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Mental Health Law: Purpose and Procedures

A INTRODUCTION

Mental health legislation faces an uncertain future. The UN Convention on the Rights of Persons with Disabilities ('CRPD')[1] has bolstered calls to repeal or fundamentally alter laws that allow for involuntary psychiatric intervention. The CRPD also strengthens calls to provide support for people in mental health crises in ways that uphold self-determination, liberty, mental and physical integrity, the right to health, and so on. In order to isolate the questions and dilemmas raised by these proposals, it is useful to identify the function, purpose and procedures of mental health law today.

Elizabeth Farr's account of her own mental health crisis helps to illustrate the broad aims of mental health law. After years of aural and visual hallucinations, Farr experienced an urgent need to undertake a dangerous act:

> I thought the voices came from other worlds. I believed I was approaching an Enlightened State. The voices told me that in order to reach this Enlightened state I would have, at the appropriate moment, to jump from the seventh floor of a building and land on my head in a certain way. This would put me in a cosmic junction whereupon … I would be able to enlighten all mankind.[2]

The dilemma that arises when people appear to be putting themselves (or others) in grave risk without apparent knowledge of that risk produces no easy answers. At present, mental health legislation provides the principal grounds in law for finding these answers.

[1] Convention on the Rights of Persons with Disabilities, opened for signature 30 March 2007, Doc.A/61/611 (entered into force 3 May 2008).

[2] E Farr, 'A Personal Account of Schizophrenia', in M Tsuang (ed), *Schizophrenia: The Facts* (Oxford University Press, 1982) 1–2.

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Brenda Hale has observed that mental health law perpetually struggles to 'reconcile three overlapping but often competing goals: protecting the public, obtaining access to the services people need, and safeguarding users' civil rights'.[3] The regulatory role of mental health law places detention in hospital and compulsory treatment in a different category to deprivation of liberty and assault. Monitoring and procedural protections then allow those subject to involuntary interventions to challenge their commitment. From this view, if emergency powers are needed in *some* circumstances for *some* mental health crises – which, it can be reasonably assumed, the majority of people agree should be the case – then these powers need to be clearly authorised and regulated. Mental health legislation currently provides this function. It offers procedural protection and safeguards to prevent paternalistic overreach, negligence or inconsistent application of the law.

However, this view has been sharply criticised by a range of commentators, including the UN Committee on the Rights of Persons with Disabilities,[4] the Office of the High Commissioner and UN Special Rapporteurs for Torture, Disability and Health.[5] In order to contextualise these criticisms, this chapter will chart the historical development of 'rights-based' mental health law. It will ask how an area of law that was widely held to be liberal, humanist and compassionate came to be seen by major UN agencies and human rights commentators today as its opposite – illiberal, cruel and a violation of human rights.

B THE ORIGINS OF MENTAL HEALTH LEGISLATION IN COMMON LAW

English statutes from the era of the reign of Edward I in the late thirteenth century form the basis of modern mental health law.[6] Those early laws permitted

[3] B Hale, 'Justice and Equality in Mental Health Law: The European Experience' (2007) 30(1) *International Journal of Law and Psychiatry* 18, 19. See also G Richardson, 'Reforming Mental Health Laws: Principle or Pragmatism?' (2001) 54 *Current Legal Problems* 415; G Richardson, 'Involuntary Treatment: Search for Principles' in K Diesfeld and I Freckelton (eds), *Involuntary Detention and Therapeutic Jurisprudence* (Aldershot, 2003) 54.

[4] 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) 11 [42].

[5] Office of the High Commissioner for Human Rights, '"Dignity Must Prevail" – An Appeal to Do Away with Non-consensual Psychiatric Treatment World Mental Health Day – Saturday 10 October 2015', Geneva, 8 October 2015.

[6] The medieval origins of mental health law are often traced back to the *Statute De Prerogativa Regis 1324*, 17 Edw 2, st 1, c IX and XP Fennell, 'Mental Health Law: History, Policy, and Regulation' in L Gostin et al. (eds), *Principles of Mental Health Law and Policy* (Oxford University Press, 2010) 1.05.

the sovereign to intervene in order to protect the private property of those deemed 'unsound of mind', on the legal basis of *parens patriae*.[7] The *parens patriae* power, translating literally as 'parent of the country', justified detaining and/or treating a person compulsorily on the basis that the person was not able to look after his or her own interests.[8] Today, *parens patriae* is typically identified with guardianship and family law, where state interventions address abusive or negligent parents or legal guardians, and the state acts as the 'parent' of any child or individual needing protection.[9]

Another important legal doctrine underpinning mental health law concerns the 'police powers' of the state. In the eighteenth century, powers of this nature were introduced into common law by the Vagrancy Act 1744.[10] Such laws were mostly designed to protect private property from the interference of 'mad' people.[11] The 'police powers' doctrine justifies intervention to protect other people from the person deemed 'mad', typically from physical violence. As with *parens patriae*, subjects became wards of the sovereign.

The entwinement of the legal doctrines of *parens patriae* and the police powers of the state have remained an important feature of mental health law. Indeed, the basis for non-consensual treatment and detention today, of posing 'risk of harm to self or others', reflects the entwinement of these dual legal doctrines.

The eighteenth and nineteenth centuries saw the development of a new role for the state in relation to treatment and welfare.[12] Laws began to reflect what was ostensibly a greater protective impulse. Theobald argues that, in the nineteenth century, two major professional groups propelled the development of 'lunacy laws' from then on: '[M]edical men … desired early and easy treatment of persons afflicted with mental disease, and at the same time demanded protection against the risks they ran in certifying persons as lunatics; lawyers … attached more weight to the liberty of the person than to the possibility of a cure by facility for compulsory confinement'.[13] Theobald's observation captures a recurring tension between the medical and legal professional frameworks along the theoretical lines of the paternalist and libertarian. (However, commentators may have overstated this case, as will be discussed shortly.)

7 Ibid. 1.06.

8 M Cavadino, *Mental Health Law in Context: Doctors' Orders?* (Aldershot, 1989) 132.

9 Cavadino distinguishes three types of paternalism which underpin *parens patriae* powers: physical (preventing physical harm), psychological (safeguarding mental health) and moral (preventing the individual from coming to 'moral harm'). Ibid.

10 Vagrancy Act 1744, 17 Geo 2, c 5.

11 For Cavadino's elaboration on 'police powers', see Cavadino, above n 8, 132.

12 See, generally, Fennell, above n 6 [1.89]–[1.103].

13 H Theobald, *The Law Relating to Lunacy* (Oxford University Press, 1987 [original publication, 1924]) 78.

Patricia Allderidge has characterised the history of mental health law as a pendulum swinging between the preference for legal regulation, on the one hand, and a greater emphasis on clinical discretion to treat and detain, on the other.[14] Thus viewed, the middle of the twentieth century saw a swing from legalism towards clinical discretion in mental health law.[15] An indication of the decisive endorsement of the medical approach is captured in the titles of the new statues – for example, the Mental Treatment Act 1930 (UK) and later the Mental Health Act 1959 (UK),[16] which were replicated in most common-law countries.[17]

The Mental Health Act 1959 (UK) saw the abolition of legal proceedings heard by magistrates in matters of detainment and detention upon which clinicians decided.[18] Detention was justified on the basis that mental illness so affected a person as to warrant his or her detention in the interests of his or her (or others') health and safety. Lunacy laws granted consulting psychiatrists plenary powers and the authority to impose detention. Once an individual had been admitted, the Mental Health Review Tribunal, a quasi-judicial body constituted under the Mental Health Act 1959 (UK), provided periodic review of the detention following the first twenty-eight-day period after certification.[19]

However, to suggest that the Mental Health Act 1959 (UK) represented a wholesale medicalisation of mental health law would be misleading. After all, social workers gained increased powers at the commitment stage, and family members were vested with equal power to apply for certification.[20] Further, the Royal Medico-Psychological Association and the British Medical Association did not entirely support the extent of the discretionary powers granted under the Mental Health Act 1959 (UK); both expressed concern that the discretionary power would delegitimise the profession.[21]

[14] P Allderidge, 'Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane' (1979) 134 *British Journal of Psychiatry* 321.

[15] Fennell, above n 6, s H[37].

[16] Mental Health Act 1959 7 & 8 Eliz. 2.

[17] In Australia, for example, the Mental Health Act 1958 (NSW) and the Mental Health Act 1959 (Vic) consolidated laws for the treatment and care of people described in the Victorian legislation as 'the mentally ill and the intellectually defective' – understood in contemporary terms as people with psychosocial and intellectual disabilities.

[18] There was, however, limited recourse for protection of patients in the form of a tribunal system. See Mental Health Act 1959 (UK) 7 & 8 Eliz. 2 s 2(1), 2(2), 2(3), and s 3(1).

[19] Mental Health Act 1959 (UK) 7 & 8 Eliz. 2 s 3(1).

[20] P Fennell, 'Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches' in B McSherry and P Weller (eds), *Rethinking Rights-Based Mental Health Law* (Hart, 2010) 13, 38.

[21] In particular, the British Medical Association and the Royal Medico-Psychological Association resisted the devolution of the power to detain from the super-intendant physician

It is debatable as to why legislation expanded clinical powers. Clive Unsworth has argued that the Mental Health Act 1959 (UK) reflects the state's ideological departure from the classical liberal emphasis on autonomy that drove the Lunacy Act 1890 and its reorientation towards the collectivist and interventionist objectives of the post-war welfare state.[22]

Regardless, the legislation expanded the scope and importance of the term 'health' in the justification of detention and treatment. Fennell argues that the term 'health' was broadened to include mental health and the justification for detention and involuntary treatment was moved further along a continuum from 'negative paternalism', where intervention was justified if it brought benefit to the subject, and not necessarily just to prevent immediate harm.[23] This new health framework in law helped establish a medical model as the dominant model of disability. The United Kingdom Mental Health Act 1959 brought both 'mental illness' and 'mental handicap' (the latter referring, in contemporary terms, to intellectual disability) under the one statute.[24]

The Mental Health Act 1959 continued authorising non-consensual treatment following admission, as had been the case since the Lunacy Act 1845.[25] Even as mainstream hospitals began to replace asylums as the main sites of state psychiatric intervention, it was still assumed that once a person was admitted, consent was not required. It is worth noting that the very *notion* of informed consent more generally was new to medical practice at this time, and was by no means predominant in general medical care.[26] Tom Beauchamp details the emerging acceptance in the 1970s among physicians and biomedical researchers that informed consent was a moral and legal duty for certain procedures.[27] Yet even then, in Beauchamp's terms, '[t]hese developments prompted an

to all consulting psychiatrists. See C Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press, 1987).

[22] Ibid.

[23] Fennell, above n 20, 38–39.

[24] It provided a guardianship regime under which appointed guardians were granted the powers of a father over a child younger than fourteen. Even at its peak, guardianship power was used infrequently, given that psychiatric institutions could readily compel people without consent and access to courts to confer guardianship powers was limited. Coverage of both disability categories under one statute becomes relevant decades later, when separate and parallel substituted decision-making legislation (guardianship and mental health statutes) emerges in developed Western jurisdictions.

[25] Fennell, above n 20, 41.

[26] R Faden and T Beauchamp, A *History and Theory of Informed Consent* (Oxford University Press, 1986) 86–90.

[27] T Beauchamp, 'Informed Consent: Its History, Meaning, and Present Challenges' (2011) 20(4) *Cambridge Quarterly of Healthcare Ethics*, The International Journal of Healthcare Ethics Committees 515.

explosion of largely negative commentary on informed consent in the medical literature of the mid-1970s', in which '[p]hysicians saw the demands of informed consent as impossible to fulfill and, at least in some cases, inconsistent with good patient care'.[28] This seems to be an important (and oft-overlooked) feature of medical history and, interestingly, echoes contemporary controversies provoked by the CRPD.[29] Beauchamp's characterisation of clinicians who viewed the 'demands of informed consent as impossible to fulfill and, at least in some cases, inconsistent with good patient care' could well summarise the response to the CRPD by some prominent commentators today.[30]

Overall, the medicalising shift of early and mid-twentieth-century mental health legislation took place in the context of increasing state intervention and social welfare in health policy, one in which the biomedical model of mental health issues was strongly endorsed.

C DEINSTITUTIONALISATION AND 'RIGHTS-BASED' LEGALISM

From the late 1970s, mental health laws began shifting towards so-called legalism, which saw the development of greater procedural protections over involuntary treatment and detention.[31] In the second half of the twentieth century, deinstutitionalisation saw the dismantling of the stand-alone psychiatric hospital system, a transition tied inextricably to the evolution of modern mental health law. The reforms established a diverse range of mental health services that included general hospital, residential, community and other support services. The number of psychiatric hospital beds gradually declined. In the United Kingdom, for example, the number of psychiatric beds diminished from 150,000 in 1954[32] to 30,533 in 2010, as recorded in the 2010 census count,[33] which is considerable given the associated population increase during that time. Governments introduced new statutes in the policy context of reforming liberal states in the 1980s, which included the language of rights.[34] Under

[28] Ibid.

[29] See Chapter 7.

[30] See, e.g., M Freeman et al., 'Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2 *Lancet Psychiatry* 844; J Dute, 'Should Substituted Decision-Making Be Abolished?' (2015) 22 *European Journal of Health Law* 315.

[31] See, generally, McSherry and Weller, above n 20.

[32] N Rose, 'Historical Changes in Mental Health Practice' in G Thornicroft and G Szmukler (eds), *Textbook of Community Psychiatry* (Oxford University Press, 2001) 13.

[33] A Molodynski, J Rugkasa and T Burns, 'Coercion and Compulsion in Community Mental Health Care' (2010) 95 *British Medical Bulletin* 107.

[34] McSherry and Weller, above n 20, 5.

the Mental Health Act 1986 (Vic), for example, section 4(1)(ac) states that one objective of the act is to 'Protect the rights of people with a mental disorder'.[35] Section 4(2)(b) states that interpretations of the act should consider that: 'Any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances'.[36]

This trend of using rights vocabularies in mental health law can be seen across common-law countries and other Western, high-income jurisdictions and is characterised by the expanded review process through mental health review tribunals or similar bodies.[37] Such courts or tribunals today continue to operate within parameters detailed in mental health laws, including review periods and requirements for procedural fairness.[38] Statutory duties introduced under mental health law include those designed to secure individual rights, including rights to access services, refuse medical treatment, and review detention and imposed treatment decisions.[39]

Bernadette McSherry and Penelope Weller characterise mental health law from this time as 'rights-based legalism' given the precedence granted to the language of rights.[40] 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').[41] Case law, as illustrated by the US case of *Rogers v Okin* (1979),[42] affords the right to refuse medication in non-emergency conditions. One reason for the introduction of new mental health statutes, typified in common-law jurisdictions by the Mental Health Act 1983 (England and Wales), was to constrain professional power and bring greater accountability to clinical discretion through the regulation of decision-making processes, combined with quasi-judicial review. There is some evidence to suggest that this change resulted in lower rates of involuntary psychiatric intervention. For example, a multistate study across the European

[35] Mental Health Act 1986 (Vic) s 4 (1)(ac).
[36] Ibid. (2)(b).
[37] Under the Mental Health Act 1986 (Vic), for example, the Mental Health Review Board was established to review and hear appeals by or on behalf of involuntary or security patients, with expanded powers to discharge. Ibid. s 22 (1a), (2).
[38] D Tait and T Carney, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* (Themis, 2011).
[39] L Gostin, 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in P Bean (ed), *Mental Illness: Changes and Trends* (Wiley, 1983) 50.
[40] See, generally, McSherry and Weller, above n 20.
[41] Ibid. 4–5.
[42] *Rogers v Okin*, 478 F Supp 1342 (1979).

Union found significantly lower compulsory admission rates in member states that mandated an independent counsel, tribunal or court process.[43]

Importantly, these 'legalist' reformers introduced new criteria for involuntary treatment and detention. Section two of the Mental Health Act 1983 (England and Wales) is typical; applications for assessment of eligibility for involuntary treatment and detention can be made where:

> (a) [the person] is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
> (b) [the person] ought to be so detained in the interests of his [or her] own health or safety or with a view to the protection of other persons.[44]

Although the added procedural protections of rights-based mental health law moved involuntary treatment closer to of the kind of procedural protections found in criminal proceedings, laws remained couched in the language of care and treatment. A paternalistic framework endured, expressed in the 'best interests' standard which guided interventions – either implicitly or explicitly – in mental health law in Canada, New Zealand, Australia, Ireland, the United Kingdom and elsewhere.[45] The power to detain was reframed to occur, as exemplified by the terms of the Mental Health Act 1986 (Vic), 'in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment'.[46]

Such legislation exists, in part, to provide a statutory basis for treatment and detention as a health issue, which might otherwise warrant a charge of assault and detention.[47] Under most contemporary mental health laws, the principal persons granted power to treat and detain involuntarily are psychiatrists.[48]

[43] H J Salize and H Dressing, 'Epidemiology of Involuntary Placement of Mentally Ill People Across the European Union' (2004) 184(2) *The British Journal of Psychiatry* 163.

[44] Mental Health Act 1983 (England and Wales) c 20, s 2(a)(b).

[45] See, e.g., 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, e.g., 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); Mental Health (Northern Ireland) Order 1986 No 595 (N.I. 4) s 3(1); Mental Capacity Bill 2014 (NI) s 1(7); Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) s 2(1). In Australia, see, e.g., Mental Health Act 2014 (WA) pt 2 div 3.

[46] Mental Health Act 1983 (England and Wales) c 20, s 5(a).

[47] Fennell, above n 20, 24–5.

[48] B Burdekin, 'Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Human Rights and Equal Opportunity Commission', vol 1 (Australian Government Publishing, 1993) 40.

In its 1993 'Report of the National Inquiry into the Human Rights of People with Mental Illness', the Australian Human Rights and Equal Opportunity Commission describes psychiatrists as being granted 'effective decision-making power under the legislation'.[49] Under the Mental Health Act (1986) (Vic), for example, the following applies: 'If an involuntary patient refuses to consent to necessary treatment or is unable to consent to treatment for his or her mental illness, consent in writing may be given by the authorised psychiatrist'.[50]

Neil Rees has characterised this power as a form of 'clinical guardianship' because 'the treating doctor becomes the substitute decision-maker for psychiatric treatment'.[51] Decisions under mental health law may regard matters of detention (in seclusion or otherwise) and in some cases may relate to accommodation and other lifestyle choices, such as driving.[52] However, clinical decisions generally regard medical treatment, typically psychiatric medication, as well as electroconvulsive therapy ('ECT'), which is commonly known as electric shock treatment, and psychosurgery. ECT refers to an intervention in which clinicians pass an electric current through a person's brain, stimulating an epileptic fit. ECT and psychosurgery treatments are administered infrequently compared to other involuntary interventions and typically require authorisation by a mental health tribunal or similar statutory body given their invasive nature.[53] Mental health tribunals and similar statutory bodies also have effective substituted decision-making power.[54] In the case

[49] Ibid.

[50] Mental Health Act 1986 (Vic) s 12AD(2).

[51] N Rees, 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?' (Mental Health Review Board of Victoria's 20th Anniversary Conference, Melbourne, 6 December 2007).

[52] The term 'treatment' is interpreted widely in legislation and in practice. It is understood by some to encompass matters beyond the explicitly medical, including, for example, accommodation or driving. Carney has identified this as a semantic issue that causes confusion where clinical imperatives for 'treatment' may veer towards 'behavioural management'. See T Carney, 'Mental Health Law in Postmodern Society: Time for New Paradigms?' (2003) 10(1) *Psychiatry, Psychology and Law* 12.

[53] For example, there is some evidence indicating that the numbers are relatively low. See, e.g., W Chanpattana, 'A Questionnaire Survey of ECT Practice in Australia' (2007) 23 *Journal of ECT* 89.The same conclusion may be drawn about psychosurgery. In Victoria, for example, the Victorian Psychosurgery Review Board, which must grant permission for any psychosurgery measure, dealt with no operations between 2001 and 2006, and 12 applications between 2007 and 2012 (all of them for 'deep brain stimulation'). Mental Health Review Board of Victoria and Psychosurgery Review Board of Victoria, *2012/2013 Annual Report* (2013) 30 <www.mht.vic.gov.au/forms-and-publication/annual-reports>.

[54] There is some controversy as to whether this is the case, as mental health tribunals are meant to be a regulatory safeguard. See, generally, E Perkins, *Decision-Making in Mental Health Review Tribunals* (Policy Studies Institute, 2003); see also W Obomanu and H Kennedy,

of *MH2 v Mental Health Review Board*,[55] for example, the Victorian Mental Health Review Board was described as having 'all the functions of the decision maker … that are relevant to the decision under review'.[56]

1 *Involuntary Interventions Outside Hospital: The Rise of Compulsory Psychiatric Interventions in the 'Community'*

Another important development in recent decades is the introduction of non-consensual psychiatric interventions outside the hospital, in people's residences. These measures are typically referred to as 'assisted outpatient treatment' ('AOT') in the United States and 'community treatment orders' ('CTOs') in jurisdictions like England, Wales, Canada, Australia and New Zealand,[57] and have been introduced in multiple jurisdictions over the past three decades (with the notable exception of jurisdictions like Northern Ireland and the Republic of Ireland). An AOT or CTO authorises the imposition of conditions on a former inpatient following hospital discharge. Conditions typically relate to medication. However, depending on the jurisdiction, conditions can also relate to where the person must live and other lifestyle matters, such as how much alcohol he or she can consume.[58] If individuals breach conditions, clinicians can recall them to involuntary hospitalisation.

Early on, reformers portrayed AOT and CTOs as middle options on a spectrum between voluntary community support and involuntary hospitalisation.[59] This claim forms the basis for an account of compulsory outpatient treatment as enhancing autonomy. According to the Australian Human Rights and Equal Opportunity Commission in 1993, for example, CTOs 'encouraged' community-based treatment by providing an alternative to detention and involuntary inpatient treatment.[60] John Dawson conducted interviews

'"Juridogenic" Harm: Statutory Principles for the New Mental Health Tribunals' (2005) 21 *Psychiatric Bulletin* 331.

55 MH2 v Mental Health Review Board (Human Rights) [2013] VCAT 734 (8 May 2013).

56 Ibid. para 2(d).

57 For example, England and Wales saw the introduction of supervised community treatment orders in 2008 through amendments to the 1983 Mental Health Act. See Mental Health Act 1983 (England and Wales) ss 3, 37. See also E Light et al., 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478. In Canada, all jurisdictions, with the exception of New Brunswick and the Territories, use CTOs or comparable legislation.

58 See, generally, SR Kisely, LA Campbell and NJ Preston, 'Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders' (2011) (2) *Cochrane Database Systematic Review* CD004408.

59 E McDonnell and T Bartholomew, 'Community Treatment Orders in Victoria: Emergent Issues and Anomalies' (1997) 4(1) *Psychiatry, Psychology, and Law* 25, 26.

60 Burdekin, above n 48, 67.

with clinical professionals in Victoria, Australia, who tended to see CTOs as being instrumental to the rapid pace of deinstitutionalisation and the associated shift of resources from hospitals to 'community-based' services.[61] This hypothesis may be true with respect to CTOs having a *role* in moving resources. However, the cause is unlikely to be the efficacy of CTOs (and Dawson's findings are perhaps more indicative of psychiatrists' increased comfort in allowing patients to leave hospital knowing that they were subject to compulsory treatment in the community). Indeed, since the introduction of CTOs, three large-scale randomised controlled trials and their meta-analyses have failed to support the view that they are effective in achieving their principal aim; that is, lowering hospitalisation rates or protecting individuals subject to them.[62] Given these results, some prominent early supporters of CTOs in England and Wales, including senior figures in the United Kingdom's Royal College of Psychiatrists, have called for their repeal;[63] human rights bodies today are unlikely to endorse CTOs, particularly given the prohibition of disability-based restrictions on rights in the CRPD (as shall be discussed in detail in the next chapter).

CTOs reflect a paradox in the era of 'rights-based legalism', one that might give pause for us to consider whether 'rights-based legalism' is the best way to characterise developments in mental health law around the turn of the twenty-first century. Despite the increasing focus on procedural protections in mental health law, the coercive 'powers' of clinicians have expanded in certain respects. Roughly one-quarter of US states, and most common-law high-income countries, have adopted outpatient commitment statutes in the past three decades, leading to increased clinical powers for the supervision and non-consensual intervention of people outside hospital.[64] In the United States, Paul Appelbaum observes that the increase in forced outpatient treatment

[61] J Dawson, *Community Treatment Orders: International Comparisons* (University of Otago, 2005).

[62] T Burns et al., 'Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial' (2013) 381(9878) *The Lancet* 1627; S Kisely and L Campbell, 'Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders' (2015) 41 *Schizophrenia Bulletin* 542; S Kisely and K Hall, 'An Updated Meta-analysis of Randomized Controlled Evidence for the Effectiveness of Community Treatment Orders' (2014) 59 *Canadian Journal of Psychiatry* 561; M Swartz et al., 'Can Involuntary Outpatient Commitment Reduce Hospital Recidivism? Findings from a Randomized Trial with Severely Mentally Ill Individuals' (1999) 156 *American Journal of Psychiatry* 1968.

[63] R Heun, S Dave and P Rowlands, 'Little Evidence for Community Treatment Orders – A Battle Fought with Heavy Weapons' (2016) 40 *BJPsych Bulletin* 115; S Manning, '"Psychiatric Asbos" Were an Error Says Key Advisor', *The Independent*, 14 April 2013.

[64] See P Appelbaum, 'Ambivalence Codified: California's New Outpatient Commitment Statute' (2003) 54 *Psychiatric Services* 26.

over the past twenty-five years has meant that legal oversight of clinical activity has diminished, which 'almost always' makes it easier for clinical authorities to enforce civil commitment and involuntary treatment.[65] Reflecting on this period of mental health law, Appelbaum observes that '[c]riteria for involuntary hospitalization have been expanded gradually in many jurisdictions, and procedural rigor has been somewhat relaxed'.[66] Similarly, in England and Wales, according to Molodynski and colleagues, the use of CTOs has 'substantially outstripped' official expectations since their introduction in 2008.[67] In Victoria, Australia, which was one of the first non-US jurisdictions to introduce CTOs, rates of use are the highest per capita in the world.[68] It also appears likely that a number of jurisdictions, at least in the US, allow preventive compulsory community treatment, even if this is not explicitly promoted in law; that is, if the person is *at risk* of becoming eligible for civil commitment.[69]

2 *Separating Mental Health and Capacity/Guardianship Laws*

The separation of adult guardianship laws and mental health legislation is relevant here. Adult guardianship laws (which are sometimes referred to as mental capacity laws)[70] provide for substituted decision-making for adults deemed to lack mental capacity. Typical legislation attributes mental incapacity to 'an impairment of, or a disturbance in the functioning of, the mind or brain'.[71] As early as the 1980s, Australia,[72] New Zealand[73] and Canada[74] saw substantial reform of adult guardianship laws along a different but parallel trajectory to

[65] P Appelbaum, 'Law and Psychiatry: Twenty-Five Years of Law and Psychiatry' (2006) 57(1) *Psychiatric Services* 18.

[66] Ibid.

[67] Molodynski, Rugkasa and Burns, above n 33.

[68] E Light et al., 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478.

[69] P Clark Robbins et al., 'Regional Differences in New York's Assisted Outpatient Treatment Program' (2010) 61(10) *Psychiatric Services* 970; E Saks, 'Involuntary Outpatient Commitment' (2003) 9(1–2) *Psychology, Public Policy, and Law* 94, 97; Treatment Advocacy Center, 'State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Services' (2014) <www.treatmentadvocacycenter.org>.

[70] See, e.g., Mental Capacity Act 2005 (England and Wales) c 9.

[71] Ibid. s 2(1).

[72] See, e.g., Guardianship and Administration Board Act 1986 (Vic); Disability Services and Guardianship Act 1987 (NSW).

[73] See WR Atkin, 'Adult Guardianship Reforms – Reflections on the New Zealand Model' (1997) 20(1) *International Journal of Law and Psychiatry* 77.

[74] R Gordon, 'The Emergence of Assisted (Supported) Decision-Making in the Canadian Law of Adult Guardianship and Substitute Decision-Making' (2000) 23(1) *International Journal of Law and Psychiatry* 61.

mental health law.[75] These new statutes created a substituted decision-making regime in step with the transition from large-scale institutions to 'community-based' services. Guardianship laws were typically designed for persons with cognitive and intellectual disabilities (who no longer fell under mental health law)[76] but could apply to anyone found to lack mental capacity, including some persons with psychosocial disabilities.[77] Typically, guardianship/mental capacity laws authorise a tribunal to appoint a guardian or a 'deputy', potentially a relative or close friend, to make decisions regarding healthcare or 'lifestyle' choices, or to appoint an administrator to manage financial matters. Public officials may serve as substituted decision-makers and/or financial administrators. Neil Rees has argued that the new wave of guardianship/mental capacity laws from the 1980s onward aimed to 'operate as a "last resort" option under legislation which promoted autonomy and self-sufficiency, encouraged the appointment of family members rather than representatives of the state as substituted decision-makers, and resulted in limited and reviewable orders'.[78]

To state the differences clearly, mental health legislation is typically concerned with the following:

a) people with psychiatric diagnoses or apparent mental disorder – mental incapacity is not used as a grounds for involuntary psychiatric intervention;[79]
b) crisis intervention, involuntary treatment and detention; and
c) the authorisation of a treating clinician, who is granted primary substituted decision-making power on matters of healthcare and detention.[80]

By contrast, a guardianship/mental capacity law, such as the Mental Capacity Act (2005) (England and Wales), is characterised by the following:

a) it is meant for those with a range of impairments that affect cognitive functioning;
b) it relies on assessing mental capacity to determine where 'deficits' are relevant to decisions that need to be made; and

[75] For example, in Victoria, Australia, the Guardianship and Administration Act 1986 (Vic) was introduced alongside the Mental Health Act 1986 (Vic) as a cluster of substituted decision-making statutes, with a view to reforming the Mental Health Act 1959 (Vic).
[76] N Rees, 'The Fusion Proposal: A Next Step?' in McSherry and Weller, above n 20, 73.
[77] Ibid. 80.
[78] Ibid. 79–80.
[79] Notable exceptions include laws introduced since the CRPD came into force, which have integrated a mental capacity assessment into criteria for involuntary interventions. See in Mental Health Law (2016) 39(2) *University of New South Wales Law Journal* 596.
[80] Burdekin, above n 48, 40.

c) the substituted decision-maker is (in ideal circumstances) a trusted person appointed according to the preference of the person, potentially a family member, but also a public official such as a 'deputy', public advocate, financial administrator or public trustee.

The idea of 'supported decision-making' evolved, in large part, from changes to adult guardianship law. British Columbia in Canada, for example, adopted one of the first legislative models for decision-making assistance from as early as 1996.[81] In the Republic of Ireland, the Assisted Decision-Making (Capacity) Act 2015 is a mental capacity law emerged from reform to the country's 'wardship' system, which may have taken the British Columbian model a step further by providing multiple statutory support options for citizens who may require support to make decisions and exercise legal capacity.[82] Specific guardianship/mental capacity laws, as well as the general literature on adult capacity law and other mental capacity-related laws, will provide a useful resource throughout this book when examining key issues in the mental health context. The differences and overlap between mental health law and guardianship law will become important later in the book, in the discussion about possible legal frameworks for mental health support in line with the CRPD.

D DISCUSSION: CHANGE AND CONTINUITY IN MENTAL HEALTH LAW

Before proceeding to outline the implications of the CRPD for mental health law, it is useful to ask what the background in this chapter means for this book. First, it is noteworthy that the function, justification and (to a lesser extent) procedures of mental health laws over time have remained largely the same. Mental health law continues to authorise the restriction of liberty and the right to refuse medical treatment through interventions that would otherwise be unlawful.

The legal basis for mental health law continues to be to prevent harm to individuals and the community by entwining the doctrine of *parens patriae* with the police powers of the state. Protection remains a major driver, in terms of addressing risk (whether real or imagined) both to the broader public and to unwell individuals.[83] So, too, there remains an unchanging premise in all domestic mental health statutes that special legal treatment is required for people with apparent or diagnosed mental disorder. This position is justified on two grounds: such persons are less responsible causally and, hence, legally

[81] Representation Agreement Act, RSBC 1996, c 405 (British Columbia).
[82] Assisted Decision-Making (Capacity) Act 2015 (Ireland).
[83] See Fennell, above n 20, 13.

for their actions,[84] and they are more dangerous than others.[85] (The veracity of these claims will be scrutinised in Chapter 3.) Overall, then, mental health laws retain the decades-long tension between the principles of autonomy and protection. In William Bingley and Chris Heginbotham's terms, these dual objectives seek 'to recognise, preserve and enhance the self-determination of individual patients whilst at the same time providing a framework for the care and treatment of those who are genuinely disabled as a result of mental illness'.[86]

This latter point – which is deeply contested, as shall be discussed in later chapters – raises another important issue regarding language. As a general comment, language around mental health law is greatly contested.[87] In particular, ongoing debates in this field have centred around two fluid and disputed topics, namely 'mental illness' and 'self-determination' (or, in earlier terminology, 'insanity' and 'liberty'). Spaulding has argued that the extent to which 'legalistic' mental health laws are seen to be libertarian 'depends on one's understanding of the relationship between liberty and mental disorder'.[88] One person may view untreated mental disorder as a *denial* of liberty; while another might see forced treatment in the same way. Using terms such as 'mental illness' and 'autonomy' without acknowledging their intended meaning, or without noting their fluidity and relationship, can result in commentators cloaking the underlying purposes of their use, which remain, at best, only vaguely stated. In analysing how the support framework of the CRPD might reshape the law's response to mental distress, disorder and disablement, it will be interesting to consider whether the 'human rights model of disability' and associated concepts can more satisfactorily address some of these persistent conceptual challenges.[89]

In terms of change, the following points are noteworthy. By the end of the twentieth century, and still today, the picture of mental health law in Western,

[84] WJ Spaulding, 'Mapping the "New Legalism" of English Mental Health Law' (1989) 17(2) *The Journal of Law, Medicine and Ethics* 187.

[85] See, e.g., G Szmukler, 'A New Mental Health (and Public Protection) Act: Risk Wins in the Balance Between Providing Care and Controlling Risk' (2001) 322(7277) *British Medical Journal* 2.

[86] W Bingley and C Heginbotham, 'Mental Health Law: Objectives and Principles' in N Eastman and J Peay (eds), *Law Without Enforcement: Integrating Mental Health and Justice* (Hart, 1999) 39, 40.

[87] In many ways, this difficulty is inherent to the entire mental health law project, as Peay has pointed out. See J Peay, *Seminal Issues in Mental Health Law* (Ashgate, 2005) xvi.

[88] For example, alleviation of psychosis might be seen as a restoration of liberty by re-establishing reason; involuntary treatment would, from this view, enhance autonomy and ostensibly minimise state intervention. If, on the other hand, involuntary treatment is viewed as an incursion by the state into the individual sphere and into legitimate ways of thinking and being, such an act becomes a paternalistic state intrusion. Spaulding, above n 84, 187.

[89] I will directly consider these issues in Chapter 5.

high-income countries has become more complex. While large-scale stand-alone institutions have largely closed, the scope of substituted decision-making powers has expanded outside hospitals and into the 'community'. Compulsory psychiatric intervention today occurs in people's residences. An apparent contradiction emerges: despite the move to rights-based legislation, rates of non-consensual psychiatric intervention appear to be increasing in some respects, particularly regarding involuntary outpatient treatment.

A number of reviews have commented upon the lack of substantive rights brought about by rights-based mental health law. For example, the Irish Department of Health's 'Interim Report of the Steering Group on the Review of the Mental Health Act' found that, although it 'was anticipated that the introduction in the [Mental Health Act 2001 (Republic of Ireland)] of the statutory "best interests" principle would lead to a new emphasis on the rights of the patient … the reality is that the principle has been interpreted by the Courts in a paternalistic manner'.[90] According to the Steering Group, this interpretation is 'undermining the significant advances in mental health law which the Act was intended to enshrine, and has given rise to concerns that the human rights aspects of the legislation have been diluted and diminished'.[91] Alternatively, consider the comment of the Australian Human Rights and Equal Opportunity Commission in 1993, which found that legislative formulations in Australian states are 'marked by circularity of reasoning and apparently designed to intrude to a minimal degree upon the territory of psychiatrists'.[92] On the other hand, as noted previously, there is some evidence to show that jurisdictions which mandate tribunal or court processes have significantly lower compulsory admission rates compared to those that do not.[93]

These paradoxes suggest that, just as mental health 'systems' have become more complex, so too have configurations of mental health laws around the world. While general principles are shared, considerable variation occurs in specificities; for example, as relates to compulsory treatment in the community, the role of family and informal carers, and the relationship between detention and non-consensual treatment. To provide one example, the Ontario Mental Health Act 1990 includes powers to detain which do not

[90] Department of Health (Ireland), Interim Report of the Steering Group on the Review of the Mental Health Act 2001 (2012) 11 <www.dohc.ie>.

[91] Ibid.

[92] Burdekin, above n 48, 40.

[93] HJ Salize and H Dressing, 'Epidemiology of Involuntary Placement of Mentally Ill People Across the European Union' (2004) 184(2) *The British Journal of Psychiatry* 163.

necessarily extend to powers for involuntary treatment.[94] Instead, Ontario's Health Care Consent Act 1996 governs rules of capacity to consent to medical treatment.[95] In contrast, all Australian states and territories (each with its own distinct mental health statute) entwine detention and involuntary treatment, whereby people detained under mental health law are automatically subject to involuntary treatment powers.[96] This is just one example highlighting the diversity of mental health laws, which adds an extra layer of complexity when discussing cross-jurisdictional trends.

Some changes in commentary on mental health law are noteworthy. The first is the increasing push to use assessments of mental capacity to activate involuntary psychiatric intervention. Peter Bartlett has argued that the idea of using mental capacity–based tests for involuntary treatment has characterised progressive mental health law reform in recent years.[97] This priority partly arises from the question of whether mental capacity should be a central criterion for involuntary treatment in all medical contexts, regardless of whether they relate to 'mental' or 'physical' health.[98] In the past, most libertarian concerns with protecting autonomy and non-interference were directed to those 'falsely accused of mental disorder', whereas recent years have seen an emphasis on equality and non-discrimination in the exercise of patient choice *regardless of diagnosis* – especially for those who retain mental capacity.[99] These concerns centre on the question, Should we respect the right of competent patients to refuse psychiatric treatment, given that we respect their right to refuse physical medical care (such as chemotherapy), even if they die?[100] This fraught line of enquiry will become particularly relevant later in Chapter 4 when considering the potential benefits and drawbacks of the support framework of the CRPD.

[94] Ontario Mental Health Act, RSO 1990, c M.7.

[95] Health Care Consent Act, SO 1996, c 2, sch A. This approach relates, in part, to ethical questions around detaining someone due to an apparent or diagnosed mental disorder, without imposing medical treatment that might alleviate the disorder. See JE Gray and RL O'Reilly, 'Supreme Court of Canada's "Beautiful Mind" Case' (2009) 32(5) *International Journal of Law and Psychiatry* 315.

[96] JE Gray et al., 'Australian and Canadian Mental Health Acts Compared' (2010) 44(12) *Australian and New Zealand Journal of Psychiatry* 1126.

[97] P Bartlett, '"The Necessity Must Be Convincingly Shown to Exist": Standards for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983' (2011) 19 *Medical Law Review* 514, 541.

[98] J Dawson and G Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *The British Journal of Psychiatry* 504.

[99] Ibid.

[100] J Dawson and G Szmukler, 'Compulsory Treatment and the Patient's Capacity to Consent' (Paper presented at the Australasian Institute of Judicial Administration Conference, Auckland, 2010).

For now, it is important to note that, despite mental capacity becoming a key concern in mental health law reform trends in mental health law are shifting still, particularly since the coming into force of the CRPD.[101] Indeed, Bartlett follows his appraisal of mental capacity as a major concern of recent mental health law reform by noting that the CRPD has created a 'significant shift in the legal landscape' away from mental capacity tests and towards evaluating a person's support requirements, and particularly his or her decision-making support needs.[102]

A second major change concerning the mental health field in recent decades is the existence of an expanded range of commentators. In particular, mental health service users and others with psychosocial disability are increasingly contributing to debates and developments in mental health law, policy and practice.[103] The fall of the asylum era in the West brought with it a rise in the 'global disability movement'. This diverse group of people with disabilities and their allies have helped change social responses to disability (including mental health) at the local, national and international level. The CRPD reflects this shift in international human rights law, as the next chapter outlines.[104] This broad social movement included persons with psychosocial disability who made a significant contribution to the development of the CRPD.[105] Sheila Wildeman describes the 'radical challenges to global mental health policy that have gained new legitimacy and momentum through the participation of [disabled people's organisations] in the CRPD process'.[106] This influence is also evident at the domestic level, where the increasing influence of persons with psychosocial disabilities, as well as family members of this group, is evident on a small and large scale across law, policy and programming.[107]

[101] See, generally, B McSherry (ed), *International Trends in Mental Health Laws* (Federation Press, 2008).

[102] Bartlett, above n 97, 541. I will discuss this shift in detail in Part II of the book.

[103] See P Weller, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Routledge, 2013) 53–60.

[104] See, generally, S Bagenstos, *Law and the Contradictions of the Disability Rights Movement* (Yale University Press, 2009); D Fleischer and F Zames, *The Disability Rights Movement: From Charity to Confrontation* (Temple University Press, 2nd ed, 2011).

[105] Weller, above n 103, 55.

[106] S Wildeman, 'Protecting Rights and Building Capacities: Challenges to Global Mental Health Policy in Light of the Convention on the Rights of Persons with Disabilities' (2013) 41(1) *The Journal of Law, Medicine and Ethics* 48, 49.

[107] See, generally, J Wallcraft et al., 'Partnerships for Better Mental Health Worldwide: WPA Recommendations on Best Practices in Working with Service Users and Family Carers' (2011) 10(3) *World Psychiatry* 229.

E CONCLUSION

This chapter has looked to the past to clarify the purposes and objectives of mental health law, providing grounds to interrogate the major issues that the CRPD might address today. Since the latter decades of the twentieth century, mental health law has struggled to balance the dual prerogatives of self-determination and protection. Mental health law outwardly seeks to uphold the Western legal doctrine of autonomy and other rights of the individual, while also imposing protective measures that mediate collective concern and fear about the danger and vulnerability (whether real or imagined) that are associated with mental illness. Historic and contemporary debates centre on a critical issue at the heart of mental health law: should 'unsoundness of mind' operate as a criterion for special exception to normative rights? Is this special exception an acceptable cost for the opportunities it affords in protecting other rights (such as the right to life, to dignity and so on)? Mental health law has retained the long-held assumption that profound distress, mental illness, extreme states of consciousness and so on, compromise human agency and volition in such a way that the law cannot operate under the same rules as it does for non-affected persons in conferring legal responsibility and competency.

The CRPD challenges this proposition on a fundamental level. It challenges the long-established sense that mental health issues constitute a special exception that allows for the suspension of principles of equality and non-discrimination. Bernadette McSherry has distilled this challenge into two major questions:

(a) whether mental health laws that enable involuntary detention and treatment should be abolished on the basis that they unjustifiably breach human rights; as well as
(b) whether such laws can be reformed in the light of human rights principles to ensure respect for individual choices in relation to treatment.[108]

Having set out the main function, purpose and procedures of mental health law, it is now useful to turn to the CRPD, to examine in detail the challenges it raises for rules on involuntary psychiatric intervention.

[108] B McSherry, 'Mental Health Law: Where To from Here?' (2014) 40(1) *Monash University Law Review* 175.