

# LITERATURE REVIEW: PROTECTION OF RIGHTS IN MENTAL HEALTH LAW

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## INTRODUCTION

This literature review uses a narrative methodology to highlight the best evidence for how mental health-related legislation has been developed and enacted to protect human rights. We consider how mental health legislation has been used to protect human rights, the evidence and outcomes available, and what factors contribute to rights protection. Finally, we consider concerns raised by some clinicians that strengthening human rights protections may cause an administrative burden on them that detracts from face-to-face care and which itself undermines certain rights, such as the right to the highest attainable physical and mental healthcare.

The review first details the rights relevant for consideration in Western Australia's mental health legislation and then presents the evidence for what has worked and why. We draw on published literature, academic reports, and 'grey literature' focused on Australian and relevant international jurisdictions. 'Grey literature' is used here to mean 'information produced on all levels of government, academia, [and civil society organisations] in electronic and print formats not controlled by commercial publishing, i.e. where publishing is not the primary activity of the producing body' (TICGL 2004). In conducting this review, we have excluded the other three topics under review by the Mental Health Commission – seclusion and restraint, advance statements and supported decision-making – though we acknowledge the significant human rights issues these topics raise, some of which intersect with the issues discussed in this report.

Using a narrative methodology, the review draws primarily on internationally-recognised documents, with additions from more recent literature, including both formal scholarship and grey literature. There are steps in policy and law, supported by strong empirical evidence, that can help protect the rights of people experiencing mental health crises and profound psychological distress. For example, the growing body of research on the relative success of measures to reduce and prevent coercion suggests a solid evidence base for responding to people in distress without coercion. Beyond the basic need for procedural justice, independent oversight and regulation, there is less certainty in how mechanisms *within* mental health legislation work best to protect rights, which also creates a lack of consensus on ways to measure such rights protections. However, in instances in which governments commit to retaining mental health legislation, we have identified some areas of agreement on mechanisms within such legislation, which we will outline shortly.

Complicating this picture is the paradox of mental health law between its intended ends (including protecting the rights of individuals deemed to be in crisis, including their right to life, health, and others) and the means to realise them (restricting individuals' rights). Mental health legislation often draws on the language of personal rights and the promotion of autonomy, independence and social inclusion, even as its principal function, like other substituted decision-making laws, is 'to strip citizens of rights, entrust proxies with the exercise of legal decision-making, and sometimes authorise incarceration through physical and chemical means' (Carney and Tait 1997, 47). Mental health legislation has the primary purpose of lawfully *limiting* certain rights held by consumers, particularly the rights to liberty and to refuse treatment.

There is tension in the literature, therefore, about what 'protecting rights' entails. At one end of the continuum, some view 'protection of rights' as primarily a matter of reducing and even eliminating the imposition of involuntary intervention. At the other end of the continuum is a view that rights protections involve minimising involuntary intervention but accepting the limited use of coercion and placing procedural safeguards around its use. Australian governments and the judiciary currently take this latter position, which may be characterised as a 'reformist' view. From this view, rights protection extends beyond simply reducing involuntary intervention and increasing voluntary support to ensuring involuntary intervention only occurs when necessary and taking steps to prevent rights violations surrounding that imposition.

We will therefore emphasise points of consensus, which might be summed up under the two broad aims of reducing rates of involuntary intervention and ensuring high-quality voluntary services. However, we will also consider the fuller range of statutory measures under mental health legislation envisaged from a 'reformist' viewpoint as being designed to protect individual rights. These measures include:

- ensuring a robust review process for decisions concerning detention and imposed treatment,
- ensuring the privacy of consumers,
- ensuring safety in authorised mental health settings,
- the provision of training so that health service provider staff are aware of their obligations and comply with them,
- ensuring individuals can be involved in their treatment, support and discharge planning.

These points of agreement do not resolve all issues. Complicating factors include problems defining rights, implementation challenges, and a lack of empirical research in key areas. These factors should be considered in any policymaking that aims to strengthen rights protection mechanisms and will be discussed throughout this report. At an individual level, a person's subjective sense of having their rights upheld is difficult to quantify. The vast majority of literature in this field is written by academics with clinical, sociological or legal backgrounds; it is not undertaken by consumer academics or using coproduced methods that actively involve people with such lived experience of mental health services. This makes successful rights protections at the individual level difficult to measure, at least concerning 'subjective' protections as reported by consumers. However, there are other ways of seeing rights protections in addition to subjective reports of those whose rights are being restricted, violated or indeed, protected; and in particular, we will discuss 'procedural protections' and 'substantive protections' later in the report.

Much of the literature from the consumer perspective, rather than showing what works to protect rights, is focused on highlighting the ways rights are *not* protected during involuntary interventions under mental health law (see, e.g. Daya 2022; Maylea et al. 2021; Wooley 2020). Still more of the literature is focused on calling for change to protect rights without providing evidence of what specific legislative and policy mechanisms work (see, e.g. Brophy et al. 2022; Minkowitz 2017).

The empirical studies that exist on the substantive differences in mental health legislation between jurisdictions, and the patterns of involuntary psychiatric interventions, are largely inconclusive about what ‘works’ (see, e.g. Rains et al. 2020; Vine et al. 2019; Ryan 2019; Salize and Dressing 2004). In one of the most comprehensive empirical studies on the variations in patterns of involuntary hospitalisation and legal frameworks, Rains and colleagues (2019, 403) found that ‘variations [in rates of involuntary intervention] between countries were large and for the most part unexplained.’ This remained the case even after taking into account multiple variables, such as legislative difference, variation in whether an independent tribunal-like body oversaw involuntary intervention decisions, and sociodemographic differences. Salize and Dressing (2004, 166) note that ‘reliability and validity of data are still imperfect, owing to non-standardised definitions of concepts or data recording methods’. Notwithstanding this imperfect data, Salize and Dressing (2004) concluded that there was no evidence of an association between the content of mental health legislation and rates of involuntary hospitalisation between jurisdictions, a conclusion echoed some 15 years later in the even larger comparative study by Rains and colleagues (2019, 415).

Despite many attempts in multiple jurisdictions to improve rights protections, including through legislation, much available evidence indicates that little progress has been made (Maylea et al. 2021; Ryan 2019; Bateren et al. 2022). In general, there is no accepted evidence base for how legislation works to protect rights. The evidence that does exist points to a need for a much broader approach than legislative reform, encompassing changes based on structural, cultural, socioeconomic, resourcing, workforce, training and many more factors (Royal Commission into Victoria’s Mental Health System 2021). There is some evidence that increased funding may reduce involuntary treatment when paired with legislative reform (see e.g. Bruckner et al. 2010), but other studies show that wealthier countries with more inpatient beds use compulsory treatment more often (Rains et al. 2019). Salize and Dressing (2004) show that jurisdictions with a legislative right to a lawyer have lower compulsory treatment rates; however, this must be paired with funding to ensure that lawyers are available to fulfil this right. There is also excellent, consistent, high-quality evidence of non-legislative reforms which protect rights (Gooding et al. 2018; Zinkler 2022), but examinations of the impact of purely legislative change tend to show little impact in practice (See, e.g., Ryan 2019; Foley and Ryan 2020). Nevertheless, we will discuss some significant legislative changes in Germany, Italy, the United States and China that significantly impacted rates of involuntary psychiatric interventions, although not always in the expected direction (Zinkler 2016; Scarpa, Castelletti, and Lega 2019; WHO 2021; Y. Ma et al. 2022). In summary, there is currently no accepted evidence base supporting the notion that legislative reform alone results in improved rights protections or substantive reductions in rights limitations.

Despite this uncertainty, the literature provides valuable insights into how legislative reform can contribute to rights protections. Primarily, these relate to non-discrimination and ensuring that people who use mental health services are afforded the same rights as others, including the support necessary to exercise

their rights. The practical steps noted throughout this report give some idea about how equal consideration of patient/consumer rights might work in practice.

This paper is set out into four sections. We first outline the rights possessed by consumers of mental health services to help define the scope of the review, then outline the methodology used. Thirdly, we present our findings before discussing implications for the Western Australian legislative context.

## ‘PROTECTING RIGHTS’

The United Nations Office of the Human Rights Commissioner notes that governments have to ‘respect, protect, and fulfil human rights’:

The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights. (OHCHR 2022)

The term ‘protecting rights’ is understood in this paper to include this broader responsibility for governments to respect, protect and fulfil rights. As noted above, discussion about rights protections in mental health is often centred on narrowing the rights restrictions on individuals that are imposed by the legislation itself.

### Rights protections as ‘procedural protections, substantive protections, or subjective protections’

Rights protections can be analysed in three main ways: in terms of *procedural* protections, such as safeguards; *substantive* protections, using objective measures such as reduced incidence or duration of compulsory treatment; or *subjective* protections, as reported by consumers. We have attempted to include all three ways of understanding rights protections in this report, given that, in theory, increased safeguards should lead to reductions in rights limitations or violations, which should result in increased reports of subjective safety. Unfortunately, as noted below, while safeguards have increased in recent decades, objective measures such as the rate of compulsory treatment have not necessarily declined and, in some cases, have increased, and literature from a consumer perspective consistently highlights subjective reports of unsafe experiences.

The most straightforward means to protect the rights of consumers is not to impose involuntary psychiatric intervention while ensuring access to the highest attainable mental health and crisis support services. The most straightforward measure of the first limb of this approach is a reduction in the rates of involuntary intervention. This is unlikely to reveal whether people are able, instead, to access high-quality voluntary care and hence better realise their right to the highest attainable physical and mental healthcare. However, the reduction in rates of involuntary intervention is a broadly shared goal in protecting rights, as even those who see some role for involuntary psychiatric intervention tend to agree that rates should be declining, or at least not increasing. Amongst those who see a role for involuntary treatment, there is universal agreement that its use should not cause more trauma or harm than is necessary. There also appears to be a lack of consensus about how best to measure the availability of high-quality voluntary care and the associated protection of rights, such as the right to the highest attainable physical and mental healthcare, although the WHO (2019) QualityRights Framework provides a starting point. We discuss the WHO QualityRights Framework below.

## Western Australian Charter of Mental Health Care Principles and other measures to protect rights

What human rights are engaged when individuals interact with mental health services and legislation in the Western Australian context? Western Australia has no Charter or Bill of Rights but does have the *Charter of Mental Health Care Principles* (the *Charter*), which is an explicitly ‘rights-based’ document and is Schedule 1 of the *Mental Health Act 2014* (WA) (*MHA14*). Other rights must be drawn from the text of the *MHA14*, as well as from other domestic legislation, case law and international human rights treaties which Australia has ratified. Principle 2 of the *Charter* legally brings international human rights standards into the *MHA14*, making the *Convention on the Rights of Persons with Disabilities* (*CRPD*) and the rights it identifies a relevant source of rights. The *CRPD* is the most relevant international framework for rights protections in mental health legislation, as this convention encompasses people with mental health-related disabilities, often described as ‘psychosocial disabilities’. Not all people with a mental health diagnosis will identify as being disabled or having a ‘psychosocial disability’, but the model of disability used by the *CRPD* – often called the ‘social model’ of disability – clearly encompasses people who are treated under mental health legislation (Australian Law Reform Commission 2014).

The authors note that the text of the *Charter* provides a comprehensive articulation of rights compared to other Australian and international jurisdictions. The rights enumerated in the *Charter* are consistent with the *CRPD* and generally reflect international human rights norms. Some elements of the *Charter* are notable for going further than other states and territories. For example, the phrase, ‘mental health services must make every effort to comply with [the Charter principles]’ (*MHA14* Sch 1(A)), is a stronger requirement than comparable Australian legislation, which requires services to ‘have regard’ to similar legislative principles (*Mental Health Act 2014* (Vic) s 11) or ‘as far as practicable, to be given effect to’ (*Mental Health Act 2007* (NSW) s 68). Section 11 of the *Charter* also requires that any person or body performing a function under the *MHA14* must ‘have regard’ to the *Charter*. This indicates that many improvements in rights protection are likely to be found in enforcement and implementation of the *Charter*, rather than the enumeration of additional rights in the *Charter*.

Another noteworthy feature of the *MHA14*, is that its criteria for involuntary intervention contain a mental capacity criterion (ss 18, 25(1)(c),(2)(c)), which many legal and clinical scholars argue is a more rights-based approach than having a ‘diagnostic’ criterion (namely, that the person has or appears to have a mental illness) (see, e.g. Callaghan and Ryan 2016; Dawson 2015). Western Australia also has, compared to other Australian jurisdictions, the lowest proportion of involuntary admissions and forced treatment in the community, the lowest rates of seclusion and mechanical restraint and is among the lowest in physical restraint (AIHW 2022). How much of this can be attributed to the *MHA14* and the *Charter* specifically is unclear, as Western Australia had, nationally, the lowest rates of involuntary treatment in 2012-13, before the passing of the *MHA14* and the *Charter* (AIHW 2022).

## Other mechanisms to promote rights in the mental health context in Western Australia: Safeguarding

Other Western Australian policies promoted by the Mental Health Commission (WAMHC), such as informal safeguarding and (pre-NDIS) forms of local area co-ordination have also been praised as promoting human

rights in the mental health context (Gooding 2017). On **safeguarding** in Western Australia, one of the authors of this review (Gooding 2017) has praised the work of the WAMHC in its efforts to foster ‘informal or natural, intentional safeguard arrangements’ (Government of Western Australia 2013) as an example of efforts that promote art 19 of the *CRPD*, concerning the right to live independently and participate in community. WAMHC (2020, 40) define safeguarding as:

measures to protect and prevent people from being harmed or badly treated. Safeguards are precautions and measures that are put in place to ensure an individual has the best possible chance of succeeding in their recovery. Safeguards may protect a person from exploitation and harm, and foreseeable unintended events. Importantly, safeguards should enhance and protect a person’s human rights, and enable a person to make choices and decisions, take considered risks, and live a life as an active and equal citizen in the community.

Although Western Australia is not the only jurisdiction to implement a blend of formal and informal safeguarding, it has demonstrated how informal safeguards can be applied to the mental health context in practice, in ways that appear to strengthen the rights of persons who are subject to or at risk of being subject to mental health legislation. We note that informal safeguarding is outside the strict scope of this review to focus on mental health legislation, which does not contain provision for such safeguarding in Western Australia, but we nevertheless note it here to highlight efforts outside of mental health legislation itself that function to protect rights that are otherwise restricted by mental health law, particularly when a person’s mental health crises escalate.

Returning to rights protections in Western Australia more broadly, other legal avenues, such as common law rules of procedural fairness and judicial review, Constitutional rights and human rights in other legislation such as the *Equal Opportunity Act 1984* (WA) or *Disability Discrimination Act 1992* (Cth) have not been included in this review. We have also excluded the right to supported decision-making and the right to bodily integrity as it relates to seclusion and restraint, both of which are covered by other review teams.

## Charter rights

The *Charter* is contained within Schedule 1 of the *MHA14*, giving legislative effect to the rights contained within. These principles are:

1. Attitude towards people experiencing mental illness
2. Human rights
3. Person-centred approach
4. Delivery of treatment, care and support
5. Choice and self-determination
6. Diversity
7. People of Aboriginal or Torres Strait Islander descent
8. Co-occurring needs
9. Factors influencing mental health and wellbeing
10. Privacy and confidentiality
11. Responsibilities and dependants
12. Provision of information about mental illness and treatment
13. Provision of information about rights
14. Involvement of other people
15. Accountability and improvement

The law requires mental health services to make every effort to comply with these principles, but it is unclear to what extent compliance is occurring. Some reports indicate a failure to achieve compliance with the *Charter* and the *MHA14*: for example, regarding the reported failure of Western Australian mental health services to ensure involvement of the affected individual and their support persons in the making of Treatment, Support and Discharge Plans in compliance with the *MHA14* sections 185-188 (MHAS 2018). Mental Health Advocacy Service (MHAS) annual reports also indicate ongoing, consistent and widespread non-compliance.

## Mental Health Act rights

In addition to the rights listed in the *Charter*, the text of the *MHA14* contains additional rights. There is some overlap between the *Charter* and these additional rights, such as Principle 13 of the *Charter* and s 244 of the *MHA14*, which both enshrine the consumer's right to have their rights explained to them. A non-exhaustive list of rights in the *MHA14* includes:

- Right to have rights explained (s 244)
- Communication (s 261, 262)
- Advocacy (s 352)
- Nominated person (s 263)
- Right of appeal/administrative review (s 434)
- Right to appeal Mental Health Tribunal decisions (s 494)
- Right to be heard (s 459)
- Right to access medical record (s 248)
- Carer rights to information (with consent or if consumer lacks capacity) (s 285)
- Carer rights to be involved (with consent or if consumer lacks capacity) (s 285)
- Carers' right to notification (s 141)
- Carers' right to have the consumer's rights explained to them (s 245)



Some of these ‘rights’, such as advocacy and nominated persons, create roles for third party individuals who are rights enablers, with an explicit role in upholding a person’s rights.

## CRPD rights

In addition to the *Charter* and the *MHA14*, the *CRPD* provides for a wide range of additional rights, brought into Western Australian law by Principle 2 of the *Charter*. There are too many *CRPD* rights to summarise here in full, however, the non-discrimination theme of the *CRPD* echoes the *Charter* but conflicts with the *MHA14* to the extent that it provides for compulsory treatment based on diagnosis. McSherry (2022, 420) outlines the general framework of the *CRPD* as follows:

- Article 1 sets out the principles of equality and inherent dignity – these can be viewed as fundamental to the interpretation of subsequent Articles;
- Article 2 defines certain terms;
- Article 3 sets out the guiding principles, again referring to equality and inherent dignity as well as individual autonomy and non-discrimination among others;
- Articles 4-9 set out general obligations;
- Articles 10-30 refer to specific rights or freedoms including:
  - Articles 10-20: civil and political rights
  - Articles 24-18 and 30: economic, social and cultural rights; and
  - Articles 31-40 set out provisions relating to the implementation and monitoring of the treaty.

The rights outlined include the right to life (Art 10), the right to equal recognition before the law (Art 12), the right to liberty and security of the person (Art 14), the right to respect for physical and mental integrity (Art 17), the right to live in the community (Art 19), the right to education (Art 24) and the right to enjoyment of the highest attainable standard of health without discrimination on the basis of disability (Art 25).

The full breadth and depth of the *CRPD* debate is too complex to summarise here, and the scope of the review as expressed in the Statutory Review of the Mental Health Act (2014): Discussion Paper (WAMHC 2021) does not envisage the fundamental changes to the *MHA14* that would result in *CRPD* compliance. As such, in this section, we provide a very brief overview of the key tensions between the *CRPD* and mental health law.

## Contradictions with human rights frameworks

When ratifying the *CRPD*, Australia declared ‘its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards’ (*CRPD* Declarations and Reservations (Australia) 2008). This interpretative declaration<sup>1</sup> asserts that mental health legislation enabling involuntary psychiatric intervention is compatible with the *CRPD*, but only in specific circumstances, as a measure of last

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<sup>1</sup> An ‘Interpretative Declaration’ is a unilateral statement made by a State or an international organisation, by which they specify or clarify the meaning or scope of a treaty or of certain of its provisions, outlining the State’s understanding of obligations under the *CRPD*, without purporting to exclude or modify its legal effects. International Law Commission, *Guide to Practice on Reservations to Treaties* (2011) [1.1–3].

resort, subject to safeguards, and when in the best interests of the person with disability. This standpoint is shared explicitly or implicitly by all state and territory governments.

Others have questioned the extent to which any mental health legislation can be compatible with the *CRPD*, a point that has been the subject of ongoing and heated international debate (see e.g., Committee on the Rights of Persons with Disabilities 2014; Dawson 2015; Dawson and Szumukler 2021). Most notably, the United Nations Committee on the Rights of Persons with Disabilities (*CRPD* Committee) (2014, para 42), which is authorised under art 34 of the *CRPD* to provide interpretive guidance to government signatories to the *CRPD*, noted that '[s]tates parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe' (see also Minkowitz 2011). This position appears to be supported by the World Health Organisation (WHO), the United Nations Special Rapporteurs for Disability and Health and others calling for an end to non-consensual psychiatric treatment (Devandas-Aguilar and Pûras 2015; Quinn et al. 2021; WHO, forthcoming). The former United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, concluded that, other than in life-threatening emergencies, compulsory treatment in mental health settings may amount to torture, and any detention must not be on the basis of mental health diagnosis (Méndez 2013). However, in a sign of the deep-seated disagreement about the application of human rights law to mental health legislation, other parts of the United Nations appear to endorse mental health legislation in alignment with the Australian Government position, a view most notably expressed by the Human Rights Committee (2014).

The right to health is also engaged. Article 25 of the *CRPD* places a requirement on 'health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent', as a component of ensuring the highest attainable physical and mental healthcare without discrimination, which must not be coerced on the basis of mental health diagnosis or disability (Weller 2012).

## Involuntary intervention

Some Australian jurisdictions have recently sought to give more practical force to a fairly long-standing policy aspiration of making involuntary measures a last resort (Carney 2012). The policy is embodied in the 'least restrictive alternative' principle and recently reinforced by measures such as enacting a presumption of mental capacity and legislative injunctions against involuntary treatment or restrictive practices for anyone with mental capacity (Human Rights Committee 2014). Human rights scholars generally agree that art 12 of the *CRPD*, which articulates the right to equal recognition before the law, means that a person's right to choose treatment cannot be denied on the basis of their disability or mental health diagnosis (Maylea and Hirsch 2017; Curry 2016; Weller 2012; O'Mahony 2012). Hence, the call by some for mental capacity-based legislation to replace the diagnostic criterion that is common in modern mental health legislation, applying the same capacity-based test as is commonly used in physical health and disability settings (Dawson and Szumukler 2021). This capacity-based approach is reflected in the text of s 25 the *MHA14*, which applies a mental capacity test to decisions to authorise involuntary treatment.

Relying on mental capacity falls foul of the *CRPD* Committee's interpretation of art 12, although it conforms with Australia's interpretive declaration about the *CRPD*. In any event, the capacity-based provisions in mental health legislation, introduced in most Australian jurisdictions, did little to reduce the incidence of involuntary measures (Foley and Ryan 2020), an outcome in line with international experience (Gooding, McSherry, and Roper 2020). Notably, the negligible impact on rates of coercion of replacing the diagnostic threshold (mental disorder) with mental incapacity extends to involuntary community-based psychiatric intervention, or 'community treatment orders' (Light 2019), contrary to what some had hoped (Newton-Howes and Ryan 2017). Indeed, the rates of such interventions appear to be rising in most Australian jurisdictions (Light 2019; Høyer et al. 2022), though we note Western Australia as a general exception to trends concerning community treatment orders, discussed below.

Several human rights scholars have rejected the mental capacity-based approach in principle as inconsistent with the *CRPD*, calling for an approach that respects the 'will and preferences' of the person and never imposes substituted decision-making (Flynn 2019; Puras and Gooding 2019). A practical example of the difference between these two positions is that a capacity-based approach might allow for an advance directive that becomes binding when a person is assessed as lacking capacity, whereas Flynn (2019) calls for an approach that allows the person to set the criteria for when their advance directive be activated, such as on a hospital admission, when exhibiting certain behaviours, or when a number of trusted supporters agree that the person is in crisis.

The deep-seated disagreements about the human rights requirements of mental health legislation, as well as emerging empirical evidence about the impact of mental capacity-based changes to mental health legislation, make it challenging to establish norms for measuring *CRPD* compliance. There is little consensus on the empirical evidence needed to demonstrate such measures. Certainly, no jurisdictions have yet attempted *CRPD* compliance in mental health settings in the sense proposed by the *CRPD* Committee, though some jurisdictions, such as Peru and Colombia, are heading in this direction.

## Other notable human rights instruments

The *CRPD* gives expression to the *Universal Declaration of Human Rights* and the *International Covenant on Civil and Political Rights*, in the context of disability and, indeed, mental health. Other important instruments are the *Convention on the Elimination of All Forms of Discrimination against Women* (entered into force 3 September 1981), the *Convention on the Rights of the Child* (entered into force 2 September 1990), and the *International Convention on the Elimination of All Forms of Racial Discrimination* (entered into force 4 January 1969), and these become relevant regarding intersecting issues of human rights concerning sexism, racism, the rights of children, and so on. It is outside the scope of this report to consider these instruments. However, we note the aspiration of governments like Australia, which have signed and ratified these instruments as to the 'universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms' (*CRPD*, Preamble (c)).

A brief point can be made on the *Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment* (entered into force 26 June 1987). Of note is the ratification of the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*. In recent years, Australia signed and ratified *OPCAT* obliging it to establish a national preventive mechanism (or NPM) for conducting ‘preventive monitoring’ of sites in which people are deprived of liberty and are susceptible to cruel, inhuman and degrading treatment. While *OPCAT* art 4 defines places of detention in the broad sense of places where human beings are or may be deprived of liberty, the Australian Government decided that the initial focus of NPMs would be limited to ‘primary places of detention’, which includes closed facilities or units where people may be detained for mental health assessment or treatment (Nowak 2019). Western Australia was the first state that nominated its NPM: the Western Australian Ombudsman (for mental health and other secure facilities) (Nowak 2019). It is outside the scope of this report to consider in detail how the Western Australian Ombudsman’s role under the NPM might complement efforts to protect rights under the *MHA14*, which does not mention the Ombudsman's office, nor the *OPCAT*, but clearly, work could be done to harmonise efforts at preventive monitoring of closed facilities or units where people may be detained for treatment or assessment under the *MHA14*, and aspirations to protect the rights of mental health consumers under the *MHA14* and in Western Australia more generally.

## METHODOLOGY

This review uses a critical narrative methodology (Grant and Booth 2009), building on existing work. A non-systematic literature search was also conducted to ensure that any recent literature was also included. Finally, the team conducted reference harvesting to ensure the inclusion of relevant literature. A full, systematic review was unfeasible due to the project timeframe, resourcing available, broad scope of the potential literature and the considerable number of peer-reviewed papers without an empirical basis. Instead, the review team relied on recent work conducted by the WHO, United Nations, Council of Europe and the Royal Commission into Victoria’s Mental Health System, noting that a considerable proportion of this existing work was authored by members of the review team, or includes their input via advisory roles. As the consumer perspective on rights protection is limited in the peer-reviewed literature, some grey literature has also been included (e.g.: Daya and Edan 2021). Again, we use the term ‘grey literature’ simply to mean material that is not published by a formal academic publisher (see above), and the term does not connote anything about the quality of the literature itself.

The key documents which formed the basis for this review are:

- WHO guidance on mental health-related law in line with the *CRPD*, developed in collaboration with the Office of the United Nations High Commissioner for Human Rights (WHO and OHCHR 2022)<sup>2</sup>
- ‘Compendium Report: Good Practices in the Council of Europe to Promote Voluntary Measures in Mental Health Services’, commissioned by the Council of Europe (Gooding 2021)

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<sup>2</sup> This document is currently unpublished and was provided in draft to the Review Team. It is due to be launched early 2023

- ‘Guidance on community mental health services: Promoting person-centred and rights-based approaches’ (WHO 2021)
- ‘Alternatives to Coercion in Mental Health Settings: A Literature Review’, commissioned by the United Nations (Gooding et al. 2018)
- Final Report of the Royal Commission into Victoria’s Mental Health System (2021)

Building on these comprehensive works, we have applied the evidence available in the literature to the Western Australian context guided by the Statutory Review of the Mental Health Act (2014): Discussion Paper (WAMHC 2021).

## HOW MENTAL HEALTH RELATED LEGISLATION HAS BEEN DEVELOPED AND ENACTED TO PROTECT HUMAN RIGHTS

Mental health legislation dates back many centuries, initially without significant rights protections. It was not until the twentieth century that ‘rights-based legalism’, or laws that aimed to protect rights rather than simply ensure treatment, became more commonplace (Gostin 2008; Weller and McSherry 2010). Initially, this legalism was largely procedural, but with the growing consumer/service user/ex-patient/survivor/disability movements of the 1970s, developments in psychotropic medication, the policy of deinstitutionalisation and a worldwide trend to promote human rights, rights-based legalism began to shape mental health legislation (Weller and McSherry 2010). Such laws formulated both defensive claims (rights not to be interfered with; for example, ensuring ‘least possible restrictive’ interventions) and positive demands (rights to be provided with quality care; for example, ‘effective giving of ... care and treatment’) (McSherry and Weller 2010, 4-5). As such, the text of mental health legislation started to partially shift from a paternalistic, ‘best interests’ approach, to one based on ideas of recovery, inclusion and rights.

In practice, however, consumer-perspective literature clearly and consistently indicates that a ‘best interests’ narrative still dominates how mental health legislation is applied in clinical settings (Daya and Edan 2021; Maylea et al. 2021; Daya 2022). Indeed, although the added procedural protections of rights-based mental health law moved involuntary treatment closer to that of criminal proceedings, laws remained couched in the language of care and treatment and a paternalistic framework endures. This is perhaps most clearly expressed in the ‘best interests’ standard, which continues guiding interventions – either implicitly or explicitly – in mental health law in countries like Australia, Canada, New Zealand, Ireland, the United Kingdom, and elsewhere.<sup>3</sup> The power to detain under rights-based legislation was reframed to occur, ‘in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment’ (*Mental Health Act 1983* (England and Wales) c 20, s 5(a)). The ideal of a ‘least restrictive’

<sup>3</sup> See, eg, *The Mental Capacity Act 2005* (England and Wales) c 9. Chapter 1, Sections 4 and 6 of the *Mental Health Act 2007* refer to the ‘appropriate treatment test’ for responding to those subject to the Act. *Mental Health Act 2007* (UK) c 12, ch 1 ss 4, 6; see, eg, *The Ontario Mental Health Act*, RSO. 1990, c M.7., s 20(1.1); *Mental Health (Care and Treatment) (Scotland) Act 2003* (Scot) asp 13 s 276(3); *Mental Health Act 2001 (Ireland)* s 4(1); *The Mental Health (Northern Ireland) Order 1986* No 595 (N.I. 4) s 3(1); *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 2(1). In Australia, Western Australia exemplifies the national approach. *Mental Health Act 2014* (WA) pt 2 div 3.

intervention has been criticised by some legal scholars, as it problematically suggests that some form of restriction will be warranted, and thus perpetuating coercive practices (Series 2022, Ch 4).

One example from Western Australia is the implementation challenge concerning treatment, support and discharge plans under the *MHA14*. Attempts were made in the *MHA14* to ensure patient and supporter involvement in such planning; yet, a report by the Mental Health Advocacy Service (MHAS 2018) demonstrated that many patients were excluded by mental health practitioners from inclusion in their treatment, support and discharge plans. Notably, since this time efforts have been made to remedy this gap between the legislative intent (to move toward active involvement of the person and supported decision-making) and implementation (which saw a failure to involve patients and their support persons in treatment, support and discharge planning). The example highlights the gap that can emerge between the content of mental health legislation and implementation, particularly considering the culture and habits of service provision.

## What works to protect rights?

Generally, attempts to protect rights through legislation have followed the trend towards rights-based laws, with steadily increasing oversight, and increased checks and balances framed as substantive and procedural safeguards, and attempts to signal cultural change through changing language and principles. In the well-studied Victorian context, for example, the *Mental Health Act 2014* (Vic), similar to and passed the same year as the Western Australian *MHA14*, introduced more stringent Mental Health Tribunal oversight, a right to a second opinion, advance statements and nominated persons, rights to communication and non-legal advocacy. A key aim of this reform was to reduce rates of compulsory interventions. Yet, despite the changes to the Act, compulsory treatment increased between 2014 and 2021, with many consumers describing rights violations to the Royal Commission into Victoria's Mental Health System (2021). The Royal Commission determined the Act to be 'no longer fit for purpose' given the aspirations behind it, 'including embedding concepts such as supported decision making... have not been realised' (Royal Commission into Victoria's Mental Health System 2021).

The vast majority of literature that relates to rights and mental health legislation focuses on involuntary treatment and detention, on the basis that such interventions limit or violate a range of rights, including the rights to non-discrimination, equality before the law, liberty, bodily integrity, and others. On this basis, it is generally assumed that a reduction in the rate of involuntary treatment is indicative of increased rights protections. However, some have raised a concern that merely limiting state powers to impose involuntary psychiatric intervention will lead to consumers 'dying with their rights on' (Treffert 1973). Increasingly, efforts have been made to foreground 'positive rights' to mitigate these concerns about the abrogation of state responsibilities to care for people in mental health crises. Positive rights in this sense refer to measures that make available high-quality voluntary resources to individuals in mental health crisis or those with ongoing support needs, thus promoting their right to the highest quality of physical and mental health care.

Much of what is said to 'work' in the literature that emphasises positive rights is not aimed at protecting consumers directly but instead at legislating for the provision of mental health services and support (Gooding

2018). This aligns with WHO recommendations, which recommend legislating a right to mental health (and other health) care, to which governments and service providers must comply (WHO 2021). Again, this approach reframes mental health legislation from having a principal focus on authorising involuntary intervention and instead focuses on how it can help secure high-quality, voluntary services for people in crisis.

## Comparing mental health legislation internationally and nationally

The most comprehensive review of the impact of legislation on the substantive right to refuse treatment is Rains et al.'s (2019) comparison of involuntary hospitalisation across 22 countries. That study created legislative 'profiles', to determine which legislative approaches led to variations in compulsory treatment. They compared legislative elements such as the presence of a risk criterion and a capacity criterion, as well as comparing the person or profession authorised to issue orders, requirements as to legal representation, appeal and review rights, and other factors. No factor was found to significantly contribute to the wide variation between rates of involuntary treatment, although wealthier countries with more inpatient beds appeared to use involuntary treatment more often. Only Italy was identified as a standout as having both distinct legislation and low rates of treatment, as noted below.

Salize and Dressing's (2004) **European** study also found involuntary treatment was stable within jurisdictions over time with unexplained variation between jurisdictions. They found no significant correlation between the presence of dangerousness or need for treatment criteria. They also found that legislation that appointed an independent legal decision-maker (often a judge), a non-legal independent decision-maker or the treating psychiatrist made no significant difference to compulsory treatment rates. They found that legislated right to be provided with legal representation *did* influence compulsory treatment rates; however, legislative change must be paired with increased funding for lawyers.

This disconnect between legislation and practice is also present in **Australia**. Light (2019) found the rate of community treatment has remained fairly stable between 2010 and 2019 at roughly 15% of community contacts provided involuntarily, but that it varied widely between 40.0 per 100,000 population in Western Australia to 112.5 per 100,000 in South Australia. Light could not explain this variation based on available data, but the variation may lie in variation in compliance with legislation rather than the legislation itself (Bateren et al. 2022; Brayley, Alston, and Rogers 2015).

Vine et al.'s (2019) study of community treatment orders in **Victoria** argued that legislative change following the *Mental Health Act 2014* (Vic) resulted in shorter order duration and an overall reduction in the number of orders, but the study also showed that many more people on community treatment orders were compulsorily readmitted to inpatient units. This study has been critiqued as failing to sufficiently account for the wide number of confounding variables, including reduced spending on mental health services, which may account for the data (Ryan, 2019). This kind of mixed or inconclusive data is characteristic of community treatment order studies more generally (Brophy, Ryan, and Weller 2018), with reliable community treatment order data in Australia not consistently available (Light 2019).

**Italy's 1978 Law no. 180 or Basaglia Law** has been described by the WHO as a 'first example of successful human rights-focused legal reform, despite the continued but limited use of involuntary treatment' (WHO 2021, 186). This law, in addition to providing safeguards, banned the building of new mental health hospitals and banned new admissions to existing hospitals, which were eventually closed. Closure efforts have more recently extended to forensic mental health settings (Scarpa, Castelletti, and Lega 2019). Today, Italy has one of the lowest rates of involuntary treatment in comparable jurisdictions, for which at least one major reason is its relatively distinct legal system that has been described as having 'unusually stringent criteria for involuntary hospitalisation, which do not include risk as a possible justification and place a strong emphasis on treatment outside of hospital' (Rains et al. 2019, 414). The law requires 'that there be an urgent need for psychiatric treatment, that appropriate treatment cannot be provided outside of hospital, and that all proposed treatment previously offered has been refused' (Rains et al. 2019, 414). Italy invested in the community-managed mental health sector to support people while closing public psychiatric hospitals. As Rains and colleagues (2019, 415) note, 'extensive efforts to develop community services and a culture in which deinstitutionalisation and reintegration into the community are highly valued might... be important contributors' to low involuntary intervention rates.

More recently, **Costa Rica, Peru and Colombia** have completed landmark reforms that attempted *CRPD* compliance according to the *CRPD* Committee's interpretation of the *CRPD* (WHO 2021). Peru, in particular, abolished guardianship on the basis of disability, and its 2020 *Mental Health Law* does not allow treatment without consent. There remain several caveats, including an established exception for 'drug addicts' and 'emergency situations', which raise questions about whether the Act achieves comprehensive adherence to the *CRPD* (*Legislative Decree 1384* (Peru), *Health Law 26842* (Peru)). Evaluation or data is not yet available that can be used to determine if this reform has been successful in protecting rights. Despite strong support for the new legislative scheme from disability rights groups and international human rights scholars (Encalada 2021), a new bill is currently before the Congress of Peru to reintroduce involuntary treatment (*Inclusión Social y Personas Con Discapacidad* 2021).

One particularly interesting case study is not of an intentional legislative reform to protect rights but an accidental legislative overhaul. In 2011 and 2012, **Germany's** Constitutional Court and Federal Supreme Court restricted involuntary treatment to only 'life threatening emergencies', citing the *CRPD*. Germany remained without involuntary treatment for 15 months. Zinkler's (2016) and Flammer and Steinart's (2015) studies show that while some long-term reductions of involuntary treatment resulted in some services, other services saw a rise in 'violent incidents'. One service saw no increase in seclusion or restraint and no increase in patient violence. This suggests that legislative change, even abolition of compulsory treatment other than in 'emergencies', is possible if adequate support is provided to services to support transition. Zinkler and von Peter (2019) have detailed the steps that might be required to achieve mental health care without coercion, although notably none of these steps are based in legislative change.

Another significant legislative change is in **China**, which, in 2013 introduced mental health legislation for the first time (H. Chen et al. 2012). China has rates of involuntary hospitalisation much higher than most Western



countries, at around 80% of admissions (H.-J. Ma et al. 2019). Following the introduction of the first mental health law, which explicitly aims to protect the rights of people in mental health services, involuntary hospitalisations actually *increased* and remain higher than prior levels (Y. Ma et al. 2022; H.-J. Ma et al. 2019). A study in one hospital showed a decrease in mechanical restraint but indicated that when psychiatrists were prevented from using mechanical restraint, they would instead use chemical restraint or forced electroconvulsive therapy (An et al. 2016). The literature indicates a range of reasons why China has such a high rate of admissions (largely because there are so few mental health services, but also culture, stigma and clinical practices) but does not explain why rates of involuntary hospitalisations increased when the law was introduced. For a detailed social-legal analysis of China's mental health law, see Chen (2022).

Less radically, **Argentina's** 2010 *National Health Law* introduces interdisciplinary evaluations of individuals in mental health crises. Rather than simply assessing if a person meets a set of criteria, these assessments consider the person's supports and potential harm caused by involuntary treatment (Bariffi and Smith 2013). A team of psychiatrists, psychologists, lawyers and social workers report to judges, making recommendations about service gaps. This is not dissimilar to the 2018 **Dutch** *Mandatory Mental Health Care Act* which stipulates that people who are confronted with coercive measures should be given the opportunity to avert these measures by establishing a plan together with their social network.

**Victoria's** new *Mental Health and Wellbeing Bill 2022*, like Argentina's 2010 *National Health Law*, requires decision-makers to 'balance harm' (s 82). Under that Bill, '[c]ompulsory assessment and treatment or restrictive interventions are not to be used unless the serious harm or deterioration to be prevented is likely to be more significant than the harm to the person that may result from their use.' This Bill also flags an intention to eventually eliminate seclusion and restraint while still providing for its ongoing use.

Limiting the number of people who can make decisions about rights limitations appears to have an impact. In **Switzerland**, compulsory treatment reduced significantly when only qualified psychiatrists were able to authorise compulsory admission, compared to when all physicians were able to do so (Eytan et al. 2013). According to the results from one major hospital, the proportion of compulsory admissions increased from 55% in 2001 to 69% in 2005. After the law was introduced, this proportion decreased to 48% in 2007 and remained below 50% thereafter. According to the authors of one study that examined the change, their findings 'strongly suggest that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions' (Eytan et al. 2013).

## APPLICATION TO THE MENTAL HEALTH ACT 2014

As discussed above, the *Charter* enumerates many of the rights that the literature argues should be present in mental health legislation, such as the right to mental health care without discrimination. However, also as discussed above, the continued use of compulsory treatment and other forms of coercion means that no additional rights 'protections' can make the *MHA14* fully rights compliant. In addition, the literature consistently indicates that legislative change alone does not translate into substantial change in practice; instead, legislation can be used to support and implement broader reform to policy and practice.

Supported decision-making, eliminating seclusion and restraint and binding advance directives are key elements to protecting rights in any reform of the *MHA14*, but are out of scope for this paper as they are covered by other literature review teams.

## Legislating for CRPD compliance

Although total *CRPD* compliance is not envisaged by the Statutory Review of the Mental Health Act (2014): Discussion Paper (WAMHC 2021), this is the only way in which legislation can effectively protect the rights of mental health consumers. This may be a long-term goal, as attempted in the *Mental Health and Wellbeing Bill 2022* (Vic) 10-year timeframe to eliminate the use of seclusion and restraint, or in more sweeping reforms attempted by Costa Rica, Peru and Colombia, discussed above. In addition to the elimination of coercion, *CRPD* compliant legislation must ensure that high-quality, appropriate mental health care is provided to all who require it when they require it, and that all support for decision-making is provided. Rights-based mental health legislation should also require governments to protect the right to housing, by providing housing, and other socioeconomic determinants of mental health. Legislation can require the provision of coercion-free crisis and respite services. The WHO and United Nations state that:

Reviewing and amending existing mental health laws to move them closer to *CRPD* standards, but not embracing its paradigm shift, will not achieve the transformation required by international human rights law (WHO and OHCHR 2022).

Despite this, there are several legislative reforms that, while not achieving full *CRPD* compliance, may improve rights protections within current frameworks. We note again that there is no widely accepted evidence base indicating which legislative reforms actually translate into increased rights protections, so the following discussion is based on literature that calls for increased rights protection rather than literature that evidences actual impact on the consumer experience.

## Support to exercise legal capacity

Although supported decision-making is covered in a separate paper, there are some legislative reform options that sit alongside supported decision-making that may assist in protecting rights. An essential rights protection, required by the *CRPD*, is the delinking of legal and mental capacity:

The Committee on the Rights of Persons with Disabilities... makes a distinction between legal capacity, the ability to hold and exercise rights and duties, and mental capacity, ‘the decision-making skills of a person’. Under the [*CRPD*], legal capacity must be de-linked from mental capacity. This means that legal capacity cannot be denied on the basis of an assessed lack of mental capacity. This has led to calls for the provision of necessary support to ensure that ‘disabled people are able to exercise full legal capacity on an equal basis with others, and addressing discriminatory attitudes and barriers that might limit the recognition and exercise of legal capacity by disabled persons’. (Maylea and Hirsch 2017, 151)

Binding advance directives and nominated persons who have equal legal footing with substitute decision-makers in physical health settings are important rights protections for supporting capacity (Edan and Maylea 2021). Legislation can also require the provision of decision supporters (personal support persons) or prioritise the best interpretation of the will and preference of a person in cases where a substitute decision-maker is appointed (Flynn 2019).

While not delinking legal and mental capacity, procedural rights protections can be improved by externalising the assessment of mental capacity to an independent third party. The *MHA14* has a 'mental capacity'-based treatment criterion, but the assessment of mental capacity is initially conducted by the psychiatrist who is making the order. In the UK, a mental capacity assessor that is separate to the clinical service conducts this assessment, called the Approved Mental Health Professional. This role is established under the *Mental Health Act 1983* (UK), and was introduced as a 'counterweight' to the medical domination of compulsory mental health (Karban et al. 2021). We note, again, that there is no definitive evidence that this has increased consumers' experience of having their rights protected.

Both legal and non-legal advocacy (such as MHAS) are well documented as supports to legal capacity (Newbigging et al. 2012; Maylea et al. 2019; Fritze 2015; Bennetts et al. 2018; Milbourn et al. 2018). Rains et al. (2019) found that a statutory right to be provided with legal representation was positively associated with reduced compulsory treatment. Western Australia already has legislated opt-out advocacy provided by MHAS but does not have a statutory right to be provided with a lawyer, although the *MHA14* does give a right to be represented. In 2020/21, consumers were represented by MHAS at 40% of hearings, but had legal representation through the Mental Health Law Centre in only 10% of cases (MHT 2021). This indicates that increased funding, rather than statutory reform, is required to support the exercise of legal capacity through legal representation and non-legal advocacy.

We anticipate that the above literature has been thoroughly covered in the review on supported decision-making and have not expounded on it here.

## Resourcing and commissioning

The WHO calls for governments to legislate funding for mental health services (WHO and OHCHR 2022). The Royal Commission into Victoria's Mental Health System recommended a (2021) mental health levy to fund reforms to the mental health system. This is contained in the *Mental Health and Wellbeing Bill 2022* (Vic), before the Victorian Parliament at the time of writing. Resourcing can also be legislated for regulatory and oversight bodies tasked with protecting rights or legislating the right to a funded lawyer for consumers before the Mental Health Tribunal.

Commissioning of services can also play a key role, with service tendering, funding and review tied to clear, transparent indicators of rights protections (Katterl and Maylea 2021). Legislation can provide a framework for commissioning, ensuring that services that are not protecting rights are defunded.

## Regulation and oversight

Legislation can, and in the case of the *MHA14*, already does, provide a framework for regulatory and oversight bodies such as the Mental Health Commission and MHAS. These existing mechanisms may be strengthened with increased powers to issue notices to cease conduct or apply penalties for failures to protect rights, as are commonly used in other, non-mental health jurisdictions (Freiberg 2017). Legislation can also empower consumers as regulatory actors in their own care, providing them with platforms to advocate for themselves with the support of regulatory bodies (Healy 2017). Legislation can broaden the jurisdiction of regulatory bodies, such as the Chief Psychiatrist, to all mental health services, not only public or authorised mental health services (Royal Commission into Victoria's Mental Health System 2021).

Legal representation and non-legal advocacy perform important oversight and regulation roles, including facilitating complaints (Maylea et al. 2019; Fritze 2015). A statutory right to be provided with legal representation (with appropriate funding) would assist with this function. The ratification of *OPCAT* has significant implications for oversight and monitoring bodies such as MHAS.

## Training

Training of mental health practitioners and other service providers is often presented in the literature as a crucial means to protecting human rights in the mental health context. For example, the Royal Commission into Victorian Mental Health Services (2021, 413) found that '[p]roviding targeted resources and ongoing training will be essential to support the workforce to meet the expectations of a reimagined mental health and wellbeing system in which the workforce is no longer constrained by the system within which it operates'.

The WHO (2021) suggests systematic training for all staff involved in mental health and crisis support, on non-coercive responses to crisis situations including de-escalation strategies and good communication practices. The WHO (2020) *QualityRights Initiative* provides a comprehensive set of resources for improving quality of care and reducing coercive practices, which includes several training resources. This includes policy and program checklists and training materials that have been piloted and launched in low-, middle- and high-income countries. These resources are free and could be integrated into mandatory training for hospital staff.

Legislation can be used to enforce training, such as is required under the *Mental Capacity Act 2005* (UK) and *Mental Health Act 1983* (UK). Under these regimes, clinicians and other decision-makers can be required to undergo rights-based training before they are permitted to exercise powers under legislation. Legislation can also be used to broadly define the content for this training, including the role of lived experience in implementing training, de-escalation and non-coercive practices.

## Privacy and information sharing

Legislation can protect consumers' rights to privacy, confidentiality and to information. For example, legislation can ensure that information in mental health services is only shared with others, including other services, carers, family and supporters, on the same basis that information is shared in physical health settings. Consumer access to their own health information should also be provided on at least the same basis as in

physical health settings. The WHO and OHCHR (2022) note that this is a standalone right to privacy and linked to the right to be free from discrimination.

## Data sharing and transparency

The United Nations Special Rapporteur on the rights of persons with disabilities has called for ‘the identification of duty bearers, the allocation of responsibilities, the adoption of human rights indicators with specific benchmarks and targets and the collection of disaggregated data to measure progress’ (Devandas-Aguilar 2020, 10). The WHO and OHCHR (2022) suggest mental health legislation should require the transparent publication of data relating to mental health services, and provide a mechanism for any person to request information or documents concerning public mental health services. An example of this is the Victorian Mental Illness Awareness Council ‘Seclusion Report’, which seeks to provide guidance for consumers on how safe is each mental health inpatient unit in the state (VMIAC 2022). The WHO and OHCHR also argue that decisions made by public authorities about the provision of mental health services should be made public, including any submissions made and who participated in the decision-making process.

## ‘Voluntarism’ in the shadow of coercion

One risk noted in the literature is the ‘gap’ between voluntary admission and involuntary psychiatric intervention in which compulsion becomes a threat. The threat of being placed on an involuntary order means voluntary service users can be coerced into agreeing to unwanted treatment, in order to avoid legal compulsion and the associated stigma, discrimination and loss of rights (Donnelly 2010; Zigmond and Holland 2000; Series 2022). Bingham (2012) refers to the ‘common clinical scenario’ in which a person ‘acquiesces to continued admission to a mental health unit primarily because he or she believes he or she will otherwise be formally detained’. Some mental health services have produced guidelines and patient information addressing informal patients. For example, the 2015 Mental Health Act Code of Practice for England and Wales made clear that ‘[t]he threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)’. However, according to Bingham (2012, 281), ‘[u]nfortunately, in many ways this sort of information simply makes explicit the original predicament: you will be “allowed” to exercise your rights, “unless ...”’.

A legislative response to this issue would be a statutory statement of rights for voluntary consumers, which explicitly required clinicians to inform consumers of their rights, including the right to leave whenever they wished, unless they were made involuntary. Legislation may also prohibit clinicians from using threats of coercion.

## Gender-based safety

Gender-based violence in mental health settings raises particularly serious human rights concerns (Watson et al. 2020). This violence not only includes ‘experiences of rape, sexual assault and physical harassment but also consumers experiencing verbal harassment and threats’, and there are signs that such violence is common in mental health settings (RCVMHS 2021, 250). Such violence primarily impacts women and girls, but is experienced by people of all genders. From a human rights perspective, art 6 of the *CRPD* requires that states

parties like Australia ‘recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms’. Protecting consumers from gender-based violence in mental health settings is a key step in realising this requirement, in combination with other articles of the *CRPD* that seek to protect the right to freedom from exploitation, violence and abuse, as well as cruel, inhuman and degrading treatment (arts 15 and 16).

Maker (2022, 152) has argued that ‘gender-related factors must be – but often are not – built into regulation and practice relating to the use of restrictive practices and other responses to women’s distress, aggression or other hazardous or unwanted behaviour’. Restrictive practices are outside the scope of this paper, but some gender-related factors to include are noteworthy. First, historically, women’s gender is not recognised as a relevant consideration in the implementation of alternatives to the use of restrictive practices (or to the use of restrictive practices themselves) (Maker 2022). Second is that the ‘association between women’s mental health and their experiences of trauma is not dealt with appropriately in mental health services generally, or in responding to women’s dangerous or undesirable behaviour more specifically’ (Maker 2022). A human rights approach requires that these gender-related factors are recognised and addressed.

The Victorian Royal Commission into Mental Health Services recommended several measures to address gender-based violence, including ‘investment in more gender-specific acute mental health units’ (Royal Commission, 2021, Vol 4: 250). This is reflected in the proposed *Mental Health and Wellbeing Act 2021*, for which section 26 establishes a ‘gender safety principle’ and states:

People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns 20 and access is to be provided to services that— (a) are safe; and (b) are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and 25 (c) recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and (d) recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Presently, the *MHA14* only refers to ‘gender’ in three instances; twice with regard to respecting diversity of adults (Sch 1, Principle 6) and children (s 303(2)(b)) and once with regard to searching individuals who are detained under the Act, with the directive in s 163(3) that ‘[t]he person conducting the search must, if practicable, be a person of the same gender as the person to be searched’. This would not appear to address gender-based harms that may result from involuntary intervention under mental health legislation.

## Cultural safety concerns

The literature consistently identifies cultural safety, particularly for First Nations Australians, as a key area of concern. Studies have shown that people who use interpreters are three times more likely to be made subject to compulsory treatment (Kisely et al. 2020). The literature is largely silent on how effective legislative reform can contribute to cultural safety, although a study by Kahan and colleagues (2010) found that a person’s culture informed how they viewed compulsory treatment, with people with hierarchical and communitarian cultural

tendencies more supportive of compulsory treatment than those with egalitarian and individualistic cultural tendencies.

Some legislative responses to this issue may include a requirement to include representatives from a person's cultural group in decision-making (on request of the person concerned and subject to safeguards), and a legislative requirement to continually document a person's cultural identity on relevant forms and administrative documents (particularly for First Nations people). This review was unable to identify any literature that provided evidence of the effectiveness of such responses, although Aotearoa New Zealand law may provide a model for integrating First Nations perspectives into mental health legislation (Gooding 2017).

## DO HUMAN RIGHTS PROTECTIONS CREATE AN ADMINISTRATIVE BURDEN THAT DETRACTS FROM FACE-TO-FACE CARE?

The review team were unable to identify any evidence within the scope of this review that increased rights protections created an increased administrative burden on clinicians, although there is a passing reference to the issue in a limited number of sources. It is clear that clinical staff spend a significant amount of time on administrative tasks (Joukes et al. 2018; Erickson et al. 2017; Lemak, Alexander, and Campbell 2003), and that clinical staff tend to resent this burden and view it as having a direct negative impact on the quality of care (Moth 2022). The literature generally reflects the administrative burden associated with the introduction of electronic information systems or risk management rather than rights protections.

In Maylea et al. (2021), clinicians specifically identified that having a lack of time translated into not being able to work in a rights-based way. This suggests that administrative burden from any source may negatively impact rights protections but does not suggest that explicit steps to protect consumer rights lead to or require increased administrative burden.

One study by Grundell (2005), interviewed psychiatrists about their attitudes regarding the implementation of the Victorian Mental Health Review Board (the Board) (since replaced by the Victorian Mental Health Tribunal). Grundell noted that 'the principal disadvantages articulated by respondents concerned administrative and procedural burdens imposed by administrative review' (Grundell 2005, 75), which could be evidence of rights protection mechanisms being seen to increase administrative burden if the administrative review by the tribunal is considered a rights protection mechanism. However, even if this were the case, Grundell (2005) found that despite initial resistance, over the ten-year period of her study, psychiatrists began to appreciate the role of the Board, with 93% eventually indicating that it was appropriate, necessary or beneficial.

There is an emerging body of literature that may indicate that increasing administrative burden may be a way to *increase* rights protections by requiring that any limitation of a patient's rights must be accompanied by a large amount of administrative work. This strategy would be an example of 'nudge theory', which is the idea that if presented with multiple viable options, a person (in this instance, the clinician) will tend to choose the easiest one (Kwan et al. 2020; Pettigrew and Mays 2021; Last et al. 2021; Sant'Anna, Vilhelmsson, and Wolf

2021). As such, linking rights protections with *reduced* administrative burden – and rights limitations with *increased* administrative burden – may be a viable method for assisting cultural change towards rights protections. We were unable to find any evidence of successful use of this approach in protecting rights in mental health settings.

In a South Australian study, Brayley et al. (2015) found that the majority (60%) of administrative forms authorising detention did not address the legal requirements under the *Mental Health Act 1993* (SA). Similarly, in a Queensland study, Bateren et al. (2022) found that over 50% of medical assessments did not comply with the *Mental Health Act 2016* (Qld). These low compliance figures suggest that increasing administrative requirements will *not* necessarily result in increased compliance with these requirements and may result in widespread non-compliance with rights protection mechanisms.

In summary, the literature on the link between rights protections and administrative burden is not well developed. It is likely that this is not the most useful framing for understanding the two distinct problems of rights limitations on the one hand, and administrative burden on the other. It can be assumed that when services are working with people in ways that maintain their rights, the administrative burdens associated with documenting rights limitations or participating in oversight mechanisms would reduce. Certainly, the literature indicates that a reduction of rights limitations and violations would lead to an increased sense of trust between clinicians and consumers, improvement in the therapeutic relationship, and reduced moral distress and burnout in clinicians (Ohnishi et al. 2019; Fourie 2017; Spivakovsky, Seear, and Carter 2018; Wyder et al. 2015; Lessard-Deschênes and Goulet 2022).

## CONCLUSION

One key message from this literature review is that mental health legislation that limits rights cannot be truly considered to also protect rights, even as procedural safeguards can be introduced and strengthened within the logic of mental health law itself. Instead, a paradigm shift is required to achieve legislation that can be said to be *CRPD* compliant and genuinely rights-based – whether this is in the form of standalone mental health-related legislation or otherwise is open to debate. The other key message from the literature is that there is little to no evidence that legislative reform alone protects rights, and any legislative reform must be part of a broader system reform agenda. Acknowledging these limitations, we have provided a range of ways in which the current legislative framework can be reformed to improve rights protections.

Regarding coercion, in particular, there is significant evidence that with investment in alternative practices and an explicit commitment to reduction and prevention initiatives, many contemporary coercive measures are not necessary – and at least some can be eliminated entirely. A compelling legal and moral case exists for mandating the introduction of such practices and providing transparent plain language accountability measures to ensure a fuller transition to rights-based and recovery-oriented responses to distress and mental health crises.

As McSherry (2021, 431) writes:



Australia's declaration on ratifying the *CRPD* makes it clear that mental health legislation will remain in place in this country at least for the short term. For those taking the reform approach to existing laws, ensuring that mental health laws protect human rights in both theory and practice is an ongoing challenge. A major challenge is for mental health laws to provide a framework for access to medical treatment for all those experiencing mental health conditions, not just those assumed to be in 'high-risk' categories. At the very least, the *CRPD* provides guidance for law reformers, with a focus now on supported rather than substituted decision-making regimes. The ultimate challenge is to ensure that the treatment and care of individuals with mental health conditions is on a par with that accorded to individuals with physical illnesses and that Australia's mental health laws conform to contemporary human rights standards.

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