

DISABILITY HUMAN RIGHTS CLINICS AS A MODEL FOR TEACHING
PARTICIPATORY INTERNATIONAL HUMAN RIGHTS LAWYERING

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Introduction

The Disability Human Rights Clinic (DHRC) was established at Melbourne Law School, the University of Melbourne, in 2015. Its supervisors and students conduct legislative and policy reform projects as well as strategic litigation. The DHRC was created by Anna Arstein-Kerslake to address a significant lack of resources in community-based organisations to undertake in-depth legal analysis. It uses an innovative model of clinical legal education to harness the skills of law students to fill that gap and to expose a new generation of lawyers to the emerging field of disability human rights law.¹ In this article, we draw on our experiences running the DHRC to argue that the model it establishes can create significant scholarly output in the human rights field,

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direct engagement with the community, and rich doctrinal and experiential learning for students.

The work of the DHRC is guided by the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD).² The CRPD obliges governments around the world to respect, protect and fulfil the civil, political, economic, social and cultural rights of persons with disabilities. The CRPD emerged as a response to persistent and serious violations of the human rights of persons with disabilities worldwide.³ It does not create any rights that were not already guaranteed under existing human rights instruments, including the Universal Declaration of Human Rights,⁴ the *International Covenant on Civil and Political Rights* (ICCPR),⁵ and the *International Covenant on Economic, Social, and Cultural Rights* (ICESCR).⁶ However, the CRPD does enumerate them in a novel manner, specifically tailored to the barriers that persons with disabilities face to the realisation of their human rights.⁷ The creation and passage of the CRPD was a victory for the international disability rights movement, with persons with disabilities and their representative organisations playing a major role in the

² *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) ('CRPD').

³ Gerard Quinn, 'The United Nations Convention on the Rights of Persons with Disabilities: Toward a New International Politics of Disability' (2009) 15(1) *Texas Journal on Civil Liberties & Civil Rights* 33–52, 37–39; Paul Harpur, 'Embracing the New Disability Rights Paradigm: the Importance of the Convention on the Rights of Persons with Disabilities' (2012) 27(1) *Disability & Society* 1–14, 4.

⁴ UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948 <<http://www.un.org/en/universal-declaration-human-rights/>>.

⁵ *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976, except art 41, which entered into force 28 March 1979).

⁶ *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

⁷ For a discussion, see Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 *Human Rights Law Review* 1, 3–4.

initiation and drafting of the instrument.⁸ The role of persons with disabilities did not end when the CRPD entered into force in 2008; the CRPD obliges governments to involve them in all aspects of implementing the CRPD and monitoring the rights and circumstances of persons with disabilities.⁹

In this article, we argue that clinical legal education offers a valuable avenue to pursue the implementation of the CRPD at the local and national level, and particularly to support persons with disabilities and their representative organisations to advocate for their rights and participate in the CRPD implementation and monitoring process. At the same time, it can provide rich experiential learning to students and meet universities' goal of engaging more meaningfully with the community. As Evans and his colleagues note, while traditional clinical legal education in Australia 'places students in the role of lawyers representing clients with legal questions or problems', the meaning of clinical legal education has evolved in recent decades.¹⁰ It now encompasses a wide range of models that share the 'common element... [of] "real" experiences',¹¹ and the model developed in the DHRC joins this growing range of innovative approaches that combine 'student learning, community service, professional engagement, research and policy development'.¹²

⁸ Ibid.

⁹ CRPD arts 4(3), 31, 33(3).

¹⁰ Adrian Evans, Anna Cody, Anna Copeland, Jeff Giddings, Peter Joy, Mary Anne Noone and Simon Rice, *Australian Clinical Legal Education* (ANU Press, 2017) 41 <<https://press.anu.edu.au/node/2366/download>>.

¹¹ Ibid.

¹² Ibid, 36 and citing Jeff Giddings, *Promoting Justice Through Clinical Legal Education* (Justice Press, 2013) 39–73.

Addressing the history of marginalisation using a human rights framework

Disability research is a unique area because it deals with a group of people who are often marginalised, and research itself has played a role in that marginalisation by, for instance, treating persons with disabilities as objects of scientific study, supporting or justifying rights violations like segregation and invasive medical ‘treatment’, and failing to take into account the priorities and concerns of persons with disabilities in designing and conducting research.¹³ A clinic focused on research related to the rights of persons with disabilities must openly recognise this history of marginalisation and must structure itself in such a way that combats marginalisation in both its methodology and the content of its outputs. One of the key ways in which we employ emancipatory methods is the use of the CRPD as the framework for the curriculum and projects of the DHRC.

The CRPD is one of the most recent United Nations human rights treaties. It establishes that ‘disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’.¹⁴ These barriers include a lack of accessible facilities and services, stigma and discrimination, and insufficient funding of services and supports. Such barriers produce and perpetuate

¹³ Mike Oliver, ‘Changing the Social Relations of Research Production?’ (1992) 7(2) *Disability, Handicap & Society* 101–114 ; Emma Stone and Mark Priestley, ‘Parasites, Pawns and Partners: Disability Research and the Role of Non-disabled Researchers’ (1996) 47(4) *British Journal of Sociology* 699–716, 700–701; Jan Walmsley and Kelley Johnson, *Inclusive Research with People with Learning Disabilities: Past, Present and Futures* (J. Kingsley Publishers, 2003).

¹⁴ CRPD Preamble para (e).

the marginalisation of persons with disabilities in many spheres of life and contribute to the high rates of human rights violations of persons with disabilities around the world. For example, the World Health Organization reports that persons with disabilities have poorer health outcomes, lower educational achievements, less economic participation and higher rates of poverty than persons without disabilities.¹⁵ Persons with disabilities are frequently subject to exclusion and segregation in many areas of life, such as education, employment and accommodation.¹⁶ The ability of persons with disabilities to live independently and to be included in the community is often questioned, especially for persons with cognitive disability.¹⁷ Another crucial issue is the ongoing legal practice in most parts of the world of restricting a person's legal capacity on the basis of disability.¹⁸ This denial of legal capacity is commonly coupled with the legitimation of 'substituted decision-making' by third parties, for

¹⁵ World Health Organisation, *Summary World Report on Disability* (Report, World Health Organisation, 2011) 10-12

<http://apps.who.int/iris/bitstream/10665/70670/1/WHO_NMH_VIP_11.01_eng.pdf>.

¹⁶ See for example Australian Government, *Shut Out: the Experience of People with Disabilities and their Families in Australia* (National Disability Strategy Consultation Report, Commonwealth of Australia, 2009) <<https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/shut-out-the-experience-of-people-with-disabilities-and-their-families-in-australia>> ; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Montenegro*, 18th sess, UN Doc CRPD/C/MNE/CO/1 (22 September 2017) paras 14, 36(c); Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Luxembourg*, 18th sess, UN Doc CRPD/C/LUX/CO/1 (10 October 2017) paras 42, 48; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Serbia*, 15th sess, UN Doc CRPD/C/SRB/CO/1 (21 April 2016) para 13; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of the European Union*, 14th sess, UN Doc CRPD/C/EU/CO/1 (2 October 2015) para 22.

¹⁷ Jenny Morris, 'Independent Living and Community Care: A Disempowering Framework' (2004) 19(5) *Disability & Society* 427-442, 431-2.

¹⁸ 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) para 8. For a discussion, see Author 2017.

example, where a person can be involuntarily admitted and treated in a psychiatric facility on the basis of an assessment of their ‘best interests’, or where a legal guardian can be appointed to make financial, healthcare, lifestyle, or other decisions on the person’s behalf.¹⁹ Other fundamental civil and political rights, such as the right to vote or protection from arbitrary deprivation of liberty, are restricted or fully denied because of impairment in many countries.²⁰

The persistence of these barriers globally, coupled with decades of advocacy and activism by persons with disabilities, led to the creation of the CRPD to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’.²¹ As noted above, the international disability community played a key role in advocating for a human rights treaty on disability, and a variety of national and international Disabled Persons’ Organisations (DPOs) contributed to the development and passage of the Convention. DPOs are civil society organisations controlled and led by persons with disabilities. They comprise a range of local, national and international non-government organisations with ‘the aim of collectively acting,

¹⁹ Ibid, paras 7, 27, 42.

²⁰ See for example the European Union Agency for Fundamental Rights’ (FRA) reports on the right to political participation and violence against children: FRA, *The Right to Political Participation of Persons with Mental Health Problems and Persons with Intellectual Disabilities* (Report, FRA, 2010) <http://fra.europa.eu/sites/default/files/fra-2010-report-vote-disability_en.pdf>; FRA, *Violence Against Children with Disabilities: Legislation, Policies and Programmes in the EU* (Report, FRA, 2015) <http://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-violence-against-children-with-disabilities_en.pdf>.

²¹ CRPD art 1.

expressing, promoting, pursuing and/or defending a field of common interest'.²² The drafting process was driven by active participation of DPOs and other civil society actors to a greater extent than other treaties.²³ The CRPD was adopted in 2006 and entered into force on 3 May 2008. As of March 2018, 176 States are party to it.²⁴

While the international disability rights movement has emphasised that persons with disabilities do not ask for special rights, the CRPD addresses specific challenges and human rights issues that are unique to the situation of persons with disabilities. They include, for example, equal recognition before the law and the prohibition of all forms of discrimination on the basis of disability;²⁵ taking appropriate measures to ensure equal access to the physical environment, transportation, information and communications technologies, and other systems and facilities;²⁶ ensuring against unlawful or arbitrary deprivation of liberty;²⁷ realizing the right to inclusive education;²⁸ and guaranteeing equal enjoyment of political rights, including the right to vote and be elected.²⁹

²² United Nations General Assembly, *Report of the Special Rapporteur on the Rights of Persons with Disabilities*, 31st sess, UN Doc A/HRC/31/62 (12 January 2016) para 36 <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session31/Documents/A_HRC_31_62_E.doc>.

²³ See Kayess and French, above n 7.

²⁴ Office of the High Commissioner for Human Rights, United Nations, *Status of Ratification Interactive Dashboard* (13 March 2018) <<http://indicators.ohchr.org/>>.

²⁵ CRPD arts 5, 12.

²⁶ CRPD art 9.

²⁷ CRPD art 14.

²⁸ CRPD art 24.

²⁹ CRPD art 29.

One of the guiding principles of the international disability rights movement, ‘nothing about us without us’, demands that all matters affecting persons with disabilities should involve persons with disabilities in positions of leadership and control.³⁰ The CRPD reflects this, explicitly obliging States to closely consult with, and actively involve, persons with disabilities and DPOs in the development and implementation of the CRPD (art 4), and in monitoring that implementation (art 33).³¹

This requirement to meaningfully include persons with disabilities applies to research that assesses the status quo in regard to the human rights situation of persons with disabilities, analyses relevant legal, political and social structures, and informs necessary policy and law reform. Historically however, as we noted above, research on disability has been conducted from a medical and deficit-oriented perspective, focusing on individual impairments and identifying approaches to ‘fix’ or ‘cure’ them. This is often referred to as a ‘medical model’ approach to disability.³² While medical research on impairment and human functioning is of course valuable for some purposes, the societal barriers facing persons with disabilities are complex and multifaceted, and cannot be redressed through medical research alone. In their role as objects of research, persons with disabilities have often been placed in a position of

³⁰ Kayess and French, above n 7, 12; Paul Harpur, ‘Embracing the New Disability Rights Paradigm: the Importance of the Convention on the Rights of Persons with Disabilities’ (2012) 27(1) *Disability & Society* 1–14.

³¹ For further information about legal mechanisms for involving and consulting DPOs, see FRA, *DPO Involvement: Indicators on Political Participation of Persons with Disabilities* (Background Information Report, FRA, 2014) <<http://fra.europa.eu/en/publications-and-resources/data-and-maps/comparative-data/political-participation/dpo-laws>>.

³² Theresia Degener, ‘Disability in a Human Rights Context’ (2016) 5(3) *Laws* 35 <<http://www.mdpi.com/2075-471X/5/3/35>>.

silence and dependency and their lived experience has not been considered to be valuable or relevant knowledge.³³ Persons with psychosocial and intellectual disabilities in particular are often questioned in terms of their ability to provide relevant and reliable information due to an assumed lack of mental capacity.³⁴ On this basis, academia has been a particular target of criticism by disability rights scholars and activists.³⁵

The call for disability research to be participatory and co-produced led to the formation of disability studies,³⁶ a research field characterised by the idea that persons with disabilities and their perspectives should have control over research, and providing them with decision-making powers regarding research questions, design and dissemination. In disability studies, researchers are held accountable by persons with disabilities and their representatives, who are involved in the research process wherever possible, as either academic researchers and/or non-academic partners.³⁷ This requires a questioning of traditional power hierarchies within academia and the opening of knowledge production to a marginalized social group.³⁸ Disability research emerges from a variety of disciplines but is always characterized by its aim to

³³ Jasna Russo and Peter Beresford, 'Between Exclusion and Colonisation: Seeking a Place for Mad People's Knowledge in Academia' (2015) 30(1) *Disability & Society* 153.

³⁴ See for instance Carol K Sigelman, Edward C Budd, Cynthia L Spanhel and Carol J Shoenrock, 'Asking Questions of Retarded Persons: A Comparison of Yes-no and Either-or Formats' (1981) 2(4) *Applied Research in Mental Retardation* 347.

³⁵ See above, n 13.

³⁶ Stone and Priestley, above n 13.

³⁷ Gerry Zarb, 'On the Road to Damascus: First Steps towards Changing the Relations of Disability Research Production' (1992) 7(2) *Disability, Handicap & Society* 125.

³⁸ Rannveig Traustadóttir, 'Research with Others: Reflections on Representation, Difference and Othering' (2001) 3(2) *Scandinavian Journal of Disability Research* 9.

empower and liberate participants and to foster social change on a broader scale. As the academic arm of the disabled peoples' movement, disability studies informed the drafting of the CRPD and provided a theoretical framework for its implementation.³⁹ Most importantly, the CRPD is premised on a 'human rights model' of disability, which is a further development of the social model of disability.⁴⁰ In comparison to the social model, the human rights model provides not only an explanation for the exclusion of persons with disabilities, but also, through the appeal to universal human rights, a framework for political and legal measures to remedy them. The model focuses not only on non-discrimination and civil rights, but also on the social, economic and cultural rights of persons with disabilities. Research that adopts a human rights-based model definition of disability, and that supports the work of persons with disabilities and their representative organisations to achieve social change in a collaborative way, can contribute to the monitoring and implementation of the CRPD at the national and international level. Student law clinics offer one means to pursue research that accords with the human rights model of disability and contributes to the implementation and monitoring of the CRPD. In clinical legal education programmes, research that pursues these goals can be conducted while also

³⁹ See Arlene S Kanter 'The Law: What's Disability Studies Got to Do with It or An Introduction to Disability Legal Studies' (2011) 42(2) *Columbia Human Rights Law Review* 40; Rannveig Traustadóttir, 'Disability Studies, the Social Model and Legal Developments' in Oddný Mjöll Arnardóttir and Gerard Quinn (eds), *The United Nations Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijhoff Publishers, 2009) 1.

⁴⁰ Degener, above n 32.

offering students crucial experiential and theoretical learning. In the next section, we discuss this second contribution of disability human rights clinics.

Clinical legal education – cause-based lawyering, experiential lawyering, and engagement

Clinical legal education is increasingly recognised as a valuable – if not essential – complement to traditional legal education. Student clinics ensure that students develop valuable professional skills for their future careers as lawyers, including legal research and analysis, teamwork, client liaison, clear writing, and advocacy. Students are then equipped with knowledge and skills for lawyering in general, as well as ‘cause-based lawyering’ in the human rights field and beyond.⁴¹ Clinics also contribute to the ‘third mission’ of universities to engage with, transfer knowledge to, and contribute to the development of, the community.⁴² This responds to calls by public and private funding agencies for universities to leave the ‘ivory tower’ and allow non-academic organizations and individuals to access and actively participate in research activities.⁴³ Most notably, clinics can increase access to justice for people who have traditionally been denied this right, for instance, by sharing knowledge,

⁴¹ Kris Gledhill, ‘Establishing An International Human Rights Clinic in the New Zealand Context’ (2013) 19 *International Journal of Clinical Legal Education* 295 <<http://dx.doi.org/10.19164/ijcle.v19i0.31>>.

⁴² Michael Loi & Maria Chaira Di Guardo, ‘The Third Mission of Universities: An Investigation of the Espoused Values’ (2015) 42 *Science and Public Policy* 855.

⁴³ Henk A. J. Mulder and Caspar F. M. De Bok, ‘Science Shops as University–community Interfaces: An Interactive Approach in Science Communication’ in Cheng Donghong, Jenni Metcalfe and Bernard Schiele (eds) *At the Human Scale – International Practices in Science Communication* (Science Press, 2006) 2.

skills and resources with community organisations, by providing research support to community legal centres, or by contributing to reports or communications to law reform or other relevant bodies.

In the next section, we describe the Disability Human Rights Clinic at Melbourne Law School, and propose that it has six key features that are necessary for the design and execution of clinical programs that can achieve these multiple purposes.

Disability human rights clinics as a means to pursue the goals of the CRPD and clinical legal education

The Disability Human Rights Clinic at Melbourne Law School

While several other disability rights-focused law clinics are in existence,⁴⁴ the DHRC was the first project-based clinic that is focused on systemic change, and the first to incorporate disability studies and disability human rights curriculum. It is offered to students completing the Juris Doctor (JD) post-graduate law degree. The degree comprises both compulsory and elective subjects, and the DHRC has been offered as a semester-long elective or a three week intensive subject. It counts towards students' academic credit. Students enrolled in the DHRC undertake 12 days of clinical work (one day per week during semester or four days per week during the intensive). Each clinic day begins with a 90-minute seminar on international human rights law,

⁴⁴ For example, the Disability Legal Information Clinic at the National University of Ireland, Galway's Centre for Disability Law and Policy (see <<https://www.nuigalway.ie/centre-disability-law-policy/dlic/>>) and the Cerebra Pro Bono Research Programme at the University of Leeds (see <<http://www.law.leeds.ac.uk/about/extra/cerebra-pro-bono-research-programme>>).

disability rights law and disability studies. Students spend the rest of the clinic day working in small teams on a disability human rights-related clinical project, with the clinic director providing ongoing guidance through informal discussions and scheduled meetings with each team. Each group works on one major project for the duration of the course; on the first day of the clinic, students are invited to rank the projects that most interest them and are allocated to a group on that basis.

As a project-based clinic, students in the DHRC engage in research and/or advocacy focused on systemic change as opposed to individual client service. Clinical projects may include law or policy submissions, amicus briefs, research support for strategic litigation, or other projects that require legal analysis. Most projects have a ‘client partner’, which is an organisation that needs a specific project to be completed. These may be documents that are internal to the organisation, such as an inclusion or diversity policy review, or they may be public documents, such as a public report or submission. Through the DHRC website⁴⁵ and the professional contacts of the clinic director and fellows, project proposals on disability human rights issues are invited from DPOs, community legal services, state and federal government agencies, researchers in other faculties at the University of Melbourne, and other stakeholders. The students work closely with their client partner, seeking guidance when developing the project and conducting the research, and inviting feedback on drafts. At the end of semester, students deliver their research findings to the partner and

⁴⁵ See <<http://law.unimelb.edu.au/students/jd/enrichment/pili/subjects/disability-human-rights-clinic>>

(where appropriate) to the academic and wider community, through both written papers and oral presentations or seminars.

Based on our experiences in the DHRC, we propose that clinics must have six essential features in order to fulfil the tripartite mission of human rights implementation, engaging with the community, and providing rich experiential learning for students. We propose that these features can also offer useful guidance to human rights clinics concerned with other groups of rights-holders such as refugees and asylum seekers, women and older persons.

Six essential features of disability human rights clinics

1. Conduct projects that share the objectives of the CRPD

Disability human rights clinics should have an overarching objective of improving the human rights situation of persons with disabilities through legal analysis, research and/or investigation of the legal, political and social barriers to the realization of the rights enshrined in the CRPD. Using the CRPD as a framework for disability human rights clinics ensures that the research being conducted is underpinned by a set of principles and values that have been determined by the disability community itself. This places the clinic in the best position to co-produce research that meets the needs of that community.

The DHRC operates under the human rights-based model. It uses the CRPD as a framework for its curriculum as well as a basis for the legal analysis within each

clinical project. Within that framework, it accepts and adopts a social model of disability that recognises that social barriers and law reform can be altered to meet the needs of persons with disabilities. The DHRC rejects the concept that disability is a burden or that it is deficient in the individual. It also rejects the notion that disability is something that inherently needs to be ‘cured.’ Instead, in following with the CRPD and the social model, the DHRC celebrates diversity and strives to remove socially constructed barriers to full participation and equal rights for persons with disabilities. Projects may encompass ‘traditional’ legal research, such as the preparation of legal submissions, amicus briefs or information for public interest litigation, but also more advocacy-focused endeavours such as assisting non-profit organisations to draft shadow reports (which offer an alternative perspective to official State reporting) to the CRPD monitoring body, the Committee on the Rights of Persons with Disabilities, or the development of training materials for self-advocates and other stakeholders (like judges and disability service providers) on the legal implications of the CRPD. For example, projects completed by DHRC students have included research for strategic litigation being contemplated by the Australian Centre for Disability Law, a Specialist Community Legal Centre based in Sydney, and contributing to the annual report of Catalina Devandas Aguilar, the United Nations Special Rapporteur on the Rights of Persons with Disabilities, to the Human Rights Council and General Assembly.

Project-based clinics are particularly well-suited to human rights subjects⁴⁶ because human rights advocacy is often based on reporting, strategic litigation, and submissions to human rights bodies.⁴⁷ There are other benefits to project-based clinics. They allow the students to work on broader social issues⁴⁸ and to play a role in strategic litigation and law and policy reform efforts. There are also practical advantages of this structure. As long as the projects do not involve the provision of specific legal advice,⁴⁹ there is usually no need for student practice orders or for the supervisor to have a practicing certificate or admission to the local bar. In jurisdictions that do not have student practice orders, this is a significant benefit. This also allows international guests or partners to engage more heavily with clinic projects.

2. Partner with DPOs (and, where appropriate, other organisations whose activities have implications for the rights of persons with disabilities)

It is vital that disability human rights clinics focused on the rights or needs of marginalized communities engage with relevant non-government organizations (especially Disabled Persons' Organisations) and community groups. This ensures

⁴⁶ See Deena R Hurwitz, 'Lawyering for Justice and the Inevitability of International Human Rights Clinics' (2003) 28(2) *Yale Journal of International Law* 505

<<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1221&context=yjil>>.

⁴⁷ For a discussion of human rights clinics, see Arturo J Carrillo, 'Bringing International Law Home: The Innovative Role of Human Rights Clinics in the Transnational Legal Process' (2003) 35 *Columbia Human Rights Law Review* 527

<https://www.law.gwu.edu/sites/www.law.gwu.edu/files/downloads/IHRC_article_AC.pdf>.

⁴⁸ For a discussion, see Katherine R Kruse, 'Biting Off What They Can Chew: Strategies for Involving Law Students in Problem-solving Beyond Individual Client Representation' (2002) 8 *Clinical Law Review* 405 <<https://ssrn.com/abstract=2172346>>.

⁴⁹ The definition of 'legal advice' varies based on jurisdiction and should be verified in any jurisdiction where a project-based clinic is running.

that they are up to date with the specific needs of the communities that they are working with. In order to meet the requirements of the CRPD in regard to the involvement of persons with disabilities in implementing and monitoring the Convention, clinics of this kind should also strive to respond directly to the needs of the specific community that they are working with. In practice, this means clinical programs should invite persons with disabilities and DPOs to propose clinical projects that will provide what they need to pursue disability human rights issues arising in relation to the CRPD.

Project-based clinics can fill a gap in the DPO community's resources.⁵⁰ These bodies are often under-funded and under-resourced with little capacity for writing and analysis, while project-based clinics have a student group that has designated time specifically for these tasks. Juris Doctor and other graduate students are usually particularly well suited to this type of work because they are post-graduate students with well-developed research and writing skills. Collaboration between project-based clinics and NGOs can often produce the best results because they combine the grassroots knowledge of the NGOs with the research and writing skills of the students and the resources of the university clinic.

While partnerships with persons with disabilities and their representative organisations should be prioritised, projects with or for other stakeholders may also

⁵⁰ For a discussion of the need for clinics to be responsive to community need, see Sameer Ashar, 'Law Clinics and Collective Mobilization' (2008) 14 *Clinical Law Review* 355.

be appropriate and consistent with the overarching objectives of disability human rights clinics. In particular, clinic students can offer training, advice and detailed analysis of the human rights implications of laws, policies and practices to government bodies, disability service providers and other organisations that may not otherwise adopt a human rights lens. Clinical projects of this nature can contribute to raising awareness about the rights of persons with disabilities (as guaranteed in article 8 of the CRPD) and increasing access to justice for persons with disabilities (article 13), among others. For example, students in the inaugural DHRC partnered with the Administrative Appeals Tribunal, an independent statutory body that decides appeals on certain administrative decisions made by the Australian government under Commonwealth laws. Its mandate includes reviewing decisions about individuals' access to the National Disability Insurance Scheme (NDIS), a new national scheme designed to give persons with disabilities access to individualised funding to purchase disability-related supports. The first object of the legislation establishing the NDIS is to 'in conjunction with other laws, give effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities'.⁵¹ In light of this, the DHRC students developed and presented a toolkit to assist Tribunal members to make decisions that are compliant with the CRPD.

In cases where person with disabilities and their representative organisations are not the primary project partners, it is especially crucial to ensure that the voices of the

⁵¹ *National Disability Insurance Scheme Act 2013* (Cth) s 3(1)(a).

disability community still guide the research. For example, research projects will only be selected if their goals are consistent with the CRPD and the statements of DPOs, the Committee on the Rights of Person with Disabilities or other United Nations mechanisms and agencies. In the DHRC, students are expected to make contact with relevant DPOs during the course of their projects, in order to seek their perspective and guidance on the issue and to invite their input. Ideally, students will also share their research outputs with interested DPOs, and produce versions of their materials that may be useful to that group. For example, one group of DHRC students who conducted comparative research on Australian and German guardianship laws for partners at the Bochum Centre for Disability Studies (BODYD) at the Protestant University of Applied Sciences RWL (Germany) also ran a workshop on Victorian guardianship laws and sought feedback on their research from the leadership group at VALiD, a Victorian organisation run by and for persons with intellectual disability and families.

The DHRC uses several methods to engage with DPOs and other potential partners. The DHRC website (hosted by Melbourne Law School) invites DPOs and persons with disabilities to propose research topics and collaborate with students and researchers to investigate those topics and produce research outputs. The clinic director and her colleagues also refer potential partners to the clinic when they are approached or otherwise hear about suitable projects. Information about human rights violations and issues of concern are also sought from other stakeholders, such as domestic

government bodies, non-DPO civil society organisations, disability service providers, and United Nations mandates and mechanisms (including members of the CRPD Committee and the Special Rapporteur on the Rights of Persons with Disabilities), although these voices are always considered to be secondary to those of persons with disabilities.

3. Participatory research methodology

Partnerships with DPOs in disability human rights clinics should not be restricted to commissioning clinical projects and taking receipt of research outputs. Rather, individuals and organisations should be involved as co-designers and co-producers of the research, in-keeping with the principles of participatory and emancipatory research developed in disability studies and reinforced in the CRPD. This means that research topics must be designed on the basis of concerns raised by, or direct research requests from, the disability community. It also requires students and researchers to discuss and agree on the design and conduct of the research project with these partners, hold regular meetings to discuss and refine the research process, and incorporate feedback from community partners before finalising their research reports or other project outcomes, including identifying accessible ways of disseminating the reports (discussed further below).

This ongoing engagement has several advantages. Research outcomes are not dictated by the initial research question but also by decisions made with the partners during the research process itself, for example regarding the operationalisation of research

questions and the selection of methods. This enables partners to understand and to actively take part in the necessary decisions-making processes.⁵² Intensive participation in the research process can be empowering for community partners who themselves gain new knowledge and skills, for example, by learning how international and national law work and how they can be useful for their own advocacy and action. At the same time, DPO involvement secures the student researchers' access to relevant stakeholder knowledge. The two-sided knowledge exchange ensures that research outcomes can be a tool for change – on one side, students are informed by needs or problems identified by the affected community, and on the other side, partnering organisations are supported by rigorous legal research and analysis.

Clinic students profit just as much from working closely with the community partners, gaining career-relevant contacts and developing their skills in project design and management, client liaison, legal and social research, advocacy, teamwork, responsiveness and communication. For example, students in the DHRC have formed working relationships that could lead to future work experience and employment, including peak national DPOs, community legal centres, United Nations mechanisms, and statutory authorities like the Victorian Office of the Public Advocate and Victoria Legal Aid. The project-based format enables students to gain lawyering skills that they

⁵² See Vivien Runnels & Caroline Andrew, 'Community-based Research Decision-making: Experiences and Factors Affecting Participation' (2013) 6 *Gateways: International Journal of Community Research and Engagement* 22.

may not have the opportunity to develop in their other studies. Working with other students, supervisors and community partners requires high-level teamwork and interviewing skills, and students are supported to develop these skills throughout the clinic teaching period.

4. *Produce accessible and useful outputs*

Law students and lawyers have long been criticised for failing to ensure that their written communications are clear and accessible to lay clients.⁵³ The issue of accessibility is of particular relevance for persons with disabilities, as they commonly face exclusion from accessing information due to communication barriers. This very much applies to academic publications, with journal articles, research reports and scientific conferences rarely being provided in accessible formats. Another crucial component of a disability human rights clinic is therefore to create outputs in shared ownership that are accessible and tailored to the needs of the community partners.

DHRC students are encouraged to identify the most useful and accessible formats for their research outputs early in the project planning process and in consultation with the partner organisation. For example, several groups of students have developed materials in ‘easy-to-read’ format, which they have utilised in workshops with persons with intellectual disability or their representative organisations.⁵⁴ The

⁵³ See for example Ros Macdonald and Deborah Clark-Dickson, *Clear and Precise Writing for Today’s Lawyer* (Queensland Law Society, 2000).

⁵⁴ Misako Nomura, Gyda Skat Nielsen and Bror Tronbacke, *Guidelines for Easy-to-Read Materials* (IFLA Professional Reports No 120, International Federation of Library Associations and Institutions, 2010) <<https://www.ifla.org/publications/guidelines-for-easy-to-read-materials>>.

DHRC's research outputs, such as written reports and videos of presentations, are published in multiple formats on the (accessible) Melbourne Law School website, including screen-reader accessible reports. The accessibility of presentations and seminars is also considered, with wheelchair accessible venues, sign-language interpretation, and other accessibility considerations factored into event planning. This is a work in progress, with future plans to develop more easy-to-read outputs and accessible events.

Where appropriate, disability human rights clinics can also provide advice and support to partner organisations to utilise the research outcomes to pursue social change by, for instance, linking them with legal services to pursue strategic litigation, or providing guidance on pursuing formal redress through a communication to the Committee on the Rights of Persons with Disabilities or other domestic or international bodies. This can also contribute to the realisation of the right to access to justice guaranteed in article 13 of the CRPD. Finally, to maximise the reach and impact of the research findings, partners are invited to share the research outputs with their members and networks. Permission is sought from the students and the partners prior to this dissemination.

5. Combine disability studies and human rights education

A detailed background in disability studies and human rights education is essential for students engaged in disability human rights clinics. The DHRC includes a teaching component – a 90-minute seminar or lecture at the beginning of every clinic day – to

equip students with a detailed knowledge of disability studies and disability human rights law and practice. Seminars address the key aspects of disability studies and teach students about the central ideas and shift of perspective that the emergence of this interdisciplinary research field brought to the scientific discussion of disability. This is particularly important for students in many universities that do not have disability studies or disability law programs.

Topics addressed in the seminars include the medical and social models of disability; discrimination (including intersectional discrimination); legal capacity; and accessibility. Other seminars deal with general human rights principles, theory and law, including the history and enforceability of international human rights, and the universal rights guaranteed in the ICCPR and the ICESCR. The application of these rights specifically to persons with disabilities in the CRPD, the implementation of disability human rights in domestic law in Australia and other parts of the world, and the mandates and activities of international human rights monitoring mechanisms, are also addressed. In the DHRC, we have very intentionally ensured that the substantive curriculum that we teach also includes knowledge of the history of marginalisation of persons with disabilities and the role that research has played. We also include an overview of new methods that have been proposed to shift research from marginalising to participatory and emancipatory.⁵⁵ Finally, we ask the students

⁵⁵ See for example Stone and Priestley, above n 36.

to explore how participatory and emancipatory methodologies can be employed in their work in the clinic and how the clinic as a whole uses those methodologies.

Lectures and seminars on disability studies and human rights (and associated readings and exercises) provide students with the background material that is essential to their ability to produce useful and legally sound research outputs for their partner organisations, and to develop essential legal knowledge for future lawyering and advocacy work in the national or international human rights fields. While students' learning is assessed primarily through a research report (or other output) produced for the partner, they are also required to complete a short exam at the end of the semester. This ensures that students have engaged with the full breadth of relevant materials, and not just the specific subject matter involved in their clinical project.

Importantly, the DHRC director and lecturers are aware of the sensitivity of some matters that arise during lectures and discussions, particularly because many of our students and lecturers are persons with disability themselves. Trigger warnings are provided for students regularly throughout the course of the clinic. Students meet individually with the director to ensure that there is adequate space for all students to express themselves, including when they are having a difficult time and experiencing anxiety or are particularly impacted by the sensitive issues such as violence and discrimination that arise in this area.

6. *Ensure that the clinic and educational experience is accessible to all*

In addition to making sure that the research outputs of disability human rights clinics are accessible, clinics (and all aspects of legal education) must also be accessible to students. This means ensuring that classrooms, learning materials and communications between lecturers, supervisors, students and partners are accessible. Frances Gibson has proposed that all clinical legal programs should follow a number of guidelines to ensure that clinics adhere to the requirements of the CRPD.⁵⁶ These include mandatory skills-based disability training for staff and students, contributing to policy-making and activities to increase the enrolment of students with disabilities in law programs, encouraging students with disabilities to enrol in clinics, teaching critical analysis of the law's approach to disability, and promoting employment of staff with disabilities.

The critical analysis of the law's approach to disability is the centrepiece of the DHRC. In addition, students are invited to note any accessibility requirements in their application to enrol in the clinic, and to attend a meeting with the clinic director prior to the commencement of the course if they so desire. Classes are conducted in an accessible room, and materials (such as the course outline and electronic versions of assigned reading materials) are provided in multiple formats as required. If requested, the director and fellows also provide support to students in their interactions with

⁵⁶ Frances Gibson, "'The Convention on the Rights of Persons with Disabilities': The Response of the Clinic' (2011) 15 *International Journal of Clinical Legal Education* 11 <<http://dx.doi.org/10.19164/ijcle.v15i0.53>>.

university services (such as the Student Equity and Disability Support service at the University of Melbourne) to make alternative exam arrangements and so on. Staff involved in the DHRC all have a background in disability rights law. They are involved in other disability rights-related research and activities within the University of Melbourne, including consultation on disability policy and student inclusion.

The multi-directional benefits of disability human rights clinics

The six principles outlined above emphasise the role of disability human rights clinics in both supporting the mission of community organisations (especially DPOs) and offering valuable experiential and traditional learning to students. Disability human rights clinics have obvious appeal for law schools and universities. They are relatively low cost – supervisors do not generally require a practising certificate for project-based clinical work, partner organisations mainly provide in-kind support rather than requiring funding, and the widespread availability of information and communication technology like video-conferencing reduces the need for travel to meet with partners or deliver research outputs.⁵⁷ Like other forms of legal clinics, they offer ‘work-integrated learning’, meaning they provide students with valuable, relevant work-experience that relates to their studies and their career aspirations, and results in new learning.⁵⁸

⁵⁷ See Gledhill, above n 41.

⁵⁸ Melinda Shirley, Iyla Davies, Tina Cockburn and Tracey Carver, ‘The Challenge of Providing Work-integrated Learning for Law Students – the QUT Experience’ (2006) 10 *Journal of Clinical Legal Education* 134, 135-6 <<http://dx.doi.org/10.19164/ijcle.v10i0.81>>.

By sharing knowledge, and the means of knowledge and research production, with the community specifically for the purpose of supporting human rights realisation, disability human rights clinics also contribute to universities' 'third mission' of engagement, as well as the so-called 'fourth mission' of establishing long-term university-community partnerships.⁵⁹ This can have wider flow-on effects for academia – civic engagement in research can help to rearrange traditional power structures in research and enable participation of stakeholders who traditionally have not been able to have a say, despite the fact that they are often significantly impacted by research activities and outcomes.

Conclusion

Disability human rights clinics can be a valuable addition to clinical legal programs in law schools worldwide. Where they have the six features identified in this paper, these clinics meet each of the three key 'motivations' for clinical legal education identified by Kris Gledhill.⁶⁰ First, they ensure that students develop valuable professional skills for their future careers as lawyers, including legal research and analysis, teamwork, client liaison, clear writing, and advocacy. Secondly, they can increase access to justice for people who have traditionally been denied this right, for instance, by sharing knowledge, skills and resources with community organisations, by providing

⁵⁹ On the third and fourth missions, see Jill Chopyak and Peter N Levesque, 'Community-based Research and Changes in the Research Landscape' (2002) 22(3) *Bulletin of Science, Technology and Society* 203; Gregory Trencher, Masaru Yarime, Kes B McCormick, Christopher N H Doll and Steven B Kraines, 'Beyond the Third Mission: Exploring the Emerging University Function of Co-creation for Sustainability' (2014) 41 *Science and Public Policy* 151.

⁶⁰ Gledhill, above n 41, 297.

research support to community legal centres, or by contributing to reports or communications to UN monitoring bodies. Finally, disability human rights clinics can contribute to social change by supporting the disability community in its pursuit of the realisation of the human rights of persons with disabilities at the local and international levels.

The model proposed here could also provide the basis for human rights clinics concerned with other groups of rights-holders, such as refugees and asylum seekers, women, and older persons. For example, the principles relating to participatory research and the accessibility of research outputs, and of the clinic itself, are relevant for all areas of research and advocacy. While the CRPD is the only human rights instrument to place such explicit emphasis on the participation of the affected persons in the implementation and monitoring of human rights, Deena Hurwitz explains that all human rights advocacy

is fundamentally participatory and equitable. That is, it requires active collaboration between lawyers, advocates, and those affected by the work (who may or may not be the clients).⁶¹

The DHRC model exposes student to this participatory methodology. Students who have completed the clinic have often commented that their perspectives of disability and human rights have shifted. They often see human rights as much more connected to their daily lives than they had previously realised, and often begin to see disability

⁶¹ Hurwitz, above n 46, 521.

as something to celebrate in appreciation of the joy of human diversity. Through the humble platform of clinical legal education, the DHRC model has had a significant impact on the students as well as the many and varied partners that have been our clients – the United Nations Committee on the Rights of Persons with Disabilities, the United Nations Special Rapporteur on Disability, the Australian Disability Discrimination Commissioner, and others.