'negative depictions of vulnerability fuel biopolitical securitization': Cole, above n 16, 265.

213 Voronka, above n 188, 193.

214 A recent collection gathering writings of psychiatric survivors and allies exploring alternatives to psychiatry, building on survivor knowledges and understandings of madness and distress, is Russo and Sweeney (eds), above n 14.

started in the 1960s and 1970s by the anti-psychiatry and Mad liberation movements.[215] Mad studies, which works in part to transform and transcend dominant approaches to madness that characterise the mental health paradigm,[216] is one of a number of sites dedicated to further developing these knowledges. Sheila Wildeman has proposed that such a project might involve, among other things, developing 'localized strategies [to] … disrupt mental health identities and so assist in unsettling the contemporary mental health imaginary'.[217]

Judith Butler, Zeynep Gambetti and Leticia Sabsay suggest that 'vulnerability' exists in a co-constitutive relationship with resistance, being bound up with the problem of precarity and entailing an exposure that can give rise to agency.[218] Individual and collective resistances of service users and psychiatric survivors emerge and persist despite, and through, the coercive framework of mental health law and biomedical notions of disability.[219] Frequently, agency and resistance are not possible in this context without exposure to bodily and psychological harm or 'laying bare' our innermost struggles, driven by the desire to transform our experiences and those of others, retain control over our lives and demonstrate alternative understandings of madness and distress. In considering how vulnerability and exposure to harm may be enabling as well as perilous, Butler uses the example of the mobilisation of vulnerability in public protests during which protestors expose their bodies to the possibility of harm or even death; she notes that such protests operate under the shadow of those who are not present because they have diminished access to public forums, including those who are incarcerated.[220]

Absence and exclusion from platforms and possibilities for dissent is the daily reality for people who are detained pursuant to mental health or criminal laws, or whose agency and autonomy are diminished because of the effects of 'chemical incarceration'. However, these states of vulnerability do not preclude dissent, no matter how strained and difficult to achieve. Like the people who protest most fiercely in the streets, people subject to involuntary mental health orders who resist clinical guidance more strenuously are more likely to be subjected to the extreme application of physical force, whether through being forcibly injected with drugs, restrained or placed in seclusion. These people are also more likely to have their involuntary status extended. Mental health laws

---

215 Menzies, LeFrançois and Reaume, above n 50, 3–6.

216 Menzies, LeFrançois and Reaume, above n 50; Gorman and LeFrançois, above n 15.

217 Sheila Wildeman, 'Agonizing Identity in Mental Health Law and Policy (Part II): A Political Taxonomy of Psychiatric Subjectification' (2016) 39 *Dalhousie Law Journal* 147, 170.

218 Judith Butler, Zeynep Gambetti and Seticia Sabsay, 'Introduction' in Judith Butler, Zeynep Gambetti and Leticia Sabsay (eds), *Vulnerability in Resistance* (Duke University Press, 2016) 1, 1–2.

219 Voronka, above n 188, 193; Katie Aubrecht, 'Disability Studies and the Language of Mental Illness' (2012) 8(2) *Review of Disability Studies: An International Journal* 31, 35. See generally Roper, above n 13; Leah M Ashe, 'Knowing Violence: Psychiatric Hegemony and the Corruption of Care' (Paper presented at the European Association of Social Anthropology, Medical Anthropology Network Conference, Lisbon, Portugal, 5–7 July 2017) <https://www.academia.edu/34336919/Knowing_violence_Scientistic_hegemony_and_the_corruption_of_care>; Chamberlin, above n 14; Fabris, *Tranquil Prisons*, above n 198.

220 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 19–20.

may constrain freedom of expression and opinion to an intolerable degree[221] and can operate not only to silence but also subvert people's dissents. Yet refusing to back down – despite the suffering this may cause – may for some people be the only way to retain a sense of agency and control.

Resistance can also take less overt forms, such as the 'sly normality' outlined by Mills.[222] For Mills, 'sly normality' takes shape when psychiatrised people pretend to agree with clinicians, pretend to take medication – pretend to be 'normal' – to escape the mental health system.[223] Ultimately, Mills suggests that acts of sly normality, although resembling a kind of 'hidden transcript', have the potential to form an underground terrain of resistance that will support and sustain more explicit acts of resistance.[224] Vulnerability on the sly,[225] simmering beneath the surface of our everyday lives but ready to be unleashed at opportune moments, may hold greater potential for countering injustice and violence than the explicit deployment of vulnerability in law and policy. Both cases – material and textual protest on the one hand, and the secret protest entailed in sly normality on the other – contain possibilities for acting on the world in a way that breaks the 'citational chains' of normativity,[226] and unsettles seemingly solidified forms of identity and subjectivity that are mandated by dominant power dynamics.[227]

Wildeman has urged recognition of the 'continuum of material and psycho-social vulnerabilities' on which we are all 'unstably positioned' with a view to disrupting seemingly fixed identities.[228] She envisions this enterprise as an exposé of liminal Mad subjectivity exploring, for example, fleeting encounters with mental health services which unsettle the sane–mad binary and thus hold potential for 'queering', 'madding'[229] or 'agonising' identity. Urging deeper engagement of disability studies with postcolonialism, Michelle Jarman suggests that the 'radical vulnerability' of disabled bodies can be read across the surface and into the reflections of motivations behind broader hegemonic projects such as colonialism and western charity.[230] These moves towards a transgressive and tendentious vulnerability are intimately connected to its intercorporeal nature – the 'intricate interpellation of the self with psychiatry and political economy',[231] and the 'displacement of social and material forces onto bodily surfaces'.[232]

221 Beaupert, above n 5.
222 Mills, above n 153, 108–21.
223 Ibid.
224 Ibid 120.
225 Thank you to Linda Steele for this point.
226 Butler, 'Rethinking Vulnerability and Resistance', above n 35, 18.
227 Shildrick, '"Why Should Our Bodies End at the Skin?": Embodiment, Boundaries, and Somatechnics', above n 32, 21–2.
228 Wildeman, above n 217, 193.
229 Ibid 181.
230 Jarman, above n 26, 115.
231 Wildeman, above n 217, 192.
232 Jarman, above n 26, 114.

VIII CONCLUSION

Drawing on Butler's model of vulnerability, I have used a concept of intercorporeal vulnerability to explore certain vulnerabilities that are produced by mental health law and policy. I have drawn attention to how this field renders individuals vulnerable in two respects. Firstly, mental health law can operate to sediment within embodied histories the injuries produced by the interpellating action upon bodies and minds of mental health norms which reconfigure their dissents as 'mental illness'. Secondly, mental health law authorises violent actions against individual minds and bodies which can leave people radically unsupported and living lives overshadowed by the constant threat of further violence. The injury and suffering created by these vulnerabilities is not adequately recognised at present. Additionally, the fortification of psychiatric discourse by the coercive powers of mental health law means that attempts to assert the existence of these vulnerabilities may be subjected to repeated and deepening cycles of exploitation.

Privileging discourses that represent mental health law as a protective mechanism which shields vulnerability perpetuates dismissal of the violence and coercion that is the lived reality for many of its subjects as either delusion or a regrettable by-product of therapeutic necessity. Alongside work to further develop approaches to providing care and support, both within and beyond mental health systems, it is imperative to build upon community initiatives, activism and scholarship which challenge and critique the assumptions underpinning mental health laws and policies. I have argued that intersectional analyses examining the interaction between different sites of identity, power and historicity are needed to ensure that injustice and inequality can be named, exposed and challenged. Further, a critical Mad perspective – exploring sites where mental health norms intersect with norms of colonialism, race, gender, sexuality, class, disability, and others, and engaging with multiple social movements and theories – holds potential for exposing how oppressive ideologies inform and sustain each other.

I have suggested that examining disability law and policies through the lens of intercorporeal vulnerability can offer a much needed 'reckoning' over the *predisposition* of these regimes to produce vulnerabilities – impacts that are muted when emphasis is placed upon ontological vulnerability. I have argued that the universal and expansive nature of dominant understandings of vulnerability within vulnerability studies mitigates against unravelling the particularities of the vulnerabilities that are generated by disability law and policy. For this reason I question the value of using vulnerability as a legal and political tool to address concrete injustices in this context or to counter the pervasive violence perpetrated against the minds and bodies of people with disability.

Superimposing vulnerability-focused reforms over laws, policies and institutional arrangements *already constituted by* discriminatory and oppressive discourses and practices may further embed disability within a negative vulnerability status. This may make it even more difficult for people to name and

assert their actual suffering, needs or claims for rights protection. The project of expanding the epistemic authority of mental health service users and psychiatric survivors must, above all, allow individuals and communities to name their own vulnerabilities.[233]

233 See Fleur Beaupert and Linda Steele, 'Legal Capacity and Australian Law Reform: Missed Opportunities?' (Paper presented at the International Symposium and Workshop on CRPD and Inclusion of the Persons with Psychosocial Disabilities, Seong-San Bioethics Research Institute, Seoul, Korea, 14 September 2017).