

Rethinking Mental Health Laws

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Rethinking Mental Health Laws: International Trends

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Introduction: The Rethinking Mental Health Laws Project

In December 2007, the Australian Research Council commenced funding a five-year Federation Fellowship project entitled: *Rethinking Mental Health Laws: An Integrated Approach* which is based at the Faculty of Law, Monash University. The project focuses on both civil and criminal laws dealing with individuals with mental illnesses in the common law countries of Australia, New Zealand, Canada, Ireland, Scotland, England and Wales. The aim is to develop frameworks for such laws which can be used by policy makers and government in their law reform endeavours.

The research team at present includes myself, Professor Ian Freckelton who is a Senior Counsel and part-time Professor of Law at Monash University, Dr Penny Weller, a postdoctoral research fellow, seven doctoral students: Annegret Kämpf, Ronli Sifris, Jamie Walvisch, Sarah McHutchison, Laura Breedon, Danielle Andrewartha and Liz Richardson, a Masters of Philosophy student, Lei Ning, two research fellows, Joanna Kyriakakis and Steven Yannoulidis, an executive officer, Kathleen Patterson and various sessional research assistants including Kay Wilson and Susan Klauber. It is the first time such a project has been established in Australia and further information can be obtained via the website:

www.law.monash.edu.au/rmhl.

This paper focuses on some of the issues arising from civil commitment laws which enable the involuntary detention and treatment of individuals with serious mental illnesses including schizophrenia and bipolar disorder.

The Importance of the Law

Clive Unsworth has made the point that '[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions'.¹ This has not always been the case.

Patricia Alderidge has suggested that there are cycles in the care of those with mental illness, with phases of treatment in hospitals and phases of detention in private psychiatric institutions.² At the same time, Alderidge points out that there are cycles giving precedence to medical discretion and cycles giving precedence to mental health laws which shift between protecting those with mental illnesses from society to protecting society from those considered dangerous. The current cycle can be viewed as being based 'upon an over-riding concept of legalism',³ with mental health laws shaping the way in which certain individuals with mental illnesses can be detained and treated.

During the 1980s, Larry Gostin urged reform based on what he termed a 'new legalism' which drew on the European Convention on Human Rights.⁴ 'Rights-based legalism' is thus a term that can be used to describe a cycle that gives precedence to mental health laws that refer to the rights of individuals with mental illnesses.

All common law countries have Mental Health Acts which enable detention and treatment against an individual's wishes. The relevant provisions in Mental Health Acts vary, but in general, they provide that if individuals appear to suffer from a

¹ C Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) p 5.

² P Alderidge, 'Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane' (1979) 134 *British Journal of Psychiatry* 321.

³ H Prins, 'Whither Mental Health Legislation? Locking Up the Disturbed and the Deviant' (2001) 41(3) *Medicine, Science and Law* 241 at 242.

⁴ LO Gostin, 'Perspectives on Mental Health Reforms' (1983) 10 *Journal of Law and Society* 47; LO Gostin, 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in P Bean (ed) *Mental Illness: Changes and Trends* (New York: John Wiley and Sons, 1983)

mental illness, if their health or safety is at risk, and if they pose a threat to themselves or others, they may be detained as involuntary patients.

It is important to note that there are no Cancer Acts or Diabetes Acts or Epilepsy Acts – why then do Mental Health Acts exist? While clinicians such as Stephen Rosenman have strongly critiqued mental health laws as discriminatory, there is a general concession that '[l]aws are needed to ensure treatment, care and (in some cases) preventive custody for mentally ill patients'.⁵ How such laws should balance the individual rights of liberty and autonomy against the interests of the state in preventing harm to the individual and to others has been the subject of much debate among mental health scholars over the past two decades.

The United Nations Convention on the Rights of Persons with Disabilities

On the 3rd May 2008, the *Convention on the Rights of Persons with Disabilities* (the Convention) came into force. Australia signed the Convention on 30 March 2007 and ratified it on 17 July 2008. Greece signed the Convention on 30 May 2007, but has yet to ratify it. Ratification means that States Parties consent to being bound by the Convention, but full implementation of its provisions generally needs the enactment of domestic legislation.

This Convention is of great significance in that it clarifies the obligations of States Parties to promote and ensure the rights of person with disabilities and sets out the steps that should be taken to ensure equality of treatment. It goes into much more detail than previous general human rights conventions concerning what action needs to be taken to prohibit discrimination.⁶ Neither 'disability' nor 'persons with disabilities' are defined in the Convention, but Article 1 states that the latter term includes 'those who have long-term physical, mental, intellectual or sensory

⁵ S Rosenman, 'Mental Health Law: An Idea Whose Time Has Passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 560 at 564.

⁶ See in general A Kämpf, 'The Disabilities Convention and its Consequences for Mental Health Laws in Australia' in B McSherry, (ed), *International Trends in Mental Health Laws* (Sydney: Federation Press, 2008).

impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.

Three particular Articles in the Convention, Articles 12, 17 and 25, have the potential to challenge existing mental health laws. These will be discussed in turn.

Recognition of Legal Capacity

Article 12 of the Convention deals with the legal capacity of persons with disabilities. It starts with the presumption that people with disabilities, including mental illnesses, are capable of making their own decisions and any other form of decision-making must be seen as a measure of last resort.⁷ Anna Lawson has argued that Article 12 shifts the focus from substituted decision-making to supported decision-making.⁸

This means that attention will need to be paid to what is meant by the capacity to consent to or refuse medical treatment. On this point, some authors have argued for the fusion of mental health and guardianship legislation in order to help combat the discrimination inherent in mental health acts,⁹ but such a fusion is dependent on a substitute decision-making model that does not fall within the tenor of the Convention, which instead endorses supported decision-making.

Article 12 of the Convention provides added impetus for the movement to include provisions for advance directives or statements into mental health laws.¹⁰ An advance directive emphasises the wishes and preferences of the individual concerning treatment options and thus enables his or her perspective to be taken into account. Provisions for advance directives have been introduced, albeit with mixed degrees of success, in some common law countries, but are not yet common in Australia.

⁷ R Kayess and B Fogarty, 'The Rights and Dignity of Persons with Disabilities: A United Nations Convention', (2007) 32(1) *Alternative Law Journal* 22 at 23.

⁸ A Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 563 at 597.

⁹ J Dawson and G Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *British Journal of Psychiatry* 504; S Rosenman, 'Mental Health Law: An Idea Whose Time Has Passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 560.

¹⁰ P Weller, 'Supported Decision-Making and the Achievement of Non-Discrimination: The Promise and Paradox of the Disabilities Convention' in B McSherry, (ed), *International Trends in Mental Health Laws* (Sydney: Federation Press, 2008).

How to include carers' perspectives in mental health laws is also an important issue. The *Mental Health (Care and Treatment) (Scotland) Act 2003* came into effect on 1 October 2005. This is one of the most progressive and comprehensive mental health acts to date and it includes a process for consumers to nominate a 'Named Person' such as a relative or friend with rights to be involved in any legal hearings. The Named Person has the same rights as the individual concerned to be notified of, appear, and be represented at hearings of the Mental Health Tribunal. The Named Person has the right to initiate appeals against the renewal of compulsory treatment measures and the right to appeal decisions of the Tribunal. Families of individuals with mental illnesses also have rights to trigger assessments when needed. The Scottish Act is detailed and complex, but the Scottish Executive has also issued a comprehensive Code of Practice in three volumes, together with specific training manuals for staff and information for patients and families, to assist in the implementation and interpretation of the Act. The Code of Practice sets out processes for ensuring that carers are given appropriate information in relation to measures taken under the Act.

The right of access to advocates, not necessarily lawyers, for those individuals with mental illnesses is also of growing concern internationally.¹¹ There is a provision in the Scottish Act setting out that individuals with mental illnesses have a right of access to independent advocacy and the onus is placed on each local authority and each Health Board to secure the availability of independent advocacy services and to ensure the individual concerned has access to them.¹²

These trends indicate that statutory provisions for supported, rather than substitute decision-making will be of growing importance.

¹¹ T Carney, F Beupert, J Perry and D Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-dreams?' in B McSherry, (ed), *International Trends in Mental Health Laws* (Sydney: Federation Press, 2008).

¹² *Mental Health (Care and Treatment) (Scotland) Act 2003*, s 259.

Respect for Physical and Mental Integrity

Article 17 of the Convention which is entitled 'Protecting the Integrity of the Person' states:

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Unlike other Articles in the Convention, there are no further paragraphs set out imposing duties on States Parties or further explanation of the scope of this right. This was partly because of the fraught negotiations that occurred in relation to this Article during the drafting process which resulted in the omission of previously drafted paragraphs dealing with protection from certain medical interventions.¹³ What Article 17 will mean in practice is open to debate.

Tina Minkowitz has argued that Article 17 means that all forced psychiatric interventions should be viewed as a violation of human rights.¹⁴ While there have been and continue to be numerous instances of inhuman and degrading treatment of individuals with mental illnesses that support this view, in practice, states will continue to have legislation and programs that enable involuntary treatment.

The more likely meaning of Article 17 is that certain treatments and practices will need to be limited. Sabine Michalowski, for example, has interpreted the right to respect for the integrity of the person in the *Charter of Fundamental Rights of the European Union* as protecting the competent patient from unwanted treatment and the incompetent patient from unbeneficial treatment.¹⁵

¹³ B McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' in B McSherry (ed) *International Trends in Mental Health Laws* (Sydney: Federation Press, 2008).

¹⁴ T Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free From Nonconsensual Psychiatric Conventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405.

¹⁵ S Michalowski, 'Health Care Law' in S Peers and A Ward (eds) *The European Union Charter of Fundamental Rights* (Oxford: Hart Publishing, 2004) at 297.

I have argued elsewhere that Article 17 may impose limitations on treatments such as electro-convulsive therapy and psychosurgery and practices such as seclusion and restraint.¹⁶

It is significant in this regard that the Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment¹⁷ has stated that '[t]he more intrusive and irreversible the treatment, the greater the obligation on States to ensure that health professionals provide care to persons with disabilities only on the basis of their free and informed consent.'¹⁸

Further, the Report states that electro-convulsive therapy 'be administered only with the free and informed consent of the person concerned'¹⁹ and that 'forced and non-consensual administration of psychiatric drugs, and in particular neuroleptics, for the treatment of a mental condition needs to be constantly scrutinized'.²⁰ The Report goes on to point out that 'the suffering inflicted (by psychiatric drugs) and the effects upon the individual's health may constitute a form of torture or ill-treatment'.²¹

Against this background, it is likely that Article 17 will be interpreted to mean more regulation of invasive treatments and practices.

Right to the Highest Attainable Standard of Mental Health

In 2007, a National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics in 2007 indicated that only 35 per cent of individuals with a mental disorder of twelve months in duration received any care.²² In 2008, The

¹⁶ B McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' in B McSherry (ed) *International Trends in Mental Health Laws* (Sydney: Federation Press, 2008) at 121.

¹⁷ United Nations General Assembly, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Note by the Secretary-General*, UN Doc A/63/175, 28 July 2008, <<http://www2.ohchr.org/english/issues/disability/torture.htm>> accessed 28 May 2009.

¹⁸ *Ibid*, p 14.

¹⁹ *Ibid*, p 15.

²⁰ *Ibid*, p 16.

²¹ *Ibid*.

²² Australian Bureau of Statistics, *4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007* (23 October 2008) 23, <[http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/\\$File/43260_2007.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf)> accessed 28 May 2009.

Victorian Government Department of Human Services stated that ‘services are too focused on the most severely mentally ill’ and that ‘current arrangements and service cultures mean that individuals with mental health problems receive inadequate services compared to those with physical health conditions’.²³

The role the law plays in providing access to good quality treatment for individuals with mental illnesses is an important one. One important international trend is a shift away from a focus on laws dealing with the involuntary treatment of those with serious mental illnesses and protecting the rights to liberty and autonomy to developing laws that encourage a right to mental health for *all* individuals with mental illnesses, supported by a right to access appropriate mental health services.²⁴

Article 25 of the Convention, which reiterates Article 12(1) of the *International Covenant on Economic Social and Political Rights*, requires States to recognise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.²⁵

However, Article 25 goes further than Article 12(1) by adding certain obligations:

States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

²³ Victorian Government Department of Human Services, *Because Mental Health Matters* Consultation Paper (Melbourne, Victorian Government Printing Service, May 2008) at 13, <<http://www.health.vic.gov.au/mentalhealth/reformstrategy/documents/mhmatters-rep08.pdf>> accessed 28 May 2009.

²⁴ S Bell, ‘What Does the ‘Right to Health’ Have to Offer Mental Health Patients?’ (2004) 28(2) *International Journal of Law and Psychiatry* 141.

²⁵ *International Covenant on Economic Social and Political Rights* 993 UNTS 3, 16 December 1966 (entered into force 3 January 1976, in accordance with Art 27).

- (c) Provide these health services as close as possible to people's own communities, including in rural areas;
- (d) Require 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 by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 25 can be viewed as helping to develop the interpretation of the right to the highest attainable standard of health set out in General Comment No 14 of the United Nations Committee on Economic, Social and Cultural Rights.²⁶ Paragraph 9 of the General Comment states that 'the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'. Article 25 of the Convention sets out the steps that should be taken to ensure that these facilities and services are provided.

Conclusion

While it remains the case that legal provisions alone do not lead to the development of new services,²⁷ any endeavour to provide proper treatment for individuals with mental illnesses will only work if there are appropriate laws in existence shaping the way in which individuals with mental illnesses can gain access to the highest

²⁶ United Nations Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health* (Art 12 of the International Covenant on Economic, Social and Cultural Rights, *General Comment No 14* (22nd Sess), UN Doc E/C12/2000/4, 11 August 2000.

²⁷ B McSherry, 'Human Rights and Mental Illness: The Legal Framework' (1994) 1 *Journal of Law and Medicine* 205.

attainable standard of mental health care. Law reform endeavours need to take into account the provisions of the Convention in introducing measures for supported decision-making and for limiting invasive treatments and practices.

Ultimately, proper care will be achieved for those with mental illnesses not only through rethinking mental health laws but also through raising awareness of discrimination and curbing indifference and neglect. As Sir William Deane has pointed out, 'the ultimate test of our worth as individuals and as a nation is how we treat the most disadvantaged and vulnerable of our fellow human beings'.²⁸

²⁸ Sir William Deane, 'Address on the Occasion of the Jesuit Refugee Service Dinner, Sydney, 19th June 2004 <http://jrs.org.au/component/option,com_docman/task,doc_view/gid,25/Itemid,47/> accessed 28 May 2009.