Human Rights protection frameworks for people being treated involuntarily for a mental illness: Literature review

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Abbreviations

AD	Advance Directive
AHD	Advance Health Directive
CTO	Community Treatment Order
f-PAD	Facilitated Psychiatric Advance Directive
IPRA	Independent Patient Rights Advisors
JCP	Joint Crisis Plan
MH	Mental Health
MHT	Mental Health Review Tribunal
PAD	Psychiatric Advance Directive
QLD	Queensland
RCT	Randomised Controlled Trials

Executive summary

A consortium comprising the University of New South Wales (UNSW Sydney), Griffith University, and the University of Sydney has been commissioned by the Queensland Mental Health Commission (the Commission) to undertake research into the processes provided in the new Queensland Mental Health Act 2016 (QLD MH Act 2016) to protect the human rights, as currently expressed in the QLD MH Act 2016, of adults who receive involuntary treatment for a mental illness in hospital and community settings. The consortium is co-led by the Social Policy Research Centre (SPRC) at UNSW Sydney and the Menzies Health Institute at Griffith University, also involving Sydney Law School and The Centre for Values, Ethics and the Law in Medicine at the University of Sydney.

Project objectives and scope

The project's objectives were to investigate:

1. the experiences of the protection of human rights, as currently expressed in the *Mental Health Act 2016*, of adults who receive involuntary treatment in hospital and community settings under the *Mental Health Act 2016*, including the views and experiences of their families and carers and a wide range of other stakeholders, including service providers, experts and advocates (Project Objective 1)
2. how the processes to protect the human rights of people who receive involuntary treatment in hospital and community settings as provided in the *Mental Health Act 2016* compare to other Australian state and territories (Project Objective 2)

The study will focus on the following five areas of investigation (referred to as case studies):

- the operation of the Mental Health Review Tribunal (MHRT)
- rights and information regarding involuntary treatment in the community
- Advance Health Directives (AHD)
- rights and information for inpatients within mental health wards
- the role of Independent Patient Rights Advisors (IPRAs)

The research project consists of a mixed-method study comprising two phases and running over 18 months: from June 2017 to December 2018.

This document reports the findings of a scoping literature review which explores national and international literature on the above five focus areas.

Method

The review adopted a scoping approach, which helps to explore topics that have not yet been extensively reviewed or are of a complex or heterogeneous nature, as in the case of this study.

Relevant keywords related to involuntary treatment and the five study focus areas (Table 1) were searched in the following electronic databases: PsycINFO, MEDLINE, SCOPUS, Google Scholar, Westlaw AU, APAFT: Australian public affairs. The keywords were combined using Boolean operators to identify relevant literature and research evidence on the views and experiences of mental health consumers.

The retrieved literature was analysed with the aim to describe the characteristics and functioning of each of the five focus areas within the *Mental Health Act 2016* and in other relevant Australian and international frameworks (Project Objectives 1 and 2), with a particular focus on their efficacy in meeting the needs and protecting the human rights of people with mental illness being treated involuntarily (Project Objectives 1,3, and 4).

Findings

Mental Health Review Tribunals. The Mental Health Review Tribunals (MHTs) is an independent decision-making body under the *Mental Health Act 2016* (Qld Health, 2018a). Section 28 of the *Mental Health Act 2016* (Mental Health Act 2016 (Qld)) states that the Mental Health Review Tribunal reviews: (a) treatment authorities; (b) forensic orders; (c) treatment support orders; (d) the fitness for trial of particular persons; (e) the detention of minors in high security units. The Mental Health Review Tribunal also hears applications for: (a) examination authorities; (b) the approval of regulated treatment; (c) the transfer of particular patients into and out of Queensland.

In addition, the Mental Health Review Tribunal has further powers in relation to appealing a limited number of decisions made by the chief psychiatrist or administrator (Sections 705(1)(c) and 533). (Qld Health, 2017d)

The reviewed literature showed that MHTs’ role of protecting the rights of people with mental illness of unjustified detention or treatment can be hampered by factors such as an over-reliance on medical opinion, the quality of the health reports provided by medical staff, and a primary focus on risk and dangerousness assessments.

The reviewed literature has also identified several limits in the implementation of MHT processes, including lack of training for clinicians on how to report to MHTs, clinicians' reliance on personal views rather than the specific circumstances of each consumer, lack of resources (MHTs in Ireland devote 16 to 18 times the Australian expenditure per case), the number of virtual hearings, the timing of tribunal reviews, and limited legal representation before tribunals.

Overall, there is agreement in the reviewed literature that there is a need for more support for consumers attending MHTs, including advocacy from lawyers, carers and peers.

The *Mental Health Act 2016* strengthened the rights of mental health consumer in relation to attending Mental Health Review Tribunal hearings by addressing many of the issues raised in the literature, including:

- The possibility for the Mental Health Review Tribunal to appoint a lawyer at no cost for the consumer, if the consumer is not represented by a lawyer or another person and if the tribunal considers it to be in the person's best interest. The Mental Health Review Tribunal must appoint a lawyer if the person is a minor, the Attorney-General is to appear or be represented at the hearing, and if the hearing is for a review of the person's fitness for trial, for an application for approval to perform electroconvulsive therapy on the person, or another hearing prescribed by regulation. The possibility for consumers who become involuntary patients to nominate up to two support persons, who can: receive notices for the appointing person under the Act; receive confidential information, under the Hospital and Health Boards Act 2011, relating to the appointing person; request a psychiatrist report under Section 90 of the Act; act as the appointing person's support person in the tribunal; or represent the appointing person in the tribunal (to the extent permitted under Chapter 12 or 16).

- Introducing the role of Independence Patient Rights Advisers (Section 6), who can advise the patient, and the patient's support persons of the patient's rights at the hearings, and, if requested, help the patient engage a representative for the hearings.

- Strengthening the use of Advance Health Directives (Section 4), which also support people with mental illness to make their own decisions.

- Regulating the possibility for patients to ask for a second option (Section 290) and allowing the Mental Health Review Tribunal to order relevant a relevant person to submit to an examination by a stated examining practitioner when a patient is already before the tribunal for a matter over which the tribunal has jurisdiction (Section 721). In Queensland, patients, their families and carers, can also use the Ryan's Rule to raise concerns if a patient's health condition is getting worse or not improving as well as expected (Section 2.4), or start a complaint process with the hospital/mental health service or the Office of the Health Ombudsman.

The reviewed literature, which discussed the role of Mental Health Tribunals across different contexts, not specifically the functioning of the Mental Health Review Tribunal under the Mental Health Act 2016, showed that the role of Mental Health Tribunals (MHTs).

Community treatment orders. Section 18 of the *Mental Health Act 2016* defines a treatment authority as ‘a lawful authority to provide treatment and care to a person who has a mental illness who does not have capacity to consent to be treated’. It further states that: ‘a treatment authority may be made for a person if an authorised doctor considers the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person’s mental illness, including, for example, under an advance health directive’. The category of a treatment authority is community, ‘if the person’s treatment and care needs can be met in the community’ (Mental Health Act 2016 (Qld)), or inpatient ‘if the person’s treatment and care needs can be met only by being an inpatient’.

Here, the expression Community Treatment Order (CTO) is used to report literature findings across different contexts. The expression Treatment Authorities – Community Category will be used to refer to findings specific to the Queensland experience under the *Mental Health Act 2016*.

Section 51 of the *Mental Health Act 2016* establishes that the category of a treatment authority can be inpatient only if the authorised doctor considers, after having regard to the relevant circumstances of the person, that one or more of the following cannot reasonably be met if the category of the authority is community: (a) the person’s treatment and care needs; (b) the safety and welfare of the person; (c) the safety of others.

Section 140 regulates community category for Forensic Orders and Section 145 regulates community category for Treatment Support Orders. A forensic order (mental health) operates in a way that is more restrictive of a person’s rights and liberties than a treatment support order (Section 130).The main difference between Forensic Orders and Treatment Support Orders is that similarly to treatment authorities, the category for Treatment Support Orders must be a community category unless it is necessary for the person to be an inpatient, having regard to the person’s treatment and care needs, the safety and welfare of the person and the safety of others. . On the other hand, Sections 138 establishes that the Mental Health Court can decide that the category of a forensic order is community only if the court considers there is not an unacceptable risk to the safety of the community, because of the person’s mental condition, including the risk of serious harm to other persons or property.

The evidence in qualitative studies about CTOs remains mixed. CTOs appear to be consumers’ preferred choice and increase some freedoms, in particular if the alternative is involuntary inpatient treatment. However, there is strong qualitative evidence that many consumers and carers in Australia and overseas complain about not having access, received, or been provided with the necessary support to fully access, comprehend, and act on information about involuntary treatment, CTOs and their legal implications, and mental health consumer rights more broadly (i.e. review process). Recent research on CTOs has highlighted that legislation needs to improve the mechanisms by which people (consumers and carers) receive mental health information and support to understand the information and manage their pathways through the mental health system.

Overall, CTOs as a treatment or procedural tool in community mental health remain controversial regarding their efficacy and outcomes and pose some risks to the rights of people with mental illnesses.

Advance directives. Advance directives (ADs) are a tool that mental health consumers can choose to use to provide information on treatment preferences and other instructions for those times when their capacity to make decisions about their care and treatment are hampered by acute mental illness or distress.

In the *Mental Health Act 2016*, ADs are referred to as Advance Health Directives. Part 8, Division 1 of the *Mental Health Act 2016* states that 'the advance health directive may include the principal's[1] views, wishes and preferences about the principal's future treatment and care for a mental illness'. In deciding the nature and extent of treatment and care to be provided to a person under a treatment authority, the authorised doctor needs to: 'a) discuss the treatment and care to be provided with the person; and b) have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an advance health directive' (*Mental Health Act 2016*, Section 53).Here, the expression mental health ADs is used to refer to the literature findings across different contexts, whereas the expression Advance Health Directive will be used to refer to findings specific to the Queensland context.

Research evidence from randomised controlled trials (RCT) are contradictory about the benefits and outcomes of ADs. Some studies found that ADs were not significantly more effective in reducing hospitalisation and levels of coercion, whereas other RCTs found some evidence that AHDs might reduce compulsory treatment, improve the therapeutic relationship between consumers and clinicians, and help consumers to feel more satisfied and involved in their mental health care.

The protocols that allow consumers with more severe mental illness to document their treatment wishes, for a time where they may lose capacity to make these decisions for themselves, differ by country and legislative context, both in their design, and their implementation. Nevertheless, research shows a low uptake of ADs in different contexts, which highlights the need for further investigation on

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[1] The Powers of Attorney Act 1998 (current as at 5 March 2017) states that in the context of advance health directive and power of attorney, principal means the person who made the advance health directive or appointed the attorney.

barriers to take up and use of ADs. Research shows that key barriers to the implementation of ADs include low engagement with the process from people with lived experience and mental health professionals alike, lack of ready access to the documents in crisis, a lack of clinician familiarity, and legal uncertainty about their application. At the service and policy level, researchers have argued that the introduction of supported-decision making regimes can help the successful implementation of mental health ADs as well as greater recognition of the intentions of the CRPD in compulsory treatment in Australia.

Rights and information for inpatients within mental health wards. The rights and information of inpatients, family and carers within mental health wards are regulated by both national documents and laws – the Australian Charter of Healthcare Rights (ACSQHC, 2008), the National Safety and Quality Health Service Standards (ACSQHC, 2017), and the National Standards for Mental Health Services (Australian Government, 2010) – and state documents and laws, including the *Mental Health Act 2016*, the Guardianship and Administration Act 2000, the Carers (Recognition) Act 2008, and the Audit tools for National Safety and Quality Health Service Standards (Queensland Government, 2017).

These laws and frameworks recognise the right of all persons to the same basic human rights, including the right to have the highest possible standard of physical and mental health. The rights to safety, respect, receiving information in a clear and open way, participating in decisions and choices about care, privacy and confidentiality, and commenting on care and having concerns addressed are listed by the Australian Charter of Healthcare Rights (ACSQHC, 2008), and included in the National Safety and Quality Health Service Standards, the National Standards for Mental Health Services, as well as the Mental Health Act 2016.

Chapter 9 of the *Mental Health Act 2016* provides for a statement of rights and the rights of patients and relevant others, including the right of a patient to:

1) be visited by the patient’s nominated support persons, family, carers and other support persons (Section 280);
2) be visited by a health practitioner (Section 282), legal or other advisers (Section 283);
3) communicate with other persons (Section 284);
4) be given information about treatment and care (Section 285);
5) ensure that the patient understands the information (Section 286);
6) a second opinion to be obtained about a patient’s treatment and care (Section 290).

Section 5 of the *Mental Health Act 2016* recognises and acknowledges Aboriginal people and Torres Strait Islander people. It states that ‘the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders must be recognised and taken into account. Similarly, Section 5 recognises and acknowledges persons from culturally and linguistically diverse backgrounds. It states that ‘services provided to persons from culturally and linguistically diverse backgrounds must have regard to the person’s cultural, religious and spiritual beliefs and practices’, including using interpreters ‘to the extent practicable and appropriate in the circumstances’.

Section 278 of the Act establishes that after admission of a patient to an authorised mental health service, the administrator of the authorised mental health service must: 1) explain the statement of rights prepared by the Chief Psychiatrist under the Act to the patient, ensuring that the patient understands the information given; 2) if requested, give a copy of the statement of rights to the patient and to the patient’s nominated support persons, family, carers or other support persons. The administrator of an authorised mental health service must also display signs in prominent positions in the service stating that a copy of the statement of rights is available on request (Section 279).

Independent Patient Rights Advisors (IPRAs). The *Mental Health Act 2016* for the first time establishes the positions of Independent Patient Rights Advisors (IPRAs). IPRAs have an important role in informing consumers of their rights under the MH Act 2016 and in liaising between clinical teams, patients and support persons. IPRAs must act independently and impartially, and they are not subject to the direction of any person in relation to the advice given to a patient or a patient’s nominated support persons, family, carers or other support persons (Section 295).

Section 294 of the *Mental Health Act 2016* establishes the functions of IPRAs, including to:

a) ensure that a patient, and the patient’s nominated support persons, family, carers and other support persons are advised of their rights and responsibilities under the *Mental Health Act 2016*;
b) help the patient, and the patient’s nominated support persons, family, carers and other support persons to communicate to health practitioners the patient’s views, wishes and preferences about the patient’s treatment and care;
c) work cooperatively with community visitors performing functions under the Public Guardian Act 2014;
d) consult with authorised mental health practitioners, authorised doctors, administrators of authorised mental health services, and the chief psychiatrist on the rights of patients under this Act, the Guardianship and Administration Act 2000, the Powers of Attorney Act 1998 and other laws;
e) in relation to tribunal hearings - (i) advise the patient, and the patient’s nominated support persons, family, carers and other support persons of the patient’s rights at the hearings; and (ii) if requested, help the patient engage a representative for the hearings;
f) identify whether the patient has a personal guardian or attorney and, if the patient has a personal guardian or attorney, work cooperatively with the personal guardian or attorney to further the patient’s interests;

g) if appropriate, advise the patient of the benefits of an advance health directive or enduring power of attorney for a personal matter.

The *Mental Health Act 2016* does not make use of the word advocacy in relation to IPRAs. However, Section 294(b) states that the functions of IPRAs include to ‘help the patient and a patient’s nominated support persons, family, carers and other support persons to communicate to health practitioners the patient’s views, wishes and preferences about the patient’s treatment and care’, which seems to entail elements of an advocacy role. The advocacy role is more prominent in other patients advisory roles in Australia and internationally, such as for example the Independent Mental Health Advocates (IMHAs) in Victoria and in England.

Conclusions

To achieve the basic human right of autonomy, individuals must be able to able to practice decision-making (Werner, 2012). Article 12 of the United Nations (UN) Convention of the Rights of Persons with Disabilities (CRPD) stresses the right of individuals with disabilities to legal capacity on an equal basis with others (Werner, 2012) and requires states parties to replace involuntary treatment provisions in mental health laws with a new model of ‘supported decision-making’ (Callaghan & Ryan, 2016). Supported decision-making entails a systemic response which implies wide networks of support, including from institutions, peers and advocate groups, who can give people a real opportunity to engage in an enabling dialogue around the issue they want to take a decision about.

The Australian Government ratified the Convention in 2008, inclusive of an interpretive declaration that retains 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.

The *Mental Health Act 2016* has introduced some important changes, for example treating persons in a ‘less restrictive way’, the role of Independent Patient Rights Advisors (IPRAs), and promoting the use of advance health directives. These changes make the *Mental Health Act 2016* more closely realise the requirements of the CRPD comparatively to the previous legislation.

However, there is a need to investigate the consumers’ experiences of protection of human rights under the *Mental Health Act 2016*. The findings of the literature review will be used to provide a background for the discussion of the findings of the interviews on the experiences of consumers, carers and stakeholders of the implementation of the *Mental Health Act 2016* across the five study focus areas.

1. Introduction

The Queensland Mental Health Commission (the Commission) commissioned a consortium comprising the University of New South Wales (UNSW Sydney), Griffith University, and the University of Sydney, to undertake research into the processes provided in the new Queensland Mental Health Act 2016 (QLD MH Act 2016) to protect the human rights, as currently expressed in the QLD MH Act 2016, of adults who receive involuntary treatment for a mental illness in hospital and community settings. The consortium is co-led by the Social Policy Research Centre (SPRC) at UNSW Sydney and the Menzies Health Institute at Griffith University, also involving Sydney Law School and The Centre for Values, Ethics and the Law in Medicine at the University of Sydney.

The project's objectives were to investigate:

1. the experiences of the protection of human rights, as currently expressed in the *Mental Health Act 2016*, of adults who receive involuntary treatment in hospital and community settings under the *Mental Health Act 2016*, including the views and experiences of their families and carers and a wide range of other stakeholders, including service providers, experts and advocates (Project Objective 1)
2. how the processes to protect the human rights of people who receive involuntary treatment in hospital and community settings as provided in the *Mental Health Act 2016* compare to other Australian state and territories (Project Objective 2)

The study focuses on the following five areas of investigation (referred to as case studies):

- the operation of the Mental Health Review Tribunal
- rights and information regarding involuntary treatment in the community
- advance health directives
- rights and information for inpatients within mental health wards, e.g. community visitors
- the role of Independent Patient Rights Advisors.

The study includes a scoping literature review, which explores national and international literature on the above five focus areas as well as fieldwork research on the experiences of human rights and their protection, across the five listed focus areas, of people who receive involuntary treatment in different national contexts, their family and carers, and relevant stakeholders.

The project does not aim to evaluate the five focus areas but investigates them to identify common factors that can help or hinder the implementation of the human rights of people treated involuntarily for a mental illness under the *Mental Health Act 2016*. The study findings will generate a conceptual framework against which the implementation of the current human rights protection processes in the *Mental Health Act 2016* can be assessed in future.

This document reports the findings of the literature review.

1.1 Background

To achieve the basic human right of autonomy, individuals must be able to able to practice decision-making (Werner, 2012). Article 12 of the United Nations (UN) Convention of the Rights of Persons with Disabilities (CRPD) stresses the right of individuals with disabilities to legal capacity on an equal basis with others (Werner, 2012) and requires states parties to replace involuntary treatment provisions in mental health laws with a new model of ‘supported decision-making’ (Callaghan & Ryan, 2016). Supported decision-making entails a systemic response which goes far beyond the information on treatment options and effects provided by doctors. It implies wider networks of support, including from institutions, peers and advocate groups, who can give people a real opportunity to engage in an enabling dialogue around the issue they want to take a decision about (Gendera & Giuntoli, 2016).

The Australian Government ratified the Convention in 2008, inclusive of an interpretive declaration that retains 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.

The Royal Australian New Zealand College of Psychiatrists submitted that there is great divergence between the various state and territory mental health acts as to the criteria that must be applied for involuntary treatment to be enacted, and also in the processes that subsequently review compulsory treatment orders (Parliament of Australia, 2016). Callaghan and Ryan (2016) showed that Queensland and the Australian Capital Territory have introduced innovative Mental Health Acts that most closely realise the requirements of the CRPD comparatively to the other states and territories in Australia. However, there is a need to investigate how the *Mental Health Act 2016* informs practice in hospital and community settings and what specific procedures are in place to protect the human rights of people with mental illness who receive involuntary treatment.

The rest of this section reports on the methods of the literature review, including the questions that were asked of the retrieved literature to address the Project Objectives.

Sections 2, 3, 4, 5, and 6 reports the findings of review on national and international literature on the processes to protect human rights in the five study focus area, with a specific focus on their efficacy under the *Mental Health Act 2016*.

1.2 Methods

The review adopted a scoping approach (Arksey & O'Malley, 2005), which is particularly helpful when a topic has not yet been extensively reviewed or is of a complex or heterogeneous nature, as in the case of this study (Pham et al., 2014).

Search strategies

The keywords reported in Table 1 were searched in the following electronic databases, which are relevant for wellbeing studies across a wide spectrum of social science and health disciplines:

- PsycINFO (Covers the professional and academic literature in psychology and related disciplines, including medicine, psychiatry, nursing, and sociology)
- MEDLINE (Premier source for bibliographic and abstract coverage of biomedical literature)
- SCOPUS (the largest abstract and citation database of peer-reviewed literature in the fields of science, technology, medicine, social sciences, and arts and humanities).
- Google Scholar (covers most disciplines and subjects)
- Westlaw AU (First Point for law reports, case citations. Commentary includes Laws of Australia and Expert Evidence. Covers Australian law journals).
- APAFT: Australian public affairs (Australian journal articles from published material on the social sciences. Also includes some international articles about Australia.)

Keywords were searched as Subject Headings (such as MeSH, Medical Subject Headings, in MEDLINE), where available, or, if not, in Titles and Abstracts. The keywords pertaining to each of the five case studies (e.g. mental health review tribunal, advance directive, independent patient right advisor, etc.) were then combined with the other keywords to identify relevant literature and research evidence on the views and experiences of mental health consumers.

Table 1. Search keywords

Involuntary treatment **OR** Compulsory treatment **OR** Outpatient treatment
Community
Care planning
Advance Directives **OR** Advance Statements
Mental Health Review Tribunal
Independent patient rights advisor

Information
Inpatients **OR** Ward
User **OR** Consumer
Experiences **OR** Views
Compliance **OR** Concordance
Australia

Relevant national and international websites, such as the Commission's website, Australian Government departments, Mental Health Tribunals, the Australian Human Rights Commission, and the UN website were also searched to identify any relevant informally published material (grey literature).

1.3 Data management and inclusion/exclusion criteria

Titles and abstracts of studies identified by the searches were downloaded into the bibliographic management software EndNote and duplicates removed. The Titles and Abstracts of the retrieved literature were screened based on their relevance with regard to the research aims.

1.4 Analysis

A copy of the literature included was retrieved and analysed with the aim to describe the main characteristics and functioning of each of the five focus areas within the QLD MH Act 2016 and in other relevant Australian and international frameworks (Project Objectives 1 and 2), with a particular focus on their efficacy in meeting the needs and protecting the human rights of people with mental illness being treated involuntarily (Project Objectives 1,3, and 4).

Adopting the framework proposed by Mathews (2017), the characteristics and efficacy of each of the five case studies was explored both in a 'narrow sense', that is focusing on their implementation, their accessibility to people with lived experience of mental illness being treated involuntarily, and the clarity and accuracy of the information provided to them (Project Objective 3), and in a 'broad sense', that is exploring the literature on the views and experiences of people who received involuntary treatment for a mental illness, their family and carers (Project Objective 4).

1.5 Limitations

The scoping nature of the literature review allowed the research team to generate a comprehensive overview of the key characteristics of each of the five case studies under the QLD MH Act 2016 and in other relevant Australian and international frameworks. However, the literature review did not aim to systematically retrieve and analyse all existing literature on each of the five case studies, so it does not offer a comparison of the QLD MH Act 2016 against the Mental Health Acts of all Australian states and territories or a fixed set of international countries.

2. Mental Health Review Tribunal

This section discusses the role of Mental Health Tribunals (MHTs) across different contexts, including the functioning of the Queensland Mental Health Review Tribunal under the *Mental Health Act 2016*. Because of the recent introduction of the *Mental Health Act 2016*, no research literature was found on its implementation.

For ease of reference, the expression Mental Health Tribunals (MHTs) is used to refer to the findings of the literature across different contexts. The expression Mental Health Review Tribunal is used to specifically refer to the tribunal in Queensland as regulated under the *Mental Health Act 2016*.

2.1 Background

Mental health tribunals (MHT) function as independent bodies that review treatment orders for people with mental illnesses. Carney (2012) notes that, as an institution, MHTs take on an important role in protecting fundamental civil and human rights of people experiencing mental ill-health who are subject to state coercion. Due to the composition of MHTs, which include multi-disciplinary membership (incorporating psychiatric and other mental health expertise in addition to lawyers), they can be ‘more sensitive to health considerations than their judicial antecedents’ (Carney, 2012).

Today tribunals are present in each Australian state or territory however they are known under different names: Mental Health Review Tribunals (QLD, NSW, NT), Mental Health Tribunals (VIC, WA, TAS), and in some state and territories (ACT, SA) Civil and Administrative Tribunals have responsibilities to review compulsory treatment orders. These differences are due to the fact that mental health laws are a State or Territory responsibility (Carney, Tait, Chappell, & Beaupert, 2008, p.6f, p.6f, p.6f, p.6f).

2.2 Queensland Mental Health Review Tribunal

The Mental Health Review Tribunals (MHTs) is an independent decision-making body under the *Mental Health Act 2016* (Qld Health, 2018a). Section 28 of the *Mental Health Act 2016* states that the Mental Health Review Tribunal reviews: (a) treatment authorities; (b) forensic orders; (c) treatment support orders; (d) the fitness for trial of particular persons; (e) the detention of minors in high security units . The Mental Health Review Tribunal also hears applications for: (a) examination authorities; (b) the approval of regulated treatment; (c) the transfer of particular patients into and out of Queensland.

In addition, the Mental Health Review Tribunal has further powers in relation to appealing a limited number of decisions made by the chief psychiatrist or administrator (Sections 705(1)(c) and 533).

Section 3 of the *Mental Health Act 2016* sets out three core objectives: (a) to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated; (b) to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of committing an unlawful act or to be unfit for trial; and (c) to protect the community if persons diverted from the criminal justice system may be at risk of harming others. The three guiding principles to achieving these objectives include first to safeguard the rights of persons; second, to provide care that is the least restrictive of the rights and liberties of a person who has mental illness; and third to promote the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care. (*Mental Health Act 2016*). These are critical guiding principles which determine the work of the Tribunal.

2.2.1 Functions of MHTs

The smallest common denominator of MHTs is to provide safeguards 'for patients to ensure their right to be free from unjustified detention or treatment' (Thom & Nakarada-Kordic, 2014). Summarising Australian MHTs, Carney and Tait (2011) point out that functions of MHT can vary considerably between states, although 'all strike some balance between clinical concerns to promote individual wellness, individual or public safety, and legal rectitude in the exercise of state power, but the balance point varies' (p.137).

The main guiding principle of MHTs in Australia is 'least restrictive' (in comparison in Ireland the guiding principle is 'best interest'). Literature preceding recent Mental Health Act reforms in different states (e.g. Queensland, ACT, and Victoria), reported that almost all Australian legislation required treatment orders to 'meet a least restrictive alternative test as a guiding principle', which 'states that effective care and treatment be provided in the manner least restrictive of freedom' (Carney, 2011, p.10, p.10, p.10, p.10). In some states law regulators reinforce that 'keeping restrictions of liberty to the minimum is necessary for those on orders' (ibid. p. 8).

Carney (2011) identifies that in Australia MHTs are empowered to review only what may be termed the 'legal rectitude' of orders, that is the 'technical satisfaction of the legal criteria for making an order, without consideration of substantive issues (such as the weight of evidence or merits of treatment needs)' (Carney, 2011, Note 1, p. 2, Note 1, p. 2, Note 1, p. 2, Note 1, p. 2). However, as mentioned above, the Australian legislation does require that treatment orders meet a 'least restrictive alternative' test. In some states, MHTs also review and approve ECT (Electroconvulsive Therapy), or handle property management applications. In

Queensland, the Mental Health Review Tribunal hears applications to perform ECT for adults who are unable to give informed consent and for minors (Section 236 of the *Mental Health Act 2016*).

MHTs provide a 'legal audit or checklist verification process, of technical satisfaction of grounds of orders' (Carney & Tait, 2011, p.138, p.138, p.138, p.138). Carney and Tait (2011) have argued that MHTs in Australia, similar to their international counterparts (Thom & Nakarada-Kordic, 2014), are 'governed by health narratives, by clinical considerations, and preferences for clinical evidence, and by the medical default rule of maintaining interventions when in doubt' (ibid p. 138).

2.3 Effectiveness

In a systematic review of the empirical literature on MHTs, Thom and Nakarada-Kordic (2014)[2] found that their efficacy has been subject to 'much criticism' internationally, and their primary role of protecting the rights of people with mental illness of unjustified detention or treatment could be hampered by a number of factors. Thom and Nakarada-Kordic (2014) found common themes across countries highlighting the limitations to the 'independence' of tribunals and challenges faced by its members in their decision-making process. The key themes emerging from across a wide range of literature included:

- Blurring of the legal and non-legal factors which can occur and impact on the decision-making process and outcomes. The authors describe this as a 'tendency for opinion, intuition and rules of thumb' (p. 116).
- An over-reliance on medical opinion; psychiatrists were found to be 'leading' in several studies (p. 117).
- Tribunal decisions were generally dominated by the health context, for example, the quality of medical reports influenced outcomes for consumers (i.e. 'discharge may be partly the result of incomplete evidence being presented to the panel' p. 118).
- 'Risk' and 'dangerousness assessments' of a patient could dominate the outcomes of the review cases in a number of UK studies.

Carney and colleagues (Carney, 2011, 2012; Carney & Tait, 2011; Carney, Tait, et al., 2008) in their multi-year comparative study (looking at the tribunal processes and outcomes in the ACT, VIC, and NSW) have identified similar issues affecting the efficacy of Australian tribunals in safeguarding patients' rights. Their research

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[2] The majority of this evidence review looked at empirical research papers on MHT from the UK (70%, n=35) and the remaining 30 per cent examined evidence from Australia (n=7), New Zealand (n=4), Canada (n=2), and Ireland (n=1). The evidence from Australia is antecedent to the introduction of the *Mental Health Act 2016*.

has highlighted a number of specific issues particular to the Australian experience, for example, the high number of cases reviewed by tribunals, comparatively low government investment and resourcing for tribunals, and additional safeguarding processes (such as another independent body, a complaint commission, rights advisors, and legal representation or advocacy support for consumers) absent or only minimally developed in several Australian state and territories. However, since Carney's and colleague's studies, both the ACT and Victoria have reformed their Mental Health Acts – ACT Mental Health Act 2015, and Victoria's Mental Health Act 2014 – and in 2015 NSW introduced amendments to the Mental Health Act 2007 (NSW). No research evidence was found on the functioning of the MHTs in the ACT, Victoria, and NSW after their reforms to the Mental Health Acts.

2.4 Implementation

In their comprehensive evidence review of MHTs, Thom and Nakarada-Kordic (2014) identified common issues across countries and studies with the implementation of MHT processes, including clinicians not always being adequately trained or prepared to report (in person or writing) to the tribunal panel, and the evidence provided being of mixed quality (Thom & Nakarada-Kordic, 2014). Several studies in the review highlighted that reports from medical witnesses were often incomplete; that the responsible clinicians' advice was based on their personal views of the case and professional expertise rather than the facts of patients' circumstances. One research study found that training to clinicians and nurses significantly improved the confidence and skills of staff in charge of presenting or preparing information.

Another key challenge for the functioning of MHTs is connected with their resourcing. Short hearings and high turnover of MHT review cases are significant characteristic of the Australian system (Carney, 2011). Carney (2011) and Carney and Tait (2011) found (based on data of three Australian MHTs – ACT, VIC, NSW – preceding recent mental health reforms in ACT and Victoria), that Australian tribunals are under-resourced compared to international counterparts, in particular considering the high-turnover of case they review (MHT in Ireland, for example, devote between 16 to 18 times the Australian expenditure per case) (Carney, 2011).

Another issue impacting on the quality of hearings has found to be the high number of 'virtual hearings' (video, teleconferencing) in Australian jurisdictions (Carney & Tait, 2011). For NSW, the study found, that 'over half' lacked the 'quality of being face-to-face'. Carney and colleagues have argued that there is a clear link between mental health consumers feeling respected and heard by MHTs and the settings in which they are performed (Carney, 2012). In their multi-year study, many consumers reported feeling unprepared for the hearing, feeling anxious during the process, and complained about the quality of the hearing itself (duration, location, virtual/face-to-face), and the manner and styles of communication of panel members and consumers particularly during the hearing (Carney, 2011, 2012; Carney & Tait, 2011; Carney, Tait, et al., 2008).

Weller, a prominent Australian law and justice commentator, examined the history, intentions and operations of MHTs with a focus on the expansion of non-adversarial justice approaches shaping the legal mental health discourse, and other law and ethics debates for the past two decades. In her paper, *Taking a reflexive turn: Non-adversarial justice and mental health review tribunals*, Weller (2011) argues that non-adversarial justice takes stronger account of 'the social context in which legal problems arise and in which they are adjudicated. Understanding the full context of a dispute or problem enables the creation of innovative solutions to difficult human interactions (Weller, 2011, p.82, p.82, p.82, p.82). This shift in perspective has culminated in the recent expression of international human rights law, *The Convention of the Rights of Persons with Disabilities* (CRPC). Weller notes, 'recognition of the subjective experience of the person at the centre of the judicial process connects non-adversarial justice with contemporary human rights perspectives', such as the CRPD (Weller, 2011, p.83, p.83, p.83, p.83), which 'has raised fundamental questions about equality and non-discrimination, the meaning of equal recognition before the law, the legitimacy of involuntary psychiatric treatment and the right to health and mental health services, including housing, social support and services that are necessary for habitation, rehabilitation, education and participation in society' (Weller, 2011, p.83, p.83, p.83, p.83).

Following this understanding – and considering an intersection of human rights and non-adversarial justice perspectives – Weller (2011) identifies four 'soft spots' in the legal MHT process that 'offer an opportunity for creative intervention' (ibid), which are:

- Timing of tribunal review
- Participation of the person in tribunal hearings
- Legal representation before tribunals, and
- Scope of tribunals powers.

Timing of tribunal review

Australian jurisdictions in their legislations have implemented different regulations for timing of reviews , ranging from 'as soon as possible', usually a week in NSW, to eight weeks in WA and VIC (Carney, Tait, et al., 2008). The *Mental Health Act 2016* establishes that reviews must be conducted within 28 days (Section 413(1)(a)) or at any time by application by the person subject to the authority, an interested person, or the chief psychiatrist (Section 413(2)).

The CRPD Human Rights Committee states that psychiatric detention ‘must not exceed a few days’ and a review should take place ‘as soon as possible’ (Weller, 2011, p.90). Weller points out that the opinions about the ‘right timing’ for reviews vary considerably, however, delaying the process may have ‘anti-therapeutic consequences’ as it could undermine the persons’ sense of justice of a fair process. Weller takes a midway stance and argues for a swift two-staged MHT review process, where the first stage fulfils a different purpose (such as, informing all parties about their rights and obligations, taking care of the person’s dependants), to the second review stage (currently taking place within a few weeks up to a couple of months). Her argument is based on protecting the human rights of the person and other people in their life:

> If the prompt review of detention is framed as a non-adversarial process, it has the potential to reduce stress, to ensure that the person and their supporters and carers know the detention has taken place, understand the reason for the detention and know about the processes that will follow. It provides an opportunity to ensure that all parties know about their rights and obligations, to ensure the proper arrangements are in place for the care of the person’s dependents and that other personal arrangements and responsibilities are attended to. Understood as a non-adversarial process, the principle of prompt or early review of the detention is justified on human rights and therapeutic grounds. This suggests that tribunal review should be structured in two stages with each review addressing the different therapeutic opportunities and utilising different processes in accordance with their different purposes (Weller, 2011, 92-93).

Other prominent law and justice commentators, Terry Carney and David Tait, have argued for similar changes to the review process – greater ‘flexibility of tribunal process’ to better ‘attune to the diversity of case trajectories’ found in their Australian ARC study (Carney, 2012). The authors argue that immediate hearings may be best suited for ‘new clients’ to the tribunal, while clients with a history of previous admissions may be better suited by hearings scheduled at a time when MHTs are fully equipped to engage with the suitability or otherwise of the medication and other treatment plans.(Carney & Tait, 2011, p.152, p.152, p.152, p.152)

Participation of the person in tribunal hearings

The proposed measures identified in the literature are intended to further break down real and perceived power imbalances between the parties, increase participation of consumers in the legal process, and reduce stress or adverse impact on the persons’ health and wellbeing.

Weller (2011), for example, argues that from a non-adversarial and human rights perspective a greater emphasis on participation can be achieved in a variety of ways. She proposes that all procedures should be reviewed to increase participation at hearings (attendance in person), minimise the person’s exposure to further distress, increase emotional support where possible, and MHTs taking into account more strongly the views and treatment wishes of the person in their decision-making.

> First, consideration should be given to whether tribunal practices may be modified in order to maximise the ability of people to participate in the process with minimum distress, for example, by limiting the use of CCTV screens if they are disturbing to a particular individual. Participation may also be achieved by the presence and participation of support persons or representatives, who may appear with or instead of the person, or by the tabling of documents, such as psychiatric advance directives or statements. (Weller, 2011, 92).

Carney (2012) has proposed a number of ways to design and fine-tune the MHT process that is focused more towards the ‘clients’ perspective’, in particular with regards to the physical space (where) and symbolic space (how) reviews are conducted and the role of consumers. (Carney, 2012)

Legal representation and advocacy before tribunals

Advocacy and support are critical as consumers and their supporters find the mental health system difficult to understand and navigate: the kinds of services that are available, where support can be sourced, and the roles of the different players in the system, including MHTs. Carney and Tait (2011) report that, based on their study findings, ‘consumers and carers require support to understand and engage in dialogues about case planning, both before and after, as well as ‘at’ hearing’ (p. 148). Carney and Tait (2011) also reported ‘a need for better education about mental health issues, as well as provision of other types of assistance, like psychological counselling or psycho-social education’ (p.148).

Some studies preceding recent reforms in the Mental Health Acts across Australia reported that Australia had comparatively low rates of representation for consumers attending MHT hearings (other than for detention cases) compared to countries like New Zealand and Ireland that feature mandatory legal representation (Carney, 2011; Carney, Beaupert, Perry, & Tait, 2008; Williams, 2009).

With regard to legal representation, Section 740 of the *Mental Health Act 2016* introduces an important innovation, establishing that if the person subject to a proceeding is not represented by a lawyer or another person at the hearing of the proceeding, and the tribunal considers it would be in the person’s best interests to be represented at the hearing, ‘the tribunal may appoint a lawyer or another person (the appointed representative) to represent the person’.

The tribunal must also appoint a lawyer (also an appointed representative) to represent the person at the hearing if:

(a) the person is a minor; or

(b) the hearing is – (i) for a review of the person's fitness for trial (under chapter 12, part 6); (ii) for an application for approval to perform electroconvulsive therapy on the person (under chapter 12, part 9, division 1); (iii) another hearing prescribed by regulation; or

(c) the Attorney-General is to appear or be represented at the hearing.

Section 740 establishes that the appointment of a lawyer as the person's appointed representative is at no cost to the person. However, if the person is an adult with capacity, the person may, in writing, waive the right to be represented by the appointed representative. In this case, the person has capacity to waive the right if the person has the ability to understand the nature and effect of a decision to waive the right, and the ability to make and communicate the decision.

Section 223 of the *Mental Health Act 2016* also establishes that consumers can nominate up to two support persons who have the following functions if the consumer become an involuntary patient (Section 224):

(a) receive notices for the appointing person under the Act;

(b) receive confidential information, under the Hospital and Health Boards Act 2011, relating to the appointing person;

(c) request a psychiatrist report under Section 90 of the Act;

(d) to the extent permitted under Chapter 12 or 16 - (i) act as the appointing person's support person in the tribunal; or (ii) represent the appointing person in the tribunal.

The reviewed literature also reports that Tasmania, implemented a pilot scheme of lay representation in 2003 (Williams, 2009); and that the Northern Territory has a legal representation close to universal (Carney, 2011).

Several commentators (Carney & Tait, 2011; Weller, 2011; Williams, 2009) have argued that Australian jurisdictions should explore 'affordable and creative ways' of advocacy and alternatives to trained lawyers, including schemes of lay legal representation such as in Tasmania (Williams, 2009). Others have suggested to extend and better link in community visitor schemes, and capitalise on the 'model of coordination offered in Victoria by the Office of Public Advocate (OPA)' (Carney & Tait, 2011, p.148, p.148, p.148, p.148). Carney and Tait (2011) advocate for the establishment of a paid 'independent support person' scheme within the community visitor program, as proposed by the Victorian OPA review of the Mental Health Act in 2009. Their argument is founded on the evidence base and understanding that the outcomes of the MHT process, 'also hinge on the richness of the adjunct supports with facilitate MHT operations, whether in the form of routine but authoritative and timely second opinions, universal access to advocacy and legal representation, or strong civil society networks and community visitor schemes'(2011, p.8, p.8, p.8, p.8).Scope of tribunals powers

In his article, *Australian mental Health Tribunals – Space for Rights, Protection, Treatment and Governance,* Carney (2012) argues that MHTs provide legal fidelity, procedural fairness, and prevent arbitrary deprivation of liberties, but they also have to take into account some health and social issues in their decision-making. This role places them in a 'unique position' to be 'part of the system of governance of public mental health care' more broadly. Penelope Weller (2011) has pointed out that research shows that MHT ' members are concerned to reach the most therapeutically appropriate outcome, notwithstanding the limitations of their statutory powers'. MHTs, however, according to Weller (2011), operate in a complex mental health system with many tensions – the need to take into account patient wishes, 'dominance of medical perspectives' and overriding powers of treating psychiatrists, deficits in service provision, a rapidly changing health environment, international human rights legislation challenging established approaches to mental health law and service provision, shifting consumers' capacity to make decision and their entitlements to human and social rights and quality health care more broadly.

> The problem-solving orientation in [MHT] work is expressed in the desire of tribunal members to achieve the best outcome. However, tribunals that engage in a problem-solving approach, implicit or otherwise, are confronted by the dominance of medical perspectives, changes in mental health service delivery, deficits in service provision, the demands of services users, the demands of families and carers, the need for effective representation and the obligation to recognise the entitlements expressed in international human rights law. The changing context in which tribunals work challenges them to stretch beyond established approaches into new terrain. (Weller, 2011, p.100, p.100, p.100, p.100)

Nevertheless, Weller (2011) argues for extensions of the powers and scope of decision making of MHTs, which she describes as follows,

> The problem-solving tribunal could be complemented by a process that reviews the initial circumstances of the psychiatric detention in order to ensure that relatives and support persons are contacted, psychiatric advance directives are found and honoured and planning for an effective transition hearing is commenced. The additional expenses incurred in restructuring the tribunal review system would be offset by savings resulting from shorter and fewer acute admissions. […] A reformed and empowered tribunal could begin to restructure the mental health system by ordering the conduct of distribution of a range of services in accordance with the needs of consumers. […] MHRTs are well positioned to respond to the deep social change expressed in non-adversarial justice and contemporary human rights. By engaging with the premise of participation they can begin to give effect to their full problem-solving potential. (Weller, 2011, p.101, p.101, p.101, p.101)

According to Carney (2011) a more person-centred approach, assuming greater capacity of people with mental illness to make decisions, which has been advocated elsewhere (Callaghan & Ryan, 2014; Ryan, Callaghan, & Peisah, 2015), is visible internationally, and in some jurisdictions in Australia; where some Governments are moving away from substitute decision-making models (built on principles of 'least restrictive', or 'best interest') towards support for people with mental illness to make their own decisions, wherever possible (Carney, 2011).

As mentioned above, the *Mental Health Act 2016* introduces the possibility for consumers who become involuntary patients to nominate up to two support persons, and for patients who are not represented by a lawyer or another person at the Mental Health Review Tribunal hearings to have a lawyer appointed at no personal cost. The *Mental Health Act 2016* also introduces the role of Independence Patient Rights Advisers (Section 6), whose roles include to support consumers with access to information, understanding their rights, assist them with communications with practitioners, advise on their rights during the tribunal hearing, or assist in finding representation if the person choses to have an advocate present at the hearings (Section 294 of the *Mental Health Act 2016*). The *Mental Health Act 2016* also strengthen the use of Advance Health Directives (Section 4), which also support people with mental illness to make their own decisions.

A greater consumer focus and an increased capacity of consumers to have a say in their own health care, as advocated by the CRPD, can mean to firmly establish complaints processes within the mental health system. Carney and Tait (2011a) found that Australian jurisdictions take different approaches of providing compulsory mental health consumers, and carers and advocates avenues to make a complaint or express their concerns about care and treatment. The authors proposed a number of ways to address these shortcomings, including introducing more opportunities for second opinions (or independent medical reports) into legislation to address concerns about accuracy of treatment; informing patients about their rights and entitlements to second opinions; and expanding the MHT review process to strengthen the importance of treatment plans (i.e. powers of Tribunals to send back an individual treatment plan for reconsideration by the treating clinicians, as in the South Australia; or MHTs to take into account alternative treatments, programs or services available, as reinforced by the ACT legislation). With regard to treatment plans, it is important to note that, in Queensland, treatment plans existed under the former *Mental Health Act 2000* (Explanatory notes, Mental Health Bill 2015 (Qld), p.2). The Mental Health Act 2016 replaces such plans by requiring doctors to record in the patient's health records the treatment and care planned to be provided, and that is provided, to the patient (Section 202(2)). According to Carney and Tait (2011), the proposed legal backing would allow MHTs to 'assume responsibilities for canvassing issues arising across the mental health care system, servicing more as a case-planning body' (Carney & Tait, 2011, p.150, p.150, p.150, p.150).

Section 290 of the *Mental Health Act 2016* introduces the right of patients to ask for a second opinion if an authorised mental health service has been unable to resolve a complaint about the provision of treatment and care. In these circumstances, 'the patient, or an interested person for the patient, may request the administrator of the service to obtain a second opinion from another health practitioner, including another psychiatrist, about the patient's treatment and care'. The *Mental Health Act 2016* establishes that 'the administrator must make arrangements to obtain the second opinion - (a) from a health practitioner who is independent of the patient's treating team; and (b) in the way required under a policy or practice guideline'. Section 721 of the *Mental Health Act 2016* allows the Mental Health Review Tribunal to also order relevant a relevant person to submit to an examination by a stated examining practitioner, which can be considered equivalent to a second opinion. However, the Mental Health Review Tribunal can ask such an examination only when a patient is already before the tribunal for a matter over which the tribunal has jurisdiction.

Further, all patients admitted to any Queensland Health public hospital and in some Hospital in the Home (HITH) services, their families and carers, can use the Ryan's Rule to raise concerns if a patient's health condition is getting worse or not improving as well as expected (QLD Health, 2018b). The Ryan's Rule is a three-step process which, once enacted, leads to a nurse or doctor undertaking a Ryan's Rule clinical review of the patient and the treatment they are receiving. Each hospital and health service in Queensland has also a complaints unit/body that can manage complaints related to mental health. Queensland had previously established an independent body, the Health Quality and Complaints Commission (HQCC), to oversee, monitor, and respond to consumer and supporters about mental health services complaints. The function of the HQCC ceased its operations in mid-2014. Since then the Office of the Health Ombudsman commenced as Queensland's independent health complaints agency replacing the HQCC.[3]

2.5 Experiences of people with lived experience of mental illness

International and Australian studies have examined the experiences of people with mental illness and Tribunals. The themes arising for mental health consumers particularly relevant to the operations of MHTs are summarised here together with policy responses from the *Mental Health Act 2016* and relevant references from other jurisdictions.

The key barriers identified in the literature for mental health consumers to access and fully participate in the legal MHT process were:

- Communication barriers, feeling disempowered and distressed
- Concerns about quality of care, access to health care, or other social supports

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[3] Information retrieved 5 December 2017 http://www.hqcc.qld.gov.au/

- Legal representation and advocacy
- Imbalance in power between parties.

These barriers are now discussed individually.

2.5.1 Communication barriers, feeling disempowered and distressed

A range of studies found that the majority of mental health consumers felt distressed, powerless, and confused about the MHT process (in particular if it was their first review case), and many expressed degrees of communication difficultly with care staff and tribunal members (Cain, Karras, Beed, & Carney, 2011; Carney, 2011, 2012; Carney & Tait, 2011; Ferencz & McGuire, 2000; Murphy et al., 2017; Thom & Nakarada-Kordic, 2014). The experience of feeling powerlessness, intimidation to speak up for oneself, and not fully understanding the mental health review tribunal process were perpetuated by the overall experience of compulsory treatment, hospitalisation, as well as the illness itself. Ferencz & McGuire's (2000) refer to these experiences as a 'cycle of distress'.

The Australian longitudinal study of three MHTs (VIC, ACT and NSW) found that more often consumers were dissatisfied with the MHT process than satisfied (Carney, 2011, 2012; Carney & Tait, 2011). The study identified a number of interconnected themes that fuelled consumers' dissatisfaction, including the quality of hearings (mostly short 15-20 minutes per case, and many of them virtual rather than face-to-face); the symbolism of the setting (location, seating and speaking order); panel members language, attitude, and limited inclusion of mental health consumers in the process (MHT members were 'not interested in what they had to say' or 'wouldn't let them talk and tell their story'); consumers feeling mostly 'unprepared' during and after the hearing; and having 'high expectations' or false expectations about what the Tribunal hearing can and cannot do as part of their case review (review concerns about medication, treatment plans, recommend alternative therapies or social supports) (Carney, 2011, 2012; Carney & Tait, 2011). As a result, some consumers felt that the review process was not independent or fair (Ferencz & McGuire, 2000; Murphy et al., 2017).

Mental Health Act 2016 The *Mental Health Act 2016* acknowledges the importance of greater support to mental health consumers and, as discussed above, has introduced lawyers, nominated support persons (Section 2.4) and also. Independent Patient Rights Advisers (IPRAs)(Section 6) (QLD Health, 2017c).

These policy implementations are in line with international recommendations of ways to improve consumers' experiences of dealing with MHTs' processes. In a recent Irish study of users' experiences with MHTs, Murphy et al. (2017) concluded that consumers 'should automatically be offered the option of having a support person of their choosing present during tribunals' to help address people feeling ill-informed, emotionally unsupported, and disempowered in their engagement with the MHT process. Similarly, Carney and Tait (2011) found that consumers, carers and other supports find the mental health system difficult to navigate and understand (types of supports are available to them, where assistance can be sourced, their rights and responsibilities) and facilitating better engagement with the system should be done by an allocated 'support body or other statutory role' (for example, review officers) (Carney & Tait, 2011, p.148, p.148, p.148, p.148).

2.5.2 Concerns about quality of care, access to health care, and other social supports

Australian research with compulsory mental health consumers and their carers has found that many expressed concerns about the quality and appropriateness of the health care and treatment they received. Some of the common themes included worries about side effects of medication; physical health issues (such as liver damage, weight gain, diabetes also due to their mental health medications); lack or limited access to alternative or complementary therapies, like psycho-social support; and addressing other social support needs (discharge planning, housing needs, community support) (Carney, 2011, p. 17-23, p. 17-23, p. 17-23, p. 17-23; Carney & Beaupert, 2008).

Many people interviewed in Carney and colleagues extensive study expressed disappointment that important issues affecting their health and wellbeing were not addressed by MHTs during the review process (Carney, 2011, 2012; Carney & Tait, 2011). A report on mental health complaints between 2009 and 2012, from the now ceased Queensland Health Quality and Complaints Commission (HQCC), states that the most frequent reported concern in complaints about mental health services was treatment (41% of complaints), followed by communication and information (21%), medication (11%), professional conduct (9%) and access (6%) (HQCC, 2014).

Mental Health Act 2016 Section 202 of the *Mental Health Act 2016* outlines the responsibilities and steps to be taken by treating clinicians, who 'must ensure the treatment and care to be provided to the patient is, and continues to be, appropriate for the patient's treatment' and in compliance with the requirements of the Act. Section 202 further states that 'the authorised doctor must record in the patient's health records the treatment and care planned to be provided, and that is provided, to the patient'.(QLD Health, 2017b, p.59, p.59, p.59, p.59) Section 285 of the *Mental Health Act 2016* states that: 'An authorised doctor providing treatment and care to a patient must, to the extent practicable, provide timely, accurate and appropriate information to the patient about the treatment and care'. Authorised doctors also need to have regard to the views, wishes and preferences of the patient, to the extent that they can be expressed, including an advance health directive (Section 4). In particular, Section 286 of the *Mental Health Act* 2016, addresses the issue of the understanding of oral information given to patients, establishing that authorised mental health practitioners, authorised doctors, including authorised psychiatrists, doctors, administrators of an authorised mental health service, and authorised persons transporting a person to an authorised mental health service must: '(a) take reasonable steps to ensure the patient understands the information; (b) tell or explain the thing to, or discuss the thing with, the patient - (i) in an appropriate way having regard to the patient's age, culture, mental illness, ability to communicate and any disability; (c) if the patient has a nominated support person—tell or explain the thing to, or discuss the thing with, the patient's nominated support person; and (d) if the patient does not have a nominated support person—tell or explain the thing to, or discuss the thing with, one or more of the patient's family, carers or other support persons'.

Section 286 also provides examples of how the above mentioned persons should explain things in an appropriate way to patients having regard to their cultural and socio-demographic background. For example, '1) if a patient is acutely unwell and does not appear to understand the information given, an authorised doctor may explain the information again when the patient's condition improves; 2) After providing information to a patient, an authorised doctor may ask the patient to restate the information to ensure it has been understood; 3) An authorised doctor may explain information to a patient in the presence of a family member who can help the patient understand it. Alternatively, the above mentioned persons can tell or provide explanations to a patient at a later time if they consider the patient would better understand the thing then.

As discussed above, Section 290 of the *Mental Health Act 2016* regulates the possibility for patients to ask for a second option and Section 721 allows the Mental Health Review Tribunal to order relevant a relevant person to submit to an examination by a stated examining practitioner when a patient is already before the tribunal for a matter over which the tribunal has jurisdiction. In Queensland, patients, their families and carers, can also use the Ryan's Rule to raise concerns if a patient's health condition is getting worse or not improving as well as expected (Section 2.4), or start a complaint process with the hospital/mental health service or the Office of the Health Ombudsman.

2.6 Legal representation and advocacy

The majority of consumers and their supporters involved in research about their experiences with MHTs reported that they were unclear about the process, had expectations outside of the scope of the Tribunal, lacked necessary information, and many felt unsupported before and after MHT hearings (Cain et al., 2011; Carney, Beaupert, et al., 2008; Carney & Tait, 2011). Research has also pointed out that few Australian mental health consumers accessing MHTs are legally assisted or supported by family and friends. Study preceding recent mental health reforms in Queensland, the ACT, and Victoria reported that low advocacy and legal representation for compulsory mental health consumers was a 'distinctive feature of the Australian MHTs, with some exceptions' (Carney & Tait, 2011, p.145ff, p.145ff, p.145ff, p.145ff).

Representation at an MHT hearing, whether through legal advocates (lawyers) or legally trained lay or peer advocates, can make a difference to some consumers. In one study, legal representation helped ensure people's wishes or views of their situation were better represented at the hearing, and many represented patients felt less intimidated by the process itself (Williams, 2009). Delaney (2003) found that legal representation significantly increased the chances of discharge for Australians receiving involuntary treatment. Other research has found that opinions about the 'value add' of lawyers during MHT hearings remains divided and inconclusive (Carney & Tait, 2011). Weller (2011) discusses the literature on perceived benefits and challenges of lawyers at MHT hearings from the MHT members' perspective, and also highlights challenges of such as coverage and costs of providing comprehensive legal services. She concludes that some consumers appear to benefit from legal representation, and many report positive outcomes with advocacy and support during the tribunal process, feeling more empowered and informed.

Similarly, Carney and Tait (2011) report mixed support for lawyers but strong support for advocacy, 'having an advocate for the consumer's sense of fairness and security' was regarded by most consumers and stakeholders as important, as one consumer in the study reported: 'When a person is silenced by their illness and the situation I think advocacy is really important. I know people who have used lawyers as advocates have gotten off and much to the carers' dismay' (ibid. p.147).

The 2011 review of the *NSW Mental Health Review Tribunal Matters and Determinations* identified a number of systemic barriers to equitable access to legal assistance for mental health consumers in the MHT review process. The main ones included: availability of affordable legal services; remote and regional issues; the physical environment and office procedures of a legal service being perceived as intimidating; also a perceived 'lack of credibility' by lawyers towards people with a mental illness (Cain et al., 2011, p.6, p.6, p.6, p.6).

Mental Health Act 2016 The innovations brought by the *Mental Health Act 2016* in relation to having a lawyer appointed at no personal cost, the possibility to nominate up to two support persons (Section 2.4) and the Independent Patient Rights Advisers (IPRAs) (Section 6), have been discussed above (Section 2.4). Sections 281, 282 and 283 of the *Mental Health Act 2016* cover the patients' rights to be visited respectively by nominated support persons, family, carers and other support persons, health practitioners, and legal or other advisers.(QLD Health, 2017b, p.75, p.75, p.75, p.75). Section 281 states that a patient in an authorised mental health service may be visited by the patient's nominated support persons, family, carers and other support persons at any reasonable time of the day or night. This does not apply if the person is excluded from visiting the patient under another provision of the *Mental Health Act 2016*; or if the patient does not wish to be visited by the person.

Section 282 states that a patient in an authorised mental health service may be visited and examined by a health practitioner at any reasonable time of the day or night. The health practitioner may also consult with an authorised doctor from the authorised mental health service about the patient's treatment and care. The health practitioner may exercise a power only if asked by the patient or one or more of the patient's nominated support persons, family, carers or other support persons, and under arrangements made with the administrator of the authorised mental health service.

Section 283 establishes that a patient in an authorised mental health service may be visited by a legal or other adviser at any reasonable time of the day or night. The adviser may exercise a power only if asked by the patient or one or more of the patient's nominated support persons, family, carers or other support persons; and under arrangements made with the administrator of the authorised mental health service.

2.7 Imbalance in power between parties

In the critical legal theory literature, there are ongoing debates about existing power imbalances between parties in the juridical process and how to overcome these (for example, for example, for example, for example, Weller, 2011).

Research with compulsory mental health consumers finds that they most often experience the tribunal process as 'formal', some even as 'authoritarian' or a 'trial', more often than not, they feel anxious and intimidated by the process and the protocols (Carney, 2011, 2012; Carney & Tait, 2011). In Carney's study many consumers described the MHT process and their experience of it as a 'one-dimensional' rather than person-centred approach (Cain et al., 2011; Carney, 2011, 2012; Carney & Tait, 2011). Feelings of non-inclusion can be heightened by the persons' circumstances (experiences of compulsory treatment, admission to hospital) as well as their state of health and the illness itself. Regardless of such personal circumstances, above we have reviewed several factors that contribute and influence consumers' sometimes negative perceptions of the MHT process: features of the MHT environment (the physical space the hearing is taking place); the 'symbolic space' such as the legal-medical context, seating order, use of jargon; number of people present, or lack of supporters present; speaking order; engagement of the person, or lack thereof, by tribunal members; or accuracy of the diagnosis presented during the hearing (Carney, 2011, 2012; Carney & Tait, 2011).

In a paper examining attendance rates by Indigenous and non-Indigenous groups to the QLD Mental Health Review Tribunal before the *Mental Health Act 2016*, Fisher, Kilcullen, Schrieber, and Hughes (2009) reported several barriers to attendance of Aboriginal and Torres Strait Islander people as well as strategies taken by the Tribunal to address these.

Mental Health Act 2016

With regard to the imbalance of power between parties, we have already reviewed above the innovations related to having a lawyer appointed at no personal cost, the possibility to nominate up to two support persons, and the introduction of the Independent Patient Rights Advisers (IPRAs), who, however, cannot advocate for the patients (Section 6).

Section 5 of the *Mental Health Act 2016* recognises and acknowledges Aboriginal people and Torres Strait Islander people. It states that 'the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders must be recognised and taken into account. Aboriginal people and Torres Strait Islanders should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom, mental health and social and emotional wellbeing, and is culturally appropriate and respectful'. Section 5 also states that 'to the extent practicable and appropriate in the circumstances, communication with Aboriginal people and Torres Strait Islanders is to be assisted by an interpreter'.

The Annual Mental Health Review Tribunal Report (2016-2017) reports several recent measures to further enhance the cultural appropriateness of the Tribunal and its operations, such as appointing a dedicated Indigenous Liaison Officer. The role of this officer is to assist the Tribunal to encourage greater participation of Indigenous persons in Tribunal hearings regarding their mental health orders (including developing culturally appropriate resources). The Indigenous Liaison Officer was involved in 'targeted initiatives' to increase the participation of Indigenous people at Tribunal hearings that relate to them, including a review of the use of 'dedicated facilities' for hearings to take place (MHRT, 2017p.11, 24 p.11, 24). The report further states that currently there are nine Indigenous Tribunal Members (consisting of two legal Members and seven community Members) who constitute the Tribunal's membership (reflecting 11.54 per cent of members with Indigenous background) which ensures that the panel reflects the broader social and cultural diversity of the community (MHRT, 2017, p.8, p.8).

Similarly, Section 5 also recognises and acknowledges persons from culturally and linguistically diverse backgrounds. It states that 'services provided to persons from culturally and linguistically diverse backgrounds must have regard to the person's cultural, religious and spiritual beliefs and practices. To the extent practicable and appropriate in the circumstances, communication with persons from culturally and linguistically diverse backgrounds is to be assisted by an interpreter'.

With regard to the location of the Mental Health Review Tribunal hearings, it is within the functions of the President of the Mental Health Review Tribunal to give directions on the places and times the tribunal is to sit (Section 714 of the *Mental Health Act 2016*).

Section 692 of the *Mental Health Act 2016* states that the Mental Health Court may, subject to the court rules: (a) sit at any time and in any place for the hearing of a proceeding; and (b) adjourn the hearing of a proceeding to any time and place.

2.8 Conclusions about MHTs

The reviewed literature showed that MHTs' role of protecting the rights of people with mental illness of unjustified detention or treatment can be hampered by factors such as an over-reliance on medical opinion, the quality of the health reports provided by medical staff, and a primary focus on risk and dangerousness assessments.

The reviewed literature has also identified several limits in the implementation of MHT processes, including lack of training for clinicians on how to report to MHTs, clinicians' reliance on personal views rather than the specific circumstances of each consumer, lack of resources (MHTs in Ireland devote 16 to 18 times the Australian expenditure per case), the number of virtual hearings, the timing of tribunal reviews, and limited legal representation before tribunals.

Overall, there is agreement in the reviewed literature that there is a need for more support for consumers attending MHTs, including advocacy from lawyers, carers and peers.

The *Mental Health Act 2016* strengthened the rights of mental health consumer in relation to attending Mental Health Review Tribunal hearings by addressing many of the issues raised in the literature, including:

- The possibility for the Mental Health Review Tribunal to appoint a lawyer at no cost for the consumer, if the consumer is not represented by a lawyer or another person and if the tribunal considers it to be in the person's best interest. The Mental Health Review Tribunal must appoint a lawyer if the person is a minor, the Attorney-General is to appear or be represented at the hearing, and if the hearing is for a review of the person's fitness for trial, for an application for approval to perform electroconvulsive therapy on the person, or another hearing prescribed by regulation. The possibility for consumers who become involuntary patients to nominate up to two support persons, who can: receive notices for the appointing person under the Act; receive confidential information, under the Hospital and Health Boards Act 2011, relating to the appointing person; request a psychiatrist report under Section 90 of the Act; act as the appointing person's support person in the tribunal; or represent the appointing person in the tribunal (to the extent permitted under Chapter 12 or 16).

- Introducing the role of Independence Patient Rights Advisers (Section 6), who can advise the patient, and the patient's support persons of the patient's rights at the hearings, and, if requested, help the patient engage a representative for the hearings.

- Strengthening the use of Advance Health Directives (Section 4), which also support people with mental illness to make their own decisions.
- Regulating the possibility for patients to ask for a second option (Section 290) and allowing the Mental Health Review Tribunal to order relevant a relevant person to submit to an examination by a stated examining practitioner when a patient is already before the tribunal for a matter over which the tribunal has jurisdiction (Section 721). In Queensland, patients, their families and carers, can also use the Ryan’s Rule to raise concerns if a patient’s health condition is getting worse or not improving as well as expected (Section 2.4), or start a complaint process with the hospital/mental health service or the Office of the Health Ombudsman.

3. Community treatment orders

This section discusses Community Treatment Orders (CTOs) across different contexts, including in Queensland under the *Mental Health Act 2016*.

Section 18 of the *Mental Health Act 2016* defines a treatment authority as 'a lawful authority to provide treatment and care to a person who has a mental illness who does not have capacity to consent to be treated'. It further states that: 'a treatment authority may be made for a person if an authorised doctor considers the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, under an advance health directive'. The category of a treatment authority is *community*, 'if the person's treatment and care needs can be met in the community' (Mental Health Act 2016 (Qld)), or *inpatient* 'if the person's treatment and care needs can be met only by being an inpatient'.

For ease of reference, the expression Community Treatment Orders (CTOs) is used to refer to the findings of the literature across different contexts. The expression Treatment Authority – Community Category is used to specifically refer to the CTOs as regulated under the *Mental Health Act 2016* in Queensland.

Because of the recent introduction of the *Mental Health Act 2016*, no research literature was found on the implementation of Treatment Authorities – Community Category.

3.1 Background

A Community treatment order (CTO) is a legal order that authorises and governs involuntary psychiatric treatment in the community (VELiM, 2013b, p.5, p.5). The order, which is made by a clinician and reviewed by mental health tribunals, sets out the conditions under which a person with severe mental illness must accept treatment (medication, therapy, rehabilitation, other services and conditions) while they are living in the community, even if the interventions are against the persons' will (VELiM, 2013a, 2013b). Under certain circumstances a clinician can reverse (recall) the CTO and involuntary detain the person with mental illness in a mental health unit. Mental health tribunals (MHTs) review CTOs for their procedural fairness.

CTOs have been introduced in all Australian jurisdictions (Canvin, Rugkåsa, Sinclair, & Burns, 2014). Mental Health Acts set out criteria and conditions under which a CTO can be applied. The two legal and ethical concepts 'capacity' and 'risk of harm' are at the heart of mental health legislation and academic debate when it comes to treatment orders or detention of people with mental illness (VELiM, 2013b). People with mental illness in Australia can be subjected to involuntary care if they:

- meet the criteria of 'mentally ill or disordered' as defined in the Acts, such as being at 'serious risk of harm' to themselves, or others in the community
- lack the capacity to refuse treatment, which would be in the 'best interests of the person' and is consented to by a substitute decision-maker (VELiM, 2013b).

Section 51 of the *Mental Health Act 2016* establishes that if the authorised doctor makes a treatment authority for a person, and the person is not a classified patient[4], the authorised doctor must decide whether the category of the authority is inpatient or community. The category of the authority can be inpatient only if the authorised doctor considers, after having regard to the relevant circumstances of the person, that one or more of the following cannot reasonably be met if the category of the authority is community: (a) the person's treatment and care needs; (b) the safety and welfare of the person; (c) the safety of others.

Section 52 of the *Mental Health Act 2016* establishes that if an authorised doctor decides that the category of the treatment authority is inpatient, they must decide whether to authorise limited community treatment, the purpose of which is to support a patient's recovery by transitioning the patient to living in the community with appropriate treatment and care (Section 16). The authorised doctor may decide to authorise limited community treatment only if satisfied limited community treatment is appropriate having regard to the relevant circumstances of the person and the purpose of limited community treatment. If limited community treatment is authorised under this section, the person's treatment authority must state: (a) the nature and conditions of the limited community treatment; (b) the period, of not more than 7 consecutive days, of the limited community treatment; and (c) the duration for which the authorisation is in force.

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[4] If the person is a classified patient, the category of the authority is inpatient. A classified patient is (a) a classified patient (involuntary); or (b) a classified patient (voluntary). A classified patient (involuntary) is a person who is: (i) subject to any of the following - (A) a recommendation for assessment; (B) a treatment authority; (C) a forensic order (mental health); (D) a treatment support order - and (ii) transported under part 2 of the *Mental Health Act 2016* from a place of custody to an inpatient unit of an authorised mental health service; and (iii) admitted to the inpatient unit of the authorised mental health service; or (b) a person who— (i) is subject to any of the following— (A) a treatment authority; (B) a forensic order (mental health); (C) a treatment support order; and (ii) remains in an inpatient unit of an authorised mental health service under Section 74 of the Act. A classified patient (voluntary) is— (a) a person who— (i) is transported under part 2 from a place of custody to an inpatient unit of an authorised mental health service; and (ii) is admitted to the inpatient unit of the authorised mental health service; and (iii) consents under Section 67 or 79 of the Act to receiving treatment and care for the person's mental illness in the inpatient unit of the authorised mental health service; or (b) a person who— (i) remains in an inpatient unit of an authorised mental health service under Section 74; and (ii) consents under Section 74 to receiving treatment and care for the person's mental illness in the inpatient unit of the authorised mental health service.

Section 140 regulates community category for Forensic Orders and Section 145 regulates community category for Treatment Support Orders. A forensic order (mental health) operates in a way that is more restrictive of a person's rights and liberties than a treatment support order (Section 130).The main difference between Forensic Orders and Treatment Support Orders is that similarly to treatment authorities, the category for Treatment Support Orders must be a community category unless it is necessary for the person to be an inpatient, having regard to the person's treatment and care needs, the safety and welfare of the person and the safety of others. On the other hand, Sections 138 establishes that the Mental Health Court can decide that the category of a forensic order is community only if the court considers there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

Section 140 establishes that if the Mental Health Court decides that the category of a forensic order for a person is community, the court must: '(a) order that an authorised doctor or a senior practitioner under the Forensic Disability Act must not change the category of the order to inpatient; or (b) approve that an authorised doctor under Section 212 or a senior practitioner under the Forensic Disability Act, Section 20 may, at a future time, change the nature or extent of treatment in the community received by the person, to the extent and subject to the conditions decided by the court.

Section 145 establishes that if the Mental Health Court decides that the category of a Treatment Support Order is community, or approves limited community treatment for the person, the court must also decide whether an authorised doctor may amend the person's treatment support order to reduce the extent of treatment in the community received by the person (Section 216(1)).

Changes to category for treatment authorities are regulated by Section 209, whereas changes to category for forensic orders (mental health) by Section 212, and changes to category for patients subject to treatment support orders by Section 216.

Section 220 establishes that for patients who are subject to a treatment authority, forensic order, or treatment support order and are authorised to receive treatment in the community outside an authorised mental health service, 'an authorised doctor must decide: (a) the treatment and care to be provided to the patient while receiving the treatment in the community; and (b) the patient's obligations while receiving the treatment in the community, including, for example, obligations to attend scheduled appointments with the patient's treating health service'. Section 220 also states that 'the authorised doctor must discuss the matters with the person. Before the patient physically leaves the authorised mental health service to receive the treatment in the community, the authorised doctor must explain to the patient the above matters, record them in the patient's health records, and give the patient a written notice summarising them.

3.2 Predictors of CTO placement

Analysis of linked mental health data from 11 years (using three linked databases in Western Australia comparing outcomes for 2958 patients on CTO and an equal number of controls from inpatient care or CTO placement) found that the characteristics of patients who were placed on CTOs remained consistent over the timeframe. A strong predictor for a CTO placement was previous mental health admissions in in- or outpatient care. Characteristics of consumers on CTOs included:

- male gender
- middle aged (around 40 years)
- a diagnosis of schizophrenia or non-affective psychotic disorder
- longer inpatient stays.

While international studies have found ethnicity was not an independent predictor of hospital admission or detention in the UK (Burns & Rugkåsa, 2016), there is evidence from some jurisdictions in Australia that Indigenous Australians are overrepresented in involuntary admissions. The Queensland Mental Health Strategy 2016-2021 highlighted the disproportionate burden of involuntary assessments on Indigenous people. Data prepared for the QLD Metal Health report showed that Aboriginal and Torres Strait Islander peoples were overrepresented in involuntary assessment and treatment: in the use of seclusion while admitted in hospital; and discharges against medical advice (QLD Health, 2016, p.11f, p.11f).

In the Northern Territory, changes in legislation have led to increasing numbers of Indigenous people being treated involuntarily in inpatient units and in the community (Nagel, 2003).

CTOs are only ‘one source of patient’s coercive experiences’, there exist various forms of leverage that psychiatric outpatients can be subjected to (i.e. control of persons’ finances) with the objective of adherence to psychiatric treatment in the community (Francombe Pridham et al., 2016). Australia has high and rising rates of CTO compared to other countries internationally (Light, Kerridge, Ryan, & Robertson, 2012a).

3.3 Effectiveness

The research on the efficacy and effectiveness of CTO is growing and it has been extensively reviewed (Maughan, Molodynski, Rugkåsa, & Burns, 2014). The efficacy of CTOs however remains highly controversial, and rigorous research documents mixed outcomes for people with severe mental illness ordered to involuntary treatment in the community. Kisely, Campbell, and O'Reilly (2017) in their Cochrane review of three large randomised control trials (in England and the US) found that CTOs may not be effective or a preferable alternative to standard, voluntary care (Kisely et al., 2017; Kisely et al., 2013). The review found no clear difference in hospitalisation rates, or compliance with medication, social functioning, or quality of life compared to outcomes of voluntary patients. The main benefit identified was that consumers on CTOs were less likely to be victims of violent or non-violent crimes. The authors concluded that ‘short periods of conditional leave may be as effective (or non-effective) as formal compulsory treatment in the community’ (ibid). Other studies found that conditional release orders reduced the likelihood of extended hospital stays, but that they were less utile in preventing hospitalisation (Segal, Preston, Kisely, & Xiao, 2009). There is some evidence that CTOs may reduce the mortality associated with preventable physical illness (Kisely et al., 2012).

Some academics have questioned whether benefits to consumers are a result of the coercive treatment or rather of increased service contact and other available supports (Dunn, Canvin, Rugkåsa, Sinclair, & Burns, 2016; Kisely, Campbell, & Preston, 2011; Molodynski, Rugkåsa, & Burns, 2010; O'Brien, McKenna, & Kydd, 2009).

3.4 Experiences of people with mental illness

Few studies have examined the lived experiences of consumers and carers, however the qualitative evidence base is growing overall. The findings from most studies examining the perspectives of stakeholders about CTOs have been overall mixed and ambivalent.

In a systematic review including 22 studies from 7 countries, Corring, O'Reilly, and Sommerdyck (2017) found several common themes in the views of the 581 participants, which included consumers, carers and some professional staff. For example, the feeling of coercion and being controlled was a common concern expressed by consumer participants. Many felt they ‘had no choice’ or they would be sent back to, or could not leave an impatient unit. Some studies found that consumers generally ‘misunderstood’ or ‘overestimated the legal powers of CTOs’ leaving them with some ambiguity about possible legal consequences (Banks, Stroud, & Doughty, 2016; Canvin et al., 2014; Francombe Pridham et al., 2016). Banks et al. (2016) report that, compared to inpatient care, consumers considered a CTO placement as ‘the lesser of two evils’, which was assumed with ‘grudging acceptance’ (Banks et al., 2016). Overall, many consumers remained ambivalent about the impact of coercion (distress, isolation, disempowerment, feeling vulnerable, loss of autonomy, and lack of input into CTO decisions and processes) versus perceived benefits of improved health (Corring et al., 2017; Dunn et al., 2016; Floyd, 2013; Light et al., 2014).

Regardless of identified issues with compulsion or the quality of care, most consumers and carers in a NSW study felt that ultimately the CTO ‘were a means of keeping a person with a severe mental illness safe' (Light et al., 2014, p.20, p.20). Banks et al. (2016) reports similar findings from a UK study with practitioners, consumers, and nearest relatives, in which many of the 21 consumers interviewed felt that restrictions were beneficial to their recovery, and some reported greater involvement in decisions at CTO review stage, when their health had improved as well as their understanding and knowledge of the process.

In a study with 75 stakeholders, Dunn et al. (2016) reported that about half of the consumers interviewed 'spontaneously identified' being placed on a CTO as a concern. Otherwise consumers focused their attention to the positive and negative aspects and impacts of CTOs on 'their self-identity, and their ability to modify their life plan in order to act in line with their own values (p.135). The authors conclude that consumers concerns were strongly focused on failings on how interventions were provided to them, and the lack of a more holistic care, which highlights the practical and ethical implications of the use of CTOs more broadly:

> 'The majority of concerns highlighted in the interviews concerned perceived failings in how interventions provided to patients are used to support their care and treatment, rather than constituting evidence that CTOs by themselves are harmful or disrespectful of patients' autonomy. [….] If patients' autonomy can be promoted through the more optimal provision of multidisciplinary forms of personal and social support within community services, rather than through the use of CTOs, this is to be preferred as these multidisciplinary interventions do not impose comparable restrictions on patients' freedoms (p.138-139).

Some academics in the field of involuntary mental health treatment have suggested that consumers' rather positive views of CTO placement reported in the literature may also be due to sampling issues, challenges with recruitment, and general difficulties of conducting research with people with severe mental illness receiving involuntary care in hospital or the community (Corring et al., 2017; VELiM, 2013a). In a systematic review of qualitative CTOs, Corring et al. (2017) found that 85% of researchers highlighted challenges in recruitment of participants to their studies. Some studies included small sample sizes and the likelihood of selection biases in the group of consumers who decided to take part in research about their CTO experiences. Corring et al. (2017) concluded that studies of CTOs 'may systematically recruit subjects with more positive views about being on a CTO' (p. 78) and therefore, 'findings are likely to be biased', although they remain very mixed.

Positive outcomes and benefits. Positive experiences reported by consumers in the literature are:

- Having more freedom and choices living in the community compared to being treated involuntarily in hospital. Several studies report this factor as a major benefit for consumers irrespective of their cultural background (i.e. Maori vs non-Maori) or type of disability (i.e. forensic patients with learning disabilities) (Davis, Doyle, Quayle, & O'Rourke, 2015; Newton-Howes, Lacey, & Banks, 2014).

- Having more regular contact with clinicians, greater access to care, the quality of the therapeutic relationship with clinical staff, and, in some cases, access to other community services and supports (i.e. case managers, access to housing) leading to improvements in the health and social functioning for some, but not all groups of consumers on CTOs (Corring et al., 2017; Dunn et al., 2016; Jansson & Fridlund, 2016; Light et al., 2014).
- Having an increased sense of safety**.** This emerged as a major theme from the analysis of the female perspectives of CTO experience in a New Zealand study (Gibbs, 2010). Increased safety was one of the few clearly measurable (RCT) outcomes for consumers on CTOs compared to consumers receiving voluntary mental health care (Kisely et al., 2017).
- Experiencing person-centeredness. Examples are when consumers feel that: they are involved in decisions about their care (i.e. at the review stage); their concerns about medication side effects, cultural needs, proximity to family are 'heard' and taken into consideration; they are provided with appropriate information and support to understand the CTO process, their rights, and how to access independent advocacy or other supports. Person-centred factors were all associated with a greater acceptance and a better experience of the CTO placement (Banks et al., 2016; J. Dawson, 2008; S. Dawson, Lawn, Simpson, & Muir-Cochrane, 2016; Newton-Howes et al., 2014; O'Donoghue et al., 2009; O'Reilly, Dawson, & Burns, 2012).

Negative outcomes and challenges. The literature reports many negative experiences and challenges that consumers associate with CTO, including resistance to coercion, sense of isolation, loss of agency and control, trauma, including lack of information or understanding of CTOs and patient rights, as well as issues with the mental health system more broadly, such as for example access to services, quality of care or lack thereof, clinical/therapeutic relationships (Banks et al., 2016; Dunn et al., 2016; Francombe Pridham et al., 2016; Jansson & Fridlund, 2016; Light et al., 2012a; Light et al., 2014; Light et al., 2017; VELiM, 2013a).

Overall, the quality of the therapeutic relationships (i.e. communication, level of coercion) combined with resourcing and systemic issues within mental health services more broadly, in hospitals and community services alike, appears to play a major role in shaping consumers' negative experiences of the CTO placement and process. In their recent review of 22 international studies of stakeholder experiences, Corring et al. (2017) found strong evidence that consumers on CTOs repeatedly complained being unaware of their rights or not fully understood the CTO process, the only exemption being the Irish study by O'Donoghue et al. (2009).

3.4.1 Rights and information

All state and territories provide information to people with mental illness who receive involuntary treatment inpatient and in the community, family and carers, and supporters, about involuntary admissions, criteria that need to be met for admission, the persons' rights, and available supports and services through which consumers and families can lodge complaints, such as for example community legal advocacy groups. The extent, form and content of information provided to consumers and families however varies slightly by jurisdiction.

In Queensland the Government Health Departments, mental health services, and the Mental Health Review Tribunal provide detailed information about involuntary treatment to a range of stakeholders. The information guides are grouped for particular applications, such as Electroconvulsive Therapy, review of involuntary treatment orders, also to particular populations groups, people on forensic orders and Indigenous Australians.[5]The *Mental Health Act 2016* established for the first time the positions of Independent Patient Rights Advisers (IPRAs), whose role is to advise patients and their nominated support persons, family, carers and other support persons of their rights under the Act (Section 6). IPRAs work cooperatively with work cooperatively with Public Guardian's Community Visitors, whose role is to visit mental health services and protect and promote the rights and interests of inpatients (Section 6.1).

In NSW, community members can access information about involuntary treatment through a variety of sources. NSW Health provide a range of factsheets, and the Mental Health Coordinating Council provides detailed information and online resources and reports. Some information is provided specific to particular groups, for example, children and young people, or Aboriginal and Torres Strait Islander people.[6]

In the Northern Territory, information for people who are involuntarily detained, their rights and treatment options are discussed online on the Government's health and wellbeing, mental health web pages. Consumers and families are informed on the website that the treatment plan will as much as possible consider 'specific needs, preference and concerns', however they may be overridden if the clinicians' assessment finds other or conflicting treatment and care needs[7].

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[5] https://www.mhrt.qld.gov.au/?page_id=68

[6] http://mhrm.mhcc.org.au/chapter-8/8b.aspx

[7] https://nt.gov.au/wellbeing/mental-health/involuntary-mental-health-treatment

3.4.2 Clarity and accuracy of the information provided

The review found strong evidence that access to information, understanding information available or provided to people with mental illness admitted involuntarily, and their supporters and family, is a consistent challenge and complaint from participants perspectives.

Several qualitative international and Australian studies have highlighted the important role of relationship and communication in the context of involuntary treatment: how information of the CTO process, patient rights, and the implications of a CTO placement are provided to consumers and carers alike (Corring et al., 2017). In an Irish study, O'Donoghue et al. (2009) found that consumers' increased understanding of rights and processes (after a major legislative change) were linked with their overall more positive reflection of their involuntary admission and treatment (O'Donoghue et al., 2009; Ramsay, Roche, & O'Donoghue, 2013). In a recent review of 22 qualitative studies looking at consumers' and stakeholder's experiences of CTOs, Corring et al. (2017) found that the factor most 'positively associated with people accepting a CTO' and their conditions was the relationships with clinical staff. One factor strongly affecting consumers (and carers alike) disapproval and dissatisfaction was lack or limited information and understanding of the CTO process (conditions, persons' rights, review process etc).

Many studies report that the majority of consumers (and carers) don't have sufficient information about and support to understand the CTO process and their rights while on a CTO, academics have stressed the need to improve the human and patient rights through legislative changes, resourcing and improved communication in therapeutic relationships. According to Corring et al. (2017), mental health legislation should incorporate 'provisions to ensure that subjects of CTOs, and any formal substitute decision makers, receive the information necessary to understand the CTO and also to have an opportunity to influence the development of the treatment plan' as well as enhancing recovery oriented information and education for clinicians, to raise awareness and improve the therapeutic relationship of clinical work in the context of compulsion (Corring et al., 2017, p.79, p.79). Francombe Pridham et al. (2016) review of 23 primary research articles (reporting on 14 international studies of patients on CTOs) concluded that,

> '[…] knowledge of legislation, the relationship between mental health providers and patients, and patient participation in treatment decisions wherever possible serve an important role in decreasing perceived coercion. Lack of knowledge and understanding of the legal processes among patients was a common theme and is an area that can be improved' (Francombe Pridham et al., 2016, p.25, p.25)

Australian studies with stakeholders have come to similar conclusions, that is that the 'distress rising from being subject to a CTO' can be significantly improved:

> ‘This can be achieved by focusing upon clearer communication about the order (including strategies to ensure consumers and their carers are aware of the specifics of that order), strategies to improve access to mental and physical health services and other social institutions, and acknowledging that the CTO is a part of the overall distress of a severe mental illness’ (Light et al., 2014, p.350, p.350).

Recent research has highlighted that understanding the conditions, process, and legal implications of CTO can however be more complex than simply improving communication between consumers, carers and clinicians, rather it requires addressing systemic issues within mental health services and the role that CTOs fulfil within the current systems (Banks et al., 2016; Canvin et al., 2014). Canvin et al. (2014) found that all study participants (psychiatrists, consumers, and carers) perceived the reinforcement of medication to be the ‘primary purpose’ of the CTO, and that ‘that legal clout was central to achieving medication adherence’ (p.1880). From the psychiatrists’ perspective, adherence to medication was often driven by ‘patients’ belief that non-adherence would automatically lead to hospitalisation via recall’. One psychiatrist explained, ‘the patient is not always entirely clear what happens, and I don’t always clarify exactly what happens either’ (p.1877). Consumers’ understanding of the inbuilt CTO mechanisms varied considerably in this study, and the lack of certainty about the recall mechanism contributed to higher medication adherence for some consumers (Canvin et al., 2014).

As discussed in Section 2.5.2, Section 286 of the *Mental Health Act 2016* requires persons to ensure understanding of information provided under the Act.

3.5 Implementation

3.5.1 Service system and policy level

The provision of mental health services in the community is common. More than 8.7 million community mental health care services contacts are provided each year in Australia, of which more than 1.1. are involuntary (AIHW, 2015). A number of Australian studies have pointed out how service systems, policy, gaps in services and policy directions, as well as the relationships between clinicians and consumers on CTO intertwine and influence the outcomes of people with severe mental illness receiving compulsory care in the community (Carney, 2011; Light et al., 2012a; Light, Kerridge, Ryan, & Robertson, 2012b; Light et al., 2014; Light et al., 2017; VELiM, 2013a). Similarly, Government reports and state mental health reviews have stressed existing gaps in mental health care for people with mental illness who have higher support needs (DHS, 2009; HREOC, 1992; National Mental Health Commission, 2014; QLD Health, 2016; QLD Mental Health Commission, 2014).

In 2013, the Queensland Mental Health Commission commissioned a research project to the Centre for Mental Health in Melbourne that sought to identify ‘system elements necessary to move towards a least restrictive environment in acute mental health inpatient units'. The research included a literature review and forums with a range of stakeholders including mental health consumers and their supporters. The report identified a range of shortcomings in the mental health system in acute inpatient units and provided extensive options for reforming (15 key recommendations). Some recommendations arising from the report included, to better document, research and understand the full extent of unintended consequences of acute inpatient mental health care; to enhance peer support worker programs in hospitals; and investigate options to enable better communication between consumers and their families and friends (e.g. through greater access to phones). The most recent Draft Fifth National Mental Health Plan for Queensland identified seven key areas of priority and action to improve the early intervention, service delivery and access, integration of services, quality of care to people with mental illness in Queensland, and move towards greater recover-oriented practice, including upholding human rights (QLD Mental Health Commission, 2016).

Academic research has highlighted challenges and implications of service system and policy for CTO use. The research by Carney at al. (2008) found that the service system capacity and policy decisions (cost savings in hospitals and emergency departments, reduction of inpatient beds, and mental health services design and policy) may influence the length that people remain on CTOs for extended periods of time in some Australian jurisdictions (ACT) compared to other states (NSW, VIC) (Carney, 2011, 2012). Qualitative research conducted by Light and colleagues (Light et al., 2015; Light et al., 2017) showed that the influence of 'system' factors was 'significant to how practitioners thought about the practical application of risk-of-harm justifications for CTOs'. A range of stakeholders (clinicians, consumers, carers) clearly suggested that one reason why CTOs were used 'is to try to counter deficiencies in the mental health care' (Light et al., 2017p. 355p. 355). Other qualitative studies found similar themes around capacity and resourcing issues (Light et al., 2014; VELiM, 2013a). A recent policy analysis found that there was very little available information about the policy principles and objectives of CTOs in Australia, with the exemption of Victoria (Light et al., 2012b). The authors argued that considering the variable and growing use of CTOs across jurisdictions, Australia requires 'a more comprehensive mental health policy that articulates the principles and objectives of CTOs' more clearly than policy in Australia currently does.

3.5.2 Therapeutic relationship

There is growing interest in how the therapeutic relationship between clinicians and consumers on CTOs impacts on the outcomes of involuntary mental health consumers (Burns & Rugkåsa, 2016; Jansson & Fridlund, 2016; O'Reilly et al., 2012). Research into the efficacy of CTOs has pointed out that they may be beneficial to some groups, to achieve specific objectives, as a result of increased service contact, medication and other available supports, and the quality of the therapeutic relationship, rather than their coercive nature (S. Dawson et al., 2016;

Dunn et al., 2016; Kisely et al., 2011; Molodynski et al., 2010; O'Brien et al., 2009). In a review of forty-eight papers from seven countries on care planning and community treatment, Dawson et al. (2016) identified as a common challenge the coercive nature of a CTO placement and its potential impact on the quality of the therapeutic relationship, essential to case management and planning. The review highlighted the need to link CTO goals (service driven) and connect them to the recovery goals (consumer driven) to achieve better outcomes. This requires CTO goals to be clearly defined and transparent to all. Furthermore, the study identified that relationships between stakeholders were essential for taking a human rights perspective in CTO planning: being aware of people's right to self-determination means involving consumers (and family) from the early stages of the CTO placement, building trusting relationships, and enhancing capacity of social workers and clinical staff in emphatic communication skills to foster participation of consumers and carers throughout the process (S. Dawson et al., 2016).

3.6 CTOs and human rights

Over the last two decades, much debate about CTOs has focused on the ethical and legal implications of their use, in particular if enforcing treatment on people affected with serious mental ill-health, regardless of their capacity to consent, can be ethically and legally justified compared to international standards, for example, the UN Principles for the Protection of Persons with Mental Illness (HREOC, 1992). This UN paper argued that CTOs restrict a persons' fundamental right to freedom, personal liberty, and security of the person, especially if there is little emphasis in legislation that treatment is 'carried out in the least restrictive environment' (HREOC, 1992), which would be voluntary treatment by multi-disciplinary health teams in the community, including the provision of other social and person supports for some consumers (Dunn et al., 2016). CTOs impact on other human rights, for example, the right of persons with disabilities to exercise legal capacity and refuse treatment, greater self-determination, including decisions about taking risks (Callaghan & Ryan, 2014). The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has laid down a 'paradigm shift' to current mental health law with its focus on enhancing people's with mental illness legal capacity, shifting away from substituted decision-making to supported decision-making schemes in mental health (Callaghan & Ryan, 2014). Callaghan and Ryan (2014) note that 'Article 12(3) suggests that a person can retain *legal capacity* at least provisionally, even if his/her *decision-making capacity* is significantly impaired or absent, but that in that case an obligation arises to provide the person with support' (ibid p.760). The authors argue that to give full effect to the CRPD, new supported decision-making regimes must be incorporated into mental health legislation, which would, as a consequence, respect the rights, will and preferences of the person affected.

In a comparative study of international legislations on CTOs, Dawson (2008) pointed out that CTO regimes in Australia and New Zealand have taken 'a distinctive approach to authorising involuntary outpatient care, particularly with regard to the scope of the community treatment powers it confers on mental health teams' […], because they do not have an entrenched bill of rights in their constitutions that controls the legislation their Parliaments may lawfully enact', as is the case in some Canadian states and the United States (ibid p.149). More recently, Light (2014) argued that Australian health policy and public debate has tended to render 'CTO as a service delivery tool […] invisible', there is a lack of clarity in public policy about their functions and health objectives; lack of publicly available data (that allows for ongoing critical examination); and lack of independent oversight mechanisms or bodies in many states to monitor transparency and accountability of the mental health system compared for example to countries like the UK.

A quarter of a century ago, the Human Rights and Equal Opportunity Commissions' review highlighted the need for Australian legislation to improve the safeguards for involuntary mental health treatment, including handling of complaints, monitoring, and review of procedures and implementation to improve the human rights protection of people with mental illness (HREOC, 1992), and these issues persist today.

3.7 Conclusions about CTOs

A CTO is a legal order that authorises and governs involuntary psychiatric treatment in the community. Section 51 of the *Mental Health Act 2016* establishes that the category of a treatment authority should be community, unless, having regard to the relevant circumstances of the person, this would not allow to reasonably meet: (a) the person's treatment and care needs; (b) the safety and welfare of the person; (c) the safety of others.

The evidence in qualitative studies about CTOs remains mixed. CTOs appear to be consumers' preferred choice and increase some freedoms, in particular if the alternative is involuntary inpatient treatment. However, there is strong qualitative evidence that many consumers and carers in Australian and overseas complain about not having access, received, or been provided with the necessary support to fully access, comprehend, and act on information about involuntary treatment, CTOs and their legal implications, and mental health consumer rights more broadly (i.e. review process). Many of these recent studies have highlighted that legislation needs to improve the mechanisms by which people (consumers and carers) receive mental health information and support to understand the information and manage their pathways through the mental health system.

Overall, CTOs as a treatment or procedural tool in community mental health remain controversial regarding their efficacy and outcomes and pose some risks to the rights of people with mental illnesses.

4. Advance Directives

4.1 Background

Advance Directives (AD) are legal documents for individuals to plan, make decisions and specify their wishes regarding their future health care and treatment during times of incapacity (when a person lacks the capacity to make those decisions) (Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008). The AD is formulated at the time when the person has capacity to do so.

In the *Mental Health Act 2016*, ADs are referred to as Advance Health Directives. Part 8, Division 1 of the *Mental Health Act 2016* states that 'the advance health directive may include the principal's[8] views, wishes and preferences about the principal's future treatment and care for a mental illness'. In deciding the nature and extent of treatment and care to be provided to a person under a treatment authority, the authorised doctor needs to: 'a) discuss the treatment and care to be provided with the person; and b) have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an advance health directive' (*Mental Health Act 2016*, Section 53).There exist a range of models and terminologies for advance health directives in Australia and internationally (Atkinson, 2007). The interventions differ by health settings, such as general health care (advance statements, advance directives, advance agreements) and psychiatric care (psychiatric advance directive (PAD), facilitated advance directives (f-PAD), psychiatric wills, joint crisis plan (JCP)) (Henderson et al., 2008). The models can also be distinguished by the extent that they are legally binding (the treating clinician can override them); the parties involved in their completion (consumers, clinicians, informal supporters, advocates) and the support provided to consumers during the completion; the role of proxy-decisionmakers during crisis; the scope of decisions they cover (only health and health related preferences or also social, financial, housing etc); their implementation and accessing the protocols when changed health circumstances prevail (Nicaise, Lorant, & Dubois, 2013).

Another overarching distinction between the models used in mental health is the instructional directive (the consumer and or a number of parties work out the treatment preferences for future times) versus the proxy directive (the consumer appoints a person or 'attorney' to make treatment decision on their behalf should they lose capacity) (Campbell & Kisely, 2009).

In mental health care settings psychiatric advance directives (PAD), advance health directives (AHD), joint crisis plans (JCP), or facilitated psychiatric advance directives (f-PAD) are the common protocols in use. Here, the expression mental health ADs is

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[8] The Powers of Attorney Act 1998 (current as at 5 March 2017) states that in the context of advance health directive and power of attorney, principal means the person who made the advance health directive or appointed the attorney.

used to refer to the literature findings across different contexts, whereas the expression Advance Health Directive will be used to refer to findings specific to the Queensland context.

Mental health ADs have been identified as ‘interventions [that] all share the goal of preventing adverse consequences of relapse’ (Henderson et al., 2008). They aim to increase consumers’ autonomy, provide timely and effective care during crisis, create empowerment through illness self-management, improve therapeutic alliances between clinicians and consumers in some cases (such as, JCP), reduce the level of compulsory care, and help protect mental health consumers’ rights (Farrelly et al., 2013; Henderson et al., 2008; Ouliaris & Kealy-Bateman, 2017).

In Australian mental health care legislation, mental health ADs have been incorporated to varying degrees in the Australian Capital Territory (ACT), Queensland (QLD), Victoria (Vic), and Western Australian (WA). A recent review found that currently mental health ADs are only legally binding in the ACT and, with limits, in QLD. Several states and territories have very limited or no legislative provisions in their Mental Health Acts for mental health ADs including Tasmania, South Australia, the Northern Territory, and New South Wales (NSW) (Ouliaris & Kealy-Bateman, 2017).

In Queensland, the *Mental Health Act 2016* frames the Advance Health Directives in terms of ‘a less restrictive way of treatment’. Section 13 of the Act states that there is a less restrictive way for a person to receive treatment and care for the person’s mental illness if, instead of receiving involuntary treatment and care, the person is able to receive the treatment and care that is reasonably necessary for the person’s mental illness in 1 of the following ways: (a) if the person is a minor—with the consent of the minor’s parent; (b) if the person has made an advance health directive—under the advance health directive; (c) if a personal guardian has been appointed for the person—with the consent of the personal guardian; (d) if an attorney has been appointed by the person—with the consent of the attorney; (e) otherwise—with the consent of the person’s statutory health attorney.

In deciding whether there is a less restrictive way for a person to receive the treatment and care that is reasonably necessary for the person’s mental illness, a person performing a function or exercising a power under this Act must— (a) consider the ways mentioned in subsection (1) in the listed order set out in the subsection; and (b) comply with the policy that must be made by the chief psychiatrist about when it may not be appropriate for a person to receive treatment and care for the person’s mental illness under an advance health directive or with the consent of a personal guardian, attorney or statutory health attorney for the person (Section 305(1)(a)).

In Queensland, there are currently two advance health directive forms. One is provided by the Department of Justice and Attorney-General, and the other is an Advance Health Directive for mental health' created by Queensland Health (QLD Health, 2017a). The QLD Department of Justice and Attorney-General developed a form (22 pages long) which is designed to assist people wishing to give directions about their health and treatment at a time when they can no longer speak for themselves. This Advance Health Directive form is organised in 11 sections, including appointing an attorney, and it is accompanied by a detailed information brochure and Advance Care Planning guide on how to complete it(QLD Health, 2004). The Queensland Health Advance Health Directive mental health form consists of 8 sections and it also includes instructions on how to complete it.

4.2 Effectiveness

Results of randomised controlled trials (RCT) in the UK comparing outcomes for participants with ADs (and similar interventions) in place to mental health consumers receiving treatment as usual, in this case compulsory care, are contradictory about the benefits and outcomes of ADs in lowering compulsory admissions to hospital and reducing the numbers of psychiatric admissions overall. A study published in the Lancet, comparing consumers with Joint Crisis Plans (JCP), which are care plans formulated by the consumer and treating clinicians in collaboration, to consumers without a JCP, found that JCP were not significantly more effective in reducing hospitalisation and levels of coercion (Thornicroft et al., 2013). Earlier RCTs found some evidence that AHDs might reduce compulsory treatment and improve the therapeutic relationship between consumers and clinicians, also that participants with AHD felt more satisfied and involved in their mental health care (Henderson et al., 2004; Sutherby et al., 1999; Swanson, Swartz, Elbogen, et al., 2006).

A recent systematic Cochrane review of mental health ADs found in their meta-analysis no overall effect of ADs (compulsory or voluntary care) on the treatment outcomes for mental health consumers (Campbell & Kisely, 2009). Although the study stated that ADs 'are well-suited to mental health settings […] provide people with these illnesses the opportunity to convey their treatment preferences when they are competent' (Campbell & Kisely, 2009, p.2, p.2). Some studies found that mental health ADs may reduce negative coercive treatment experiences. Compared to consumers without mental health ADs, consumers with facilitated ADs were approximately half as likely to require a coercive intervention during a mental health crisis over a 24-month follow-up period (Swanson, Swartz, Elbogen, et al., 2006; Swanson et al., 2008).

4.3 Take up

In a computer-assisted telephone interview survey in which 2405 people participated (50% of whom were female), only 14 per cent had an AD[9]. The proportion of people who had an AD was found to be significantly smaller than those of respondents who had a financial EPA (30%) or a will (59%). Strong predictors for having an AD in place were if the person had undertaken financial planning, will making, or had a financial enduring power of attorney in place, and relationship status. Jurisdictions with long-standing, well publicised statutory AD forms, also had a higher uptake of ADs, such as for example South Australia and Queensland (White et al., 2014).

Internationally, and in Australia, the take up rates of mental health ADs remains low and they are not widely implemented in mental health care settings (Nicaise et al., 2013; Ouliaris & Kealy-Bateman, 2017; Weller, 2010). The take up rates of mental health ADs remain low, for example compared to those in palliative care, even in countries that have a long standing history in the use of advance directives in psychiatric settings, such as the US (Amering & Schaffer, 2007; Elbogen et al., 2007; Swanson, Swartz, Elbogen, et al., 2006; Szmukler, 2006).

A comprehensive review of existing research into mental health ADs identified three theoretical frameworks that underlie the process. Originally, designed to enhance consumers autonomy, empower them to take a more active role in their care and treatment, the authors suggest that their findings highlight how the intervention is 'more efficient within a therapeutic alliance framework': to improve the therapeutic alliance, and the integration of care, providers working in partnerships (Nicaise et al., 2013). They conclude that the mixture or expectations and perceptions of mental health ADs from a range of stakeholders may explain the low uptake of this complex and 'multistage intervention process' (Nicaise et al., 2013, p.11-12, p.11-12).

4.4 Implementation

In the academic literature there is recognition that mental health ADs may be a useful process for implementing supported decision-making in psychiatric context, to enhance mental health consumers autonomy, and promote recovery-oriented practice (Heather, Kathleen, & Richard, 2015; Henderson et al., 2008; Swanson, Swartz, Elbogen, et al., 2006; Weller, 2010). The research evidence has identified a range of barriers in practice that have contributed to low uptake rates and implementation of advance directives in psychiatric settings worldwide and in Australia. A review of the legal determinants of mental health ADs highlighted the

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[9] The survey was implemented with a national sample of the Australian adult population (aged 18 and above) representative of age and state. A total of 12110 households was randomly contacted by telephone with 40% (4846) of households falling outside the proposed sample (e.g. no one over 18 available, jurisdictional or age quotas already met), leaving a potential 7264 respondents to be interviewed. Of the 7264 respondents within the inclusion criteria, 2405 agreed to be interviewed, 50% of whom were female.

‘common experience of difficult implementation’ in praxis across jurisdictions (including the US, CA, Scotland, England, New Zealand) (Weller, 2010).

In their comparative legislative review, Ouliaris and Kealy-Bateman (2017) identify the ACT Mental Health Act 2015, and how it implements mental health ADs, as a stand out model for other Australian jurisdictions. According to the authors, the ACT makes the most extensive mental health AD provisions. First, it encourages the uptake of mental health ADs by requiring consumers be informed about this possibility. Second, while in other states, including QLD, clinicians can override the consumers preferences, when they are regarded as clinically inappropriate, in the ACT the Act provides stronger safeguards for the person’s wishes, requiring consent from the person and a nominated proxy-decision maker (guardian, health attorney). Alternatively, the clinician can put in an application to the Mental Health Tribunal for an order. Third, in the ACT Mental Health Act 2015, a mental health AD does not remain a binding agreement: the consumer does not have to accept treatment that they previously consented to in writing. The authors conclude that unless jurisdictions make ‘explicit legislative requirements, such as those in the ACT Act, the likelihood of [mental health ADs] being widely utilised is dubious at best’ (ibid.p.4).

Key barriers to the implementation of mental health ADs include stakeholders’ and clinicians’ perceptions and attitudes towards them, administrative, structural, organisational barriers, and lack of clarity of the purpose and legal implications of mental health ADs. To date, there has been little research specific to the implementation of mental health ADs in Australia, more research has been conducted on the use and acceptability of ADs more broadly (e.g. in palliative care and general health care).

Prominent commentators in mental health law, like Penelope Weller, have argued to use international experiences of mental health ADs as lessons for Australian jurisdictions on how to introduce more effective consumer control in psychiatric settings that also adheres to the standards set out by the Convention:

> The challenge for law reform [in Australia] in relation to advance directives is not to abandon the concept, but to understand the process that will be necessary to support their effective introduction. There is little empirical evidence available that might help to flesh out an accurate analysis of the reasons that underpin success or failure of different psychiatric advance directive strategies. On its face, the adoption of psychiatric advance directive provisions goes towards satisfying the requirement that legislative regimes are non-discriminatory and uphold the principle of equality before the law. […] Its [the CRPD] deference to the underlying principles of non-discrimination and equality before the law indicates that psychiatric advance directives represent only one component of an integrated human rights approach. (Weller, 2010, p. 226).

4.4.1 Individual level barriers and perceptions

Research shows that support with the completion of documents and associated processes can impact on the likelihood of consumers having a mental health AD in place. Two RCT studies found that facilitated psychiatric advance directives (f-PADs) may be the way forward to achieve greater consumer self-determination (Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002; Swanson, Swartz, Elbogen, et al., 2006). Mental health consumers and their families require a range of supports in the planning and completion of a mental health AD process (Kemp, Zelle, & Bonnie, 2015). However, in her comprehensive review of mental health ADs in Australia and international experiences (US, CA, Scotland, England, New Zealand), Weller (2010) points out that 'comprehension and ability to complete the documents are not significant factors' for their low utilisation internationally. Instead, Weller (2010) argues that key barriers to the implementation of mental health ADs are 'lack of ready access to the documents in crisis, a lack of clinician familiarity, and legal uncertainty about their application' (Weller, 2010, p.224, p.224; White et al., 2014).

Perceptions about what an AD is, and the role that it fulfils or should fulfil, have been identified as critical elements to the effectiveness of ADs as an intervention in clinical practice. Research evidence suggests that the perceptions of the usefulness of ADs and their purpose can vary significantly between stakeholder groups. One study on perceptions of content and usability of ADs in Queensland found important differences in the perceptions on the role of ADs between people who completed an AD and treating clinicians (Willmott, White, Tilse, Wilson, & Purser, 2013). Clinicians expressed concerns about interpreting an AD, about the fact that treatment wishes may not be in the patient's best interest, and that a directive may not represent the 'true wishes' of a consumer (they may not understand the full treatment and options available). Medical practitioners were more supportive of AD if they were not legally binding, directions were made in form of general treatment outcomes, and if the treating clinician or a medical practitioner had been involved in their completion.

An Australian online survey that was completed by 143 psychiatrists found that few participants supported the idea of consumers completing a mental health AD, based on concerns about risk, the clinical profile, and ethical imperatives. On the other hand, those psychiatrists who supported mental health ADs did so mainly with a strong focus on patient autonomy. The study concluded that the majority of psychiatrists participating in the survey either did not support or were unsure about the usefulness of mental health ADs in clinical practice (Sellars et al., 2017).

Clinicians views and attitudes towards mental health ADs, such as legal uncertainties about their application, or their perceived value, have been identified as a significant barriers to their implementation at times of crisis (in contexts where a consumer has an advance directive in place) (Farrelly et al., 2016; Farrelly et al., 2013). In an UK RCT study, Thornicroft et al. (2013) identified three barriers to the implementation of mental health ADs for patients who had a joint crisis plan in place:

1) clinicians' beliefs that they were already carrying out joint care planning, and therefore a mental health AD would have added little benefit; 2) a required change in the power dynamics of the clinician-consumer relationship, i.e. clinicians encouraging consumer led and active discussions about treatment options and their preferences; 3) lack of investment of resources by all participants within a complex system.

4.4.2 Service system and policy level barriers

Implementation barriers, such as lack of access to the document in a crisis, have been identified as a persistent issue for the implementation of mental health ADs. These have been addressed internationally through so called 'crisis cards', which people carry with them, and the development of electronic registers, national directories that provide online storage and ready access to these protocols (Nicaise et al., 2013; Sutherby et al., 1999; Weller, 2010).

Section 225 of the *Mental Health Act 2016* establishes that the Chief Psychiatrist must establish and maintain a system (the records system) for keeping electronic records of advance health directives, enduring powers of attorney for a personal matter; and appointments of nominated support persons. The records system must be capable of keeping an electronic record for these matters consisting of: '(a) a record stating the directive, power of attorney or appointment has been made by a stated person on a stated date; and (b) an electronic copy of the directive, power of attorney or notice of appointment'. The Chief Psychiatrist policy on patients' records states that 'The State-wide electronic mental health database, the Consumer Integrated Mental Health Application (CIMHA), is the designated patient record for the purposes of the Act' (QLD Health, 2017e).

Section 226 establishes that a person who makes an advance health directive, or enduring power of attorney for a personal matter, relating to the person's future treatment and care for a mental illness, or appoints a nominated support person, can: '(a) give the administrator of an authorised mental health service a copy of the directive, power of attorney or notice of appointment; and (b) ask the administrator to keep a record for the matter in the records system. In these cases, the administrator must comply with the request and give the person written notice confirming compliance with the request.

Other research has pointed out the complex systems that mental health ADs are embedded in and the number of participants involved, including appointed attorney or carers, that have to be consulted and called upon at times of crisis (Thornicroft et al., 2013). A recent realist systematic review of 47 research papers found that integration of care, through clinicians working in partnership, was perceived essential to the implementation of mental health ADs. However, this ideal is not always easily achieved in clinical practice (Nicaise et al., 2013; Thornicroft et al., 2013).

Weller (2010) and others (Callaghan & Ryan, 2014) have argued that a successful implementation of mental health ADs, and greater recognition of the intentions of the CRPD in compulsory treatment in Australia, would mean for law reformers to challenge ‘best interests’ principles (substituted decision making) and introduce supported-decision making regimes, which question common assumption that people living with mental illness automatically lack capacity. Callaghan and Ryan (2014) further stress that such new supported-decision making regimes however must be incorporated into mental health legislation and these must admit a limited role for substituted decisions, including involuntary treatment.

Weller (2010) drawing on the New Zealand case of mental health ADs, suggests that a consumer-clinician cooperative formulation of mental health ADs, (although it is not a legislative requirement in NZ), combined with a comprehensive framework of supported-decision making, appear to be most promising model for Australian jurisdictions to follow suit, if providing greater self-determination to people with mental illness, as advocated by the Convention, should also find its applicability in clinical practice. Such an approach would not remain without criticism, as it risks that the clinical views prevail or dominate the formulation of a mental health AD and would need to be accompanied with a shift in legislation. Weller (2010) uses the experiences of the Scottish model and legislation to highlight this point:

> The legislation has shifted away from the concept of “best interest” entirely. The Scottish Act acknowledges the wishes of the patient, but uses the language of participation, benefit, and non-discrimination (rather than “best interest”) to guide the conduct of persons under the Act. (Weller, 2010, p. 225, p. 225).

Together, the collaborative formulation of PADs and a shift away from “best interest” principles in legislation, embed advance directives in psychiatric settings in a framework of supported decision-making, and challenge ‘the paternalistic assumptions about the ability of people living with mental illness to make decisions for themselves’ (Weller, 2010, p.225-226).

4.4.3 Role of the therapeutic relationship

There is growing evidence in the literature about the importance of the consumer-clinician therapeutic relationship, as well as of the consumer therapeutic alliances with a range of stakeholders in relation to the implementation of mental health ADs (Nicaise et al., 2013). The reviewed literature has identified three main reasons for this. First, an improved therapeutic alliance or working relationship appears to be one of the benefits and primary outcomes of many larger and smaller studies looking at the effects of mental health ADs on services, stakeholder relationships, and consumer outcomes (Nicaise et al., 2013; Ruchlewska, Kamperman, Wierdsma, Van der Gaag, & Mulder, 2016). Second, research has found that engagement and involvement of treating clinicians in the drafting of mental health ADs – as in the case of New Zealand, where all mental health ADs are a collaborative formulation, or in the UK with Joint Crisis Plans – can: 1) increase the likelihood of clinicians support for a mental health AD; 2) increase commitment and adherence to the drafted treatment decisions in clinical practice; and 3) improve communication exchange between consumers and clinicians (Amering & Schaffer, 2007; Henderson et al., 2004; Henderson et al., 2009; Nicaise et al., 2013; Papageorgiou et al., 2002; Weller, 2010).

In an European study, Ruchlewska et al. (2016) found that higher completion rates of mental health ADs were associated with a ‘better clinician-rated working alliance’. On the one hand, the creation of a mental health AD can improve the working relationship. On the other hand, a better relationship between clinician and patient can help with the formulation and completion of a mental health AD. Third, the collaborative formulation of directives in psychiatric and mental health contexts appears to address real and perceived legal uncertainties on part of the treating clinicians, as well as improve clinical compliance with the mental health AD (Szmukler, 2006; Weller, 2010). Such an approach would also require a legislative review and shift in legislation away from the “best interest” principle towards greater acknowledgement of consumer wishes, preferences and capacity of people with mental illness to have a say in their care and treatment, as advocated by the Convention (Weller, 2010).

With regard to this, Flood et al. (2006) found that working in a collaborative way that enhances therapeutic alliances with a range of stakeholders (consumer, family, advocate, appointed attorney) in the implementation of mental health ADs was not more costly than mental health consumers receiving standard care. The use of a joint crisis plan in the UK economic evaluation was associated with less service use and lower costs on average than in the standardised service information group, but differences were not significant (Flood et al., 2006).

4.5 Experiences of people with mental illness

Research with consumers finds strong support for the concept of ADs. If provided with the option of completing a mental health AD, most consumers in this US study opted for one. The study, which reports on over 1000 consumers, found that only 4 to 13 percent of participants had completed a mental health AD depending on location/city; however, the majority (66 to 77 per cent) said that they would like to complete one if given the right information and assistance (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006).

The key message from a growing body of research with mental health consumers who have a mental health AD in place is that ADs can increase people’s sense of involvement in their treatment, feeling more empowered or positive, and more in control of their health problem (Farrelly et al., 2014; Henderson et al., 2009; Thornicroft et al., 2013). For some, especially consumers who had their wishes adhered to at times of crisis, research reports increased satisfaction with their care;

improved relationships with treating clinicians, in particular consumers report (feeling more respected, more understood, and heard by practitioners) (Amering & Schaffer, 2007; Scheyett, Kim, Swanson, & Swartz, 2007; Swanson, Swartz, Ferron, et al., 2006; Swanson, Swartz, Elbogen, et al., 2006; Swanson et al., 2008; Thornicroft et al., 2013); and in some studies, reduction of coercion in their care (Swanson et al., 2008).

The message from consumers participating in research about their treatment wishes and preferences is clear. In a study that analysis 221 completed Joint Crisis Plans in the UK, two major preferences were identified: first the way crisis care was to be delivered, and second, specific treatment interventions. Some consumers in the study opted for hospitalisation; the majority preferred alternative treatment and care. The most preferred option was treatment in a familiar home by a home mental health treatment team (Farrelly et al., 2014). Another study applying a similar method looked at JCP of people with borderline personality. Most consumers (n=37) included at least one specific treatment refusal, most commonly, a preference regarding their medication and or involuntary treatment. Most consumers also wanted a community mental health coordinator and their preferred GP to receive a copy of their PAD (Borschmann et al., 2014).

4.6 Conclusions about advance directives

Advance directives are a tool that mental health consumers can choose to use to provide information on treatment preferences and other instructions for those times when their capacity to make decisions about their care and treatment are hampered by acute mental illness or distress.

Research evidence from randomised controlled trials (RCT) are contradictory about the benefits and outcomes of AHDs. Some studies found that AHDs were not significantly more effective in reducing hospitalisation and levels of coercion, whereas other RCTs found some evidence that AHDs might reduce compulsory treatment, improve the therapeutic relationship between consumers and clinicians, and help consumers to feel more satisfied and involved in their mental health care (Amering & Schaffer, 2007; Scheyett et al., 2007; Swanson, Swartz, Ferron, et al., 2006; Swanson, Swartz, Elbogen, et al., 2006).

The protocols that allow consumers with more severe mental illness to document their treatment wishes, for a time where they may lose capacity to make these decisions for themselves, differ by country and legislative context, both in their design, and their implementation. Nevertheless, research shows a low uptake of ADs in different contexts, which highlights the need for further investigation on barriers to take up and use of ADs. Research shows that key barriers to the implementation of ADs include low engagement with the process from people with lived experience and mental health professionals alike, lack of ready access to the documents in crisis, a lack of clinician familiarity, and legal uncertainty about their application. At the service and policy level, researchers have argued that the introduction of supported-decision making regimes can help the successful implementation of mental health ADs as well as greater recognition of the intentions of the CRPD in compulsory treatment in Australia.

5. Rights and information for inpatients within mental health wards

5.1 Background

The rights and information of inpatients, family and carers within mental health wards are regulated by both national documents and laws – the Australian Charter of Healthcare Rights (ACSQHC, 2008), the National Safety and Quality Health Service Standards (ACSQHC, 2017), and the National Standards for Mental Health Services (Australian Government, 2010) – and state documents and laws, including the Queensland Mental Health Act 2016 (*Mental Health Act 2016*), and Queensland Health policies.

No critical research on the implementation of these policies or consumers' experiences of them has been found in the searches. Consequently, this section first briefly introduces each document individually and then discusses them together to identify the overall framework and guidelines they propose in relation to rights and access to information in mental health wards.

5.2 National frameworks

5.2.1 Australian Charter of Healthcare Rights

The Australian Charter of Healthcare Rights (the Charter) was developed by the Australian Commission on Safety and Quality in Health Care in 2007 and 2008 and was adopted by the Australian Health Ministers on 22 July 2008 (ACSQHC, 2008). The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care (ACSQHC, 2008). It applies to all health settings anywhere in Australia, including public hospitals, private hospitals, general practice and other community environments.

The Charter is underpinned by three guiding principles, which describe how it applies in the Australian Health System (ACSQHC, 2008):

- Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
- The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
- Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

The Charter outlines seven rights (ACSQHC, 2008; OHO, 2015):

- A right to health care (Access)
- A right to safety and high quality health care (Safety)
- A right to be shown respect, dignity and consideration (Respect)
- A right to be informed about services, treatment, options and costs in a clear and open way (Communication)
- A right to be included in decisions and choices about care (Participation)
- A right to privacy and confidentiality of provided information (Privacy)
- A right to comment on care and having concerns addressed (Comment)

5.2.2 National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards (the Quality Standards) were first developed by the Australian Commission on Safety and Quality in Health Care in 2011 (ACSQHC, 2012). A second edition of the Quality Standards, which addresses some gaps identified in the first edition, was released in November 2017 and assessments using it will start from January 2019.The primary aim of the NSQHS Standards is to protect the public from harm and improve the quality of health care (ACSQHC, 2017). They describe the level of care that should be provided by health service organisations and the systems that are needed to deliver such care (ACSQHC, 2017).

The second edition of the Quality Standards includes eight standards (ACSQHC, 2017), of which six focus on clinical care – i.e. clinical governance, preventing and controlling healthcare-associated infection, medication safety, comprehensive care, blood management, and recognising and responding to acute deterioration – and two aim to strengthen the roles of consumers, carers and families as partners in their own care:

- Partnering with consumers, which aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care.
- Communicating for safety, which aims to ensure that there is effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation, to support continuous, coordinated and safe care for patients.

Overall, the Quality Standards (second edition) recognises that patient involvement leads to a more positive experience for consumers, and also enables high-quality health care and improved safety (ACSQHC, 2017).

5.2.3 National Standards for Mental Health Services

The National Standards for Mental Health Services (the National Standards) were first introduced in 1996 to guide continuous quality improvement in mental health services, which back then were predominantly provided through State and Territory funded specialist clinical mental health services (Australian Government, 2010, p. 2, p. 2). Over the years, there has been increased clinical and non-clinical service provision in the community, including an expansion of the non-government and private sectors, and greater focus on the role of the primary care sector in mental health (Australian Government, 2010, p. 2, p. 2). Consequently, the National Standards were reviewed in November 2006, leading to the inclusion of a recovery standard and a focus on: how services are delivered; whether they comply with policy directions; whether they meet expected standards of communication and consent; whether they have procedures and practices in place to monitor and govern areas that may be associated with risk to the consumer, or which involve coercive interventions (Australian Government, 2010). The National Standards were developed to be applied across the broad range of mental health services, including bed based and community mental health services, clinical and non-government sectors, those in the private sector as well as those in primary care and general practice.

There are 10 standards:

1) **Rights and responsibilities**. 'The rights and responsibilities of people affected by mental health problems and/or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care' (Australian Government, 2010, p. 7, p. 7). These include the MHS:

   - Providing consumers and their carers with a written statement, together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care (Australian Government, 2010, p. 7).

   - Providing staff and volunteers with a written statement of the rights and responsibilities of consumers and carers, together with a written code of conduct as part of their induction to the MHS.

   - Communicating with consumers, carers and other service providers and applying the rights and responsibilities of involuntary patients as per relevant Commonwealth, state / territory mental health legislation and related Acts.

2) **Safety**. 'The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community' (Australian Government, 2010, p. 9), including protecting consumers from abuse and exploitation and eliminating the use of restraint and seclusion within all MHS settings.

3) **Consumer and carer participation**. 'Consumers and carers are actively involved in the development, planning, delivery and evaluation of services', (Australian Government, 2010, p. 11), including providing ongoing training, support, supervision and mentoring to consumers and carers who are employed by the MHS or are involved in formal advocacy and/or support roles within the MHS.

4) **Diversity responsiveness**. 'The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care' (Australian Government, 2010, p. 12).

5) **Promotion and prevention**. 'The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness' (Australian Government, 2010, p. 13).

6) **Consumers**. 'Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery' (Australian Government, 2010, p. 14). This standard includes the right to:

   - be treated with respect and dignity at all time
   - receive service free from abuse, exploitation, discrimination, coercion, harassment and neglect
   - receive a written statement, together with a verbal explanation, of their rights and responsibilities in a way that is understandable to them as soon as possible after entering the MHS
   - be educated about their rights and responsibilities
   - receive the least restrictive treatment appropriate, considering the consumer's preference, the demands on carers, and the availability of support and safety of those involved.

7) **Carers.** 'The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness' (Australian Government, 2010, p. 16), including providing carers with a written statement, together with a verbal explanation of their rights and responsibilities in a way that is understandable to them as soon as possible after engaging with the MHS.

8) **Governance, leadership and management.** 'The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services' (Australian Government, 2010, p. 18).

9) **Integration.** 'The MHS collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers' (Australian Government, 2010, p. 18).

10) **Delivery of care.** 'The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery., including supporting recover, access, entry, assessment and review, treatment and support, exit and re-entry' (Australian Government, 2010, p. 20).

All the National Standards, except the consumer standard, are designed to be assessed. The consumer standard is designed to inform consumers about their rights and responsibilities and the key elements underpinning the provision of quality service, so its criteria are assessable within the other standards (Australian Government, 2010).

5.3 Queensland frameworks

The rights and information of inpatients, family and carers within mental health wards are also regulated by national laws and frameworks, including the *Mental Health Act 2016*, the Guardianship and Administration Act 2000, the Carers (Recognition) Act 2008, and the Audit tools for National Safety and Quality Health Service Standards (Queensland Government, 2017).

Chapter 9 of the *Mental Health Act 2016* provides for a statement of rights and the rights of patients and relevant others, including the right of a patient to:

7) be visited by the patient's nominated support persons, family, carers and other support persons (Section 280);
8) be visited by a health practitioner (Section 282), legal or other advisers (Section 283);
9) communicate with other persons (Section 284);
10) be given information about treatment and care (Section 285);
11) ensure that the patient understands the information (Section 286);
12) a second opinion to be obtained about a patient's treatment and care (Section 290).

Section 278 of the Act establishes that after admission of a patient to an authorised mental health service, the administrator of the authorised mental health service must: 1) explain the statement of rights prepared by the Chief Psychiatrist under the Act to the patient, ensuring that the patient understands the information given; 2) if requested, give a copy of the statement of rights to the patient and to the patient's nominated support persons, family, carers or other support persons. The administrator of an authorised mental health service must also display signs in prominent positions in the service stating that a copy of the statement of rights is available on request (Section 279).

Here we focus on the Statement of Rights, which is prepared by the Chief Psychiatrist under the *Mental Health Act 2016*. Section 277 of the *Mental Health Act 2016* states that the statements of rights contains information about:

- the rights of patients, nominated support persons, family, carers and other support persons under the Act
- the rights of patients to make complaints about the treatment and care provided at a mental health service and how complaints are made.

The Statement of Rights (the Statement) specifies that inpatients in a hospital have the right to:

- Be visited by family, carers and other support persons at any reasonable time. However, the Statement specifies that a person can be excluded from visiting if the service believes it would adversely affect the patient's treatment and care. This can be appealed to the Mental Health Review Tribunal.
- Be visited and examined by a health practitioner at any reasonable time under arrangements with the service.
- Receive timely, accurate and appropriate information about one's treatment and care.
- Be involved in decisions about one's treatment and care, and have important matters, including key clinical decisions, explained or discussed in an accessible way, for example, by having regard to the consumer's age, culture, mental illness, ability to communicate and any disability.
- Request the service to obtain a second opinion about one's treatment and care from another health practitioner. A family member, carer or other support person can also make this request.
- Receive written notices and other documents about important matters under the Act, such as hearings of the Mental Health Review Tribunal.
- Be visited by legal or other advisers at any reasonable time under arrangements with the service.
- Communicate with other persons by post, telephone or electronic communication device. However, the Statement specifies that this does not

apply if the other person asks that the communication does not take place, if there is a ‘non-contact’ condition of an order in place under the *Mental Health Act 2016*. The service may also restrict communication by phone or electronic device for a particular patient or patients if it is likely to be detrimental to the health and wellbeing of the patient or others.

Finally, the Statement specifies that if the consumer believes they should not be an inpatient in a hospital, but should be treated while living at home, they may apply to the Mental Health Review Tribunal to have this reviewed. A support person may also apply to the Tribunal on behalf of the consumer.

With regard to families and carers, the Statement specifies that inpatients have the right to appoint one or two nominated support persons to assist them if they become unwell and become an involuntary patient under the *Mental Health Act 2016*. A nominated support person has the right to:

- Receive a copy of the notices under the Act that the inpatient is entitled to receive
- Discuss confidential information about treatment and care with the inpatient’s treating team
- Support the inpatient, or represent the inpatient, at Tribunal hearings
- Request a psychiatrist report for the inpatient if they were to be charged with a serious offence.

5.4 Concluding remarks

The reviewed laws and frameworks all recognise the right of all persons to the same basic human rights, including the right to have the highest possible standard of physical and mental health. The rights to safety, respect, receiving information in a clear and open way, participating in decisions and choices about care, privacy and confidentiality, and commenting on care and having concerns addressed are listed by the Australian Charter of Healthcare Rights (ACSQHC, 2008), and included in the National Safety and Quality Health Service Standards, the National Standards for Mental Health Services, as well as the Mental Health Act 2016.

6. Independent Patient Rights Advisors

The *Mental Health Act 2016* established for the first time the positions of Independent Patient Rights Advisers (IPRAs). Section 293 of the *Mental Health Act 2016* states that authorised mental health services must have systems in place to ensure that patients are advised of their rights under this Act. As part of such systems, the health service chief executive responsible for a public sector mental health service must appoint one or more independent patient rights advisers. IPRAs can be an employee of an entity that a Hospital and Health Service has engaged to provide services, or an employee of a Hospital and Health Service but not employed in the Service's mental health service.

IPRAs play a very important role in liaising between clinical teams, patients and support persons. One key function of IPRAs is to advise patients and their nominated support persons, family, carers and other support persons of their rights under the MH Act (QLD Health, 2017c).

No critical research on the implementation of IPRAs or consumers' experiences of them has been found in the searches. Consequently, this section first describes the main characteristics of the role of IPRAs to then discuss them against similar roles, such as the Independent Mental Health Advisors in Victoria and in England.

6.1 Role of IPRAs

Section 294 of the *Mental Health Act 2016* states the functions of IPRAs, which are to:

a) Ensure the patient and the patient's nominated support persons, family, carers and other support persons are advised of their rights and responsibilities.

b) Help the patient and a patient's nominated support persons, family, carers and other support persons to communicate to health practitioners the patient's views, wishes and preferences about the patient's treatment and care.

c) Work cooperatively with community visitors performing functions under the Public Guardian Act 2014[10].

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[10] Community visitors independently monitor three different types of accommodation called 'visitable sites' where vulnerable adults live: disability accommodation provided or funded by the Department of Communities; authorised mental health services; and private hostels (level 3 accreditation) (OPG, n.d.). Differently from IPRAs, community visitors make inquiries and lodge complaints for, or on behalf of consumers (OPG, n.d.). Issues that community visitors may investigate include assessing: the adequacy of services for the consumers' assessment,

d) Consult with authorised mental health practitioners, authorised doctors, administrators of mental health services, and the Chief Psychiatrist on the rights of patients under this Act, the Guardianship and Administration Act 2000, the Powers of Attorney Act 1998.

e) In relation to Mental Health Review Tribunal hearings:

    - Advise the patient, and the patient’s nominated support persons, family, carers and other support persons of the patient’s rights at the hearings
    - If requested, help the patient engage a representative for the hearings

f) Identify whether the patient has a personal guardian or attorney and, if so, work cooperatively with the personal guardian or attorney to further the patient’s interests.

g) Advise the patient of the benefits of an advance health directive or enduring power of attorney for a personal matter.

IPRAs must act independently and impartially, and they are not subject to the direction of any person in relation to the advice given to a patient or a patient’s nominated support persons, family, carers or other support persons (Section 295).

The *Mental Health Act 2016* does not use the word advocacy in relation to IPRAs. However, Section 294(b) states that the functions of IPRAs include to ‘help the patient and a patient’s nominated support persons, family, carers and other support persons to communicate to health practitioners the patient’s views, wishes and preferences about the patient’s treatment and care’, which seems to entail elements of an advocacy role. The advocacy role is more prominent in other patient advisory roles in Australia and internationally, such as for example the Independent Mental Health Advocates (IMHA) in Victoria (IMHA, 2018b) and in England (SCIE, 2015).

6.2 Independent Mental Health Advisors in Victoria

In Victoria, The Mental Health Act 2014 (VIC Governement, 2014) states that people who receive compulsory treatment have the right to be involved in all decisions about their assessment, treatment and recovery, including the right to be supported in making or participating in those decisions.

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treatment and support; the standards of consumers’ accommodation; the appropriateness of consumers’ health and wellbeing; the provision of services in a way least restrictive of rights; the adequacy of the information available for consumers about their rights; the accessibility and effectiveness of the complaints process (OPG, n.d.). Where appropriate, community visitors have the power to refer complaints to an external agency, including the Department of Communities, Queensland Health, or the Residential Services Unit.

Independent Mental Health Advocates can help people who are on a compulsory treatment order, either in the community or as an inpatient, to understand and act on their rights in the mental health system, including (IMHA, 2017a):

- listen to what patients want and talk to them about their options;
- give them information and support to act on their rights;
- work with them so that they can have their say;
- refer them to other services as requested.

The IMHA service is advertised as independent, free and confidential. The service is delivered by Victoria Legal Aid and funded by the Victorian Department of Health and Human Services, but operate independently of government (IMHA, 2018a).

Although delivered by Victoria Legal Aid, IMHA is not a legal service. IMHAs do not provide medical or legal advice, state a preference about any course of action consumers wish to take, try to convince consumers to make a decision or comply with actions that others believe is in their ‘best interests’, represent consumers at Mental Health Tribunal hearings, provide case management or advocate on behalf of carers (IMHA, 2017b).

The IMHAs website states that, aside from giving information about people’s rights and supporting them to speak up about their assessment, treatment and recovery, IMHAs can also advocate for what consumers want. This means that, depending on the consumer’s situation, IMHAs can go to meetings with the consumer’s treating team and support them to have their say.

6.3 Independent Mental Health Advisors in England

In England, people who are treated under the MH Act, including both hospital patients and those who are on Supervised Community Treatment Orders or under guardianship, can receive help and support from an Independent Mental Health Advocate (IMHA). IMHAs are not a member of the medical or social care teams, and play no part in the patients’ treatment and care (Voice Ability, 2018).

The role of IMHAs is to support consumers to get their views heard by helping them to decide what they want, including:

- Explaining and exercising their rights;
- Request a review of their section through access to a mental health tribunal;
- Understanding how to raise concerns about their experience and/or care in hospital;

- Helping them to find out information about their treatment;
- Preparing and supporting them at meetings, ward rounds or care reviews;
- Being fully involved in their care planning;
- Helping them to find out whether any conditions or restrictions apply to them.

6.4 Concluding remarks

IPRAs have an important role in informing consumers of their rights under the *Mental Health Act 2016*. The Act does not refer to advocacy as being a function of IPRAs. This differentiates IPRAs from Independent Mental Health Advocates (IMHAs) in Victoria, where IMHAs can go to meetings with a consumer’s treating team and support them to have their say.

7. Conclusions

This report has summarised the findings of a scoping review of national and international literature on the project's five focus areas: the operation of the Mental Health Review Tribunal; rights and information regarding involuntary treatment in the community; advance health directives; rights and information for inpatients within mental health wards; the role of Independent Patient Rights Advisors. Each section has explored findings related to the effectiveness and implementation of each focus area, including research evidence on the consumers' experiences of them.

Traditionally, provision of mental health treatment has been informed by 'best interest principles', which assume that people with mental illness lack capacity to make decisions for themselves. The United Nations (UN) Convention of the Rights of Persons with Disabilities (CRPD) challenges best interest principles. In particular, the UN Committee has indicated that involuntary treatment is no longer permissible under the CRPD and that the focus should be on providing the support that people with lived experience of mental illness may need to choose the care and treatment they prefer. Supported decision-making entails a systemic response which implies wide networks of support, including from institutions, peers and advocate groups, who can give people a real opportunity to engage in an enabling dialogue around the issue they want to take a decision about (Gendera & Giuntoli, 2016).

The Australian Government ratified the Convention in 2008, inclusive of an interpretive declaration that retains 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. Overall, involuntary psychiatric treatment is still allowed and accepted in all but one Australian jurisdiction, i.e. Tasmania (Callaghan & Ryan, 2014). A person may be treated against their will, regardless of his or her ability to make their own decisions about treatment and care (Callaghan & Ryan, 2014).

The Queensland Mental Health Act 2016 (QLD MH Act 2016) has introduced some important changes, for example treating persons in a 'less restrictive way', the role of Independent Patient Rights Advisors (IPRAs), and promoting the use of advance health directives. These changes make the MH Act 2016 most closely realise the requirements of the CRPD comparatively to the other states and territories in Australia (Callaghan & Ryan, 2016).

However, there is a need to investigate the consumers' experiences of protection of human rights under the QLD MH Act 2016. The findings of the literature review will be used to provide a background for the discussion of the findings of the interviews on the experiences of consumers, carers and stakeholders of the implementation of the QLD MH Act 2016 across the five study focus areas.

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