International Journal of Law and Psychiatry 44 (2016) 30–40

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

An international comparison of legal frameworks for supported and substitute decision-making in mental health services

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ARTICLE INFO

Available online 28 August 2015

Keywords:
Mental health law
Mental capacity law
Guardianship
UNCRPD
Supported decision-making
Substitute decision-making

ABSTRACT

There have been important recent developments in law, research, policy and practice relating to supporting people with decision-making impairments, in particular when a person's wishes and preferences are unclear or inaccessible. A driver in this respect is the United Nations Convention on the Rights of Persons with Disabilities (CRPD); the implications of the CRPD for policy and professional practices are currently debated. This article reviews and compares four legal frameworks for supported and substitute decision-making for people whose decision-making ability is impaired. In particular, it explores how these frameworks may apply to people with mental health problems. The four jurisdictions are: Ontario, Canada; Victoria, Australia; England and Wales, United Kingdom (UK); and Northern Ireland, UK. Comparisons and contrasts are made in the key areas of: the legal framework for supported and substitute decision-making; the criteria for intervention; the assessment process; the safeguards; and issues in practice. Thus Ontario has developed a relatively comprehensive, progressive and influential legal framework over the past 30 years but there remain concerns about the standardisation of decision-making ability assessments and how the laws work together. In Australia, the Victorian Law Reform Commission (2012) has recommended that the six different types of substitute decision-making under the three laws in that jurisdiction, need to be simplified, and integrated into a spectrum that includes supported decision-making. In England and Wales the *Mental Capacity Act 2005* has a complex interface with mental health law. In Northern Ireland it is proposed to introduce a new *Mental Capacity (Health, Welfare and Finance) Bill* that will provide a unified structure for all substitute decision-making. The discussion will consider the key strengths and limitations of the approaches in each jurisdiction and identify possible ways that further progress can be made in law, policy and practice.

1. Introduction

This article seeks to reflect on issues of law, research, policy and practice in the context of what is described in international disability law as supported and substitute decision-making. To do so it will compare developments across four chosen jurisdictions: Ontario, Canada; Victoria, Australia; England and Wales; and Northern Ireland. We are particularly interested on decision-making that may be impaired due to mental health problems, because, in many jurisdictions, substitute decision making laws based on decision making ability—in particular, guardianship and other mental capacity laws—have been developed in parallel to existing and separate mental health laws. In a number of situations this has created complex overlaps and some logical inconsistencies that discriminate against people with mental health problems. To deal with this Dawson and Szmukler (2006) and Szmukler, Daw, and Callard (2014) have proposed that there should be a single or fused framework to facilitate interventions, based on a mental capacity approach, with appropriate safeguards for everyone.

Previous international comparisons of legal frameworks for decision-making have highlighted important commonalities and differences. Campbell, Brophy, Healy, and O'Brien (2006) focused on the use of compulsory powers in the community and made the important point that for any legal framework to be successfully and ethically implemented, adequate services and support must be available. Fistein, Holland, Clare, and Gunn (2009) compared 32 Commonwealth mental health laws and identified that only two of them, Scotland and South Africa, have included an ability-based capacity test for both hospitalisation and

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http://dx.doi.org/10.1016/j.ijlp.2015.08.029
0160-2527/

treatment. Gray, McSherry, O' Reilly, and Weller (2010) examined mental health laws across Australian and Canadian jurisdictions and concluded that mental health law in Australia has tended to have to have a stronger focus on treatment rather than a rights-based focus to be found in some Canadian laws. In the light of such comparisons, and a number of recent developments in policy and law, we later re-examine and compare some of these issues in the context of our chosen four jurisdictions.

Before doing so it is important to acknowledge some of the on-going debates that have been raised about supported and substitute decision-making, particularly with reference to the CRPD (Power, Lord, & DeFranco, 2013). The CRPD, and its associated jurisprudence (Committee on the Rights of Persons with Disabilities, 2014) have provoked discussion on a range of key questions about legal frameworks for supported and substitute decision-making:

(i) *Should mental health problems be framed and regarded as a form of disability?* Article 1 of the CRPD states that "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". This would suggest that long-term impairments due to mental health problems should be regarded as a form of disability. Kelly (2014) points out that this definition is not presented as being comprehensive, it includes people with long-term impairments but does not exclude others. It is hard to justify why short-term and/or fluctuating disabling mental health problems would not also raise the same issues and require the same protections. Substitute decision-making under mental health law, usually in the form of compulsory intervention, has traditionally been based on the criteria of mental disorder and risk.

(ii) *Is any form of substitute decision making necessary? And can any form of substitute decision making be compatible with the CRPD?* Article 12 of the CRPD requires States to: "recognize that persons with disabilities enjoy legal capacity on an equal basis with others" (12.2); that States "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity" (12.3); and States should "ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards" (12.4). There has been considerable argument about what 'exercising legal capacity on an equal basis with others' actually means. McSherry (2012) has asserted that legal capacity, as it is advanced in international human rights law, includes both a person's legal standing or status, and their legal agency or power to act. This notion of legal capacity is distinct from *mental* capacity, which refers to a designation of cognitive functioning. This suggests that even if a citizen is not able to make a specific decision, in other words they do not have the mental capacity to decide and cannot exercise their power to act, their legal rights should not be compromised, hence the need for 'appropriate and effective safeguards'. The terms 'supported decision-making' and 'substitute decision-making' are also contested, interpreted variously by commentators and governments. At issue is how states can adhere to the mandate of Article 12 to ensure that people with disabilities can be provided with 'support to exercise legal capacity' on an equal basis with others; this we argue below is a particularly challenging proposition in the context of mental health law and service provision. It would be concerning if this notion was to be interpreted as requiring the extreme libertarian or Szasz (1961) position where compulsory intervention, based on impairment due to mental health problems, should not be allowed in any circumstances.

(iii) *How can people with mental health problems be supported to make decisions?* Although making every effort to support people to make their own decisions is already considered good practice, Article 12 of the CRPD now requires states to: "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity" (12.3). This question raises a number of issues for practice, in particular the need for clarification between formal supports to ensure legal capacity and more general supports for decision making (Browning, Bigby, & Douglas, 2014). Then (2013) highlights remaining conceptual, legal and practical problems in defining and implementing supported decision-making. Reviews of the research evidence on what works in supporting people to make decisions suggest that, although there are some approaches that do appear to be effective for some people, further research is needed to develop effective, comprehensive supported decision making systems (Carney, 2014; Davidson et al., 2015; Kohn, Blumenthal, & Campbell, 2012).

In addition to the impact of the CRPD on debates about reforming mental health law and policy, two other significant issues in the literature are relevant to this article—risk assessment and effectiveness. Large, Ryan, Singh, Paton, and Nielssen (2011) have argued that risk assessment cannot sufficiently and accurately predict who is, or is not, going to harm themselves or others; the result is that a very high number of false positives are assumed (in other words people who are assessed as presenting a high risk who will not cause harm). Szmukler and Rose (2013) have further explored some of the unintended consequences of basing substitute decision-making on such an inaccurate process and highlighted its negative impact on trust in therapeutic relationships and in the consequent implications for social exclusion and discrimination.

The final development, which will only be considered briefly here, is the outcome of research into risk-based legal frameworks for involuntary treatment in community settings (often referred to as Community Treatment Orders (CTOs) or 'assisted outpatient treatment'). The most recent randomised controlled trial of CTOs (Burns et al., 2013), which compared brief to prolonged compulsion, mirrored findings from previous studies (Churchill, Owen, Singh, & Hotopf, 2007). The evidence indicates that assessment approaches focusing on the duality of mental disorder and risk, and subsequent restrictions on autonomy, do not appear to be an effective approach to reducing readmission rates in these contexts (Rugkåsa & Dawson, 2013).

Given the developments in research and in international human rights law noted above we believe that it is timely to consider current legal frameworks for supported and substituted decision-making in the context of mental health law, policy and context, in particular which aspects may need to be reformed or replaced.

2. Supported and substitute decision-making

Before examining each chosen jurisdiction it is useful to consider the meaning of the terms 'supported decision-making' and 'substitute decision-making.' The term 'supported decision-making' is not defined in the CRPD, but some understanding can be found in Article 12(3), particularly the obligation it places on States to provide 'access by persons with disabilities to the support they may require in exercising their legal capacity' on an equal basis with others. Hence, in international human rights law, 'supported decision-making' is *one* constitutive element of 'support to exercise legal capacity,' and refers to a person making a decision on his or her own behalf, with support in order to exercise his or her legal capacity (Browning et al., 2014). Further elaboration is provided by the Office of the High Commissioner for Human Rights in its United Nations (2007), which states that:

> *Supported decision-making can take many forms. Those assisting a person may communicate the individual's intentions to others or help him/*