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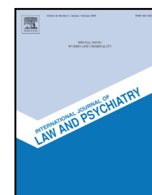
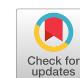


A new tool to assess compliance of mental health laws with the convention on the rights of persons with disabilities☆



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ABSTRACT

Since the introduction of the Convention on the Rights of Persons with Disabilities (2006) (CRPD), there have been calls to establish standards to measure compliance of domestic mental health laws with the human rights outlined in the CRPD. This article aims to address this gap by proposing a tool: the Analysis Instrument for Mental health (AIM). In particular, the tool's purpose is to enable states and civil society to assess the compliance of non-forensic domestic mental health laws with Article 12 of the CRPD. It responds to Dawson's (2015) call for a mechanism designed to provide clear and measurable standards for which to undertake this exercise. The content of AIM draws directly from the authoritative interpretation of Article 12 provided by the United Nations Committee on the Rights of Persons with Disabilities (the Committee) in its General Comment, as well as the substantial body of academic and other literature about Article 12.

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1. Introduction

The *Convention on the Rights of Persons with Disabilities* (2006) recognises the fundamental right of a person with disability (including mental illness), to exercise legal capacity, and make and act upon their own decisions (CRPD, 2006, art. 12(3); preamble paras. (n), (j); United Nations Committee on the Rights of Persons with Disabilities, 2014, paras. 3, 14–17). In recognising this right, the CRPD demands a paradigm shift away from substitute decision-making towards supported decision-making. However, this is problematic for traditional mental health laws. Such laws generally provide legal mechanisms for another person (most often a doctor)[1] to authorise involuntary treatment for mental illness where certain criteria are met, such as where the person does not have mental 'capacity to consent' to their own mental health treatment and care (Rosenman, 1994). A key issue for the state, as well as a person with mental illness treated under traditional domestic mental health laws, is that this right to exercise legal capacity is rendered meaningless if mental health laws neither recognise, nor make provision for upholding the exercise of legal capacity at law.

This failure of mental health laws to comply with the CRPD has been identified as a long-standing problem, yet there has been limited change to such laws (Committee, 2014).[2] One identified barrier to legislative reform is the lack of certainty regarding what CRPD-compliant mental health laws should look like. This uncertainty has also impeded measuring and gathering evidence of compliance, or non-compliance, in order to advocate for legislative change. Since the introduction of the CRPD, there have been calls for the establishment of standards that domestic mental health laws should meet in order to satisfy compliance (Dawson, 2015). While there are two existing audit tools to measure legislative compliance with human rights in mental health laws (the *WHO Resource Book on mental health, human rights and legislation* and the *Rights Analysis Instrument*), these are based on rights set out in the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991) (MI Principles). As such, they are now outdated and indeed conflict with current international human rights as set out in the CRPD. This article aims to address this gap by proposing an audit tool that would enable states and civil society to assess the compliance of non-forensic[3] domestic mental health

☆ Declarations of interest: Marion Byrne is employed by the Office of the Public Guardian in Queensland. The Office of the Public Guardian is an independent statutory office that protects the rights and interests of vulnerable Queenslanders, including adults with impaired capacity to make their own decisions.Ben White and Fiona McDonald have no conflicts of interest to declare.

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[1] For example, while a doctor may be the most likely person to authorise treatment and care, some laws use alternative mechanisms such as the use of guardians or attorneys to obtain consent to treatment. See for example the 'less restrictive way' under section 13 of the *Mental Health Act 2016* (Queensland) Australia.

[2] The Committee on the Rights of Persons with Disabilities observed Article 12 requires the abolition of legislative provisions and practice that did not comply with the right to equal recognition before the law. See in particular paragraphs 7 and 42.

[3] Non-forensic laws are understood within this paper to concern involuntary commitment laws. Criminal or forensic mental health laws are currently outside the scope of this paper and AIM.

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laws with Article 12 of the CRPD. The tool, entitled the Analysis Instrument for Mental health (AIM), responds to Dawson's (2015) call for a mechanism designed to provide clear and measurable standards for which to undertake this exercise. In becoming a signatory to the CRPD, states have a duty to instantiate the human rights contained within it and should be held accountable for their action or inaction in this regard. The main objective of using an audit tool is to identify, analyse and measure the commitment of governments to enact the provisions of a key article of the CRPD into domestic law. AIM enables governments, or other parties, to undertake a robust, criteria-based assessment of the degree of commitment by governments to Article 12 in their mental health legislation. Some countries, such as for example Australia, have become signatories to the CRPD but noted that they believe Article 12 still allows substitute decision-making as a last resort and with appropriate safeguards. While mental health legislation in these jurisdictions may not prima facie be compliant with the Committee's interpretation of Article 12, there is still merit in using AIM in such jurisdictions. This is because a finding of non-compliance in relation to this aspect of Article 12 is significant and appropriate to note. But AIM also steps beyond this threshold aspect of Article 12 and allows the degree of compliance or convergence to be assessed in relation to the other rights guaranteed under this Article. AIM is limited to measuring compliance with Article 12 of the CRPD, although it also examines other Articles of the CRPD as they interact with Article 12. This focus of AIM is justified as Article 12 proposes a paradigm shift in an approach to protecting and promoting the rights of persons with mental disability, which is central to the design of mental health legislation. This is reflected in the significant body of literature that examines only the role of Article 12 in shaping mental health and other legislation (Freeman et al., 2015; Gooding, 2017; Quinn, 2010; Szmukler, 2015). The Committee has also noted that Article 12 is indispensable for the exercise of other human rights (Committee, 2014). Additionally, while other Articles in the CRPD are important to realise the rights of persons with mental illness or other disabilities, but are not necessarily contained within mental health legislation.

The article begins by outlining the way in which the achievement of human rights norms can be measured in legislation, including a discussion of two earlier audit tools. It then introduces the AIM tool, outlining its scope and how it should be applied. The article next turns to matters of substance, providing a short overview of Article 12 underpinning AIM before outlining the tool, its core rights and key indicators.

A final point is that we acknowledge our objective is ambitious. We recognise that the boundaries of the tool and the inclusion or not of particular indicators (or how they are expressed) will attract comment and critique. We welcome this debate and put forward the AIM tool with the hope that it will generate further discussion about how best to measure compliance of domestic mental health laws with the CRPD.

2. Measuring human rights in legislation

National, provincial or territorial based legislation is the primary mechanism used to incorporate human rights into the domestic legal framework, and to provide enforceability of these rights at law. Legislation can declare rights, offer the prospect of justiciable rights, and provide a person with standing in the judicial system to enforce human rights. Without such mechanisms for enforcement, the promise of human rights can be illusory and without substance in reality (Kaiser, 2009). For, when legislation provides for a right without limitation, it simultaneously commits a government to funding and resourcing recognition of such rights (Freeman & Pathare, 2005; Kaiser, 2009; McSherry & Wilson, 2015).

A roadblock to legislative reform can arise where legislators are unsure of how to legislate and enforce human rights, particularly those seen as 'aspirational'. The challenge is to provide tangible 'standards' or 'benchmarks' for aspirational rights against which to measure compliance, while catering for a variety of legislative approaches that can give effect to the aspirational intent and aim of human rights. Accordingly, measurement or audit can be a powerful means to drive law reform. Audit tools can provide tangible evidence to governments to see how, and to what extent, their laws comply with human rights norms and can provide impetus for change (United Nations Development Programme, 2000; Watchirs, 2002, 2005).

2.1. Two existing audit tools: WHO and RAI

There are only limited examples of tools designed to assess whether policy or legislation complies with human rights norms,[4] with two that were designed for the mental health context. One is the *WHO Resource Book on mental health, human rights and legislation* (the Resource Book) (Freeman & Pathare, 2005) developed by the World Health Organization (WHO). The other is the *Rights Analysis Instrument* (RAI) developed in the late 1990s by the Australian Commonwealth government (Watchirs, 2002).[5] The pilot version of the RAI was later revised into an 'Audit Tool' and adapted to measure human rights compliance within Australian legislation regarding persons with HIV/AIDS (Watchirs, 2002). These tools were not designed to measure specific functions or outcomes such as human rights 'enjoyment', or service delivery and practice, and were not intended to be the sole measure by which to ensure full compliance with human rights norms (Watchirs, 2005). Rather, these tools were designed to measure human rights within mental health legislation.

The Resource Book was the culmination of over a decade of work by the WHO to assist interpretation of the MI Principles (Freeman & Pathare, 2005; Weller, 2010). Its purpose was to provide a broad overview of human rights for people with mental disabilities and guide development of mental health legislation according to human rights principles. The Resource Book adopts a predominantly qualitative approach to guide review of legislation. It uses a flexible checklist of questions set out in a detailed annexure, the 'WHO Checklist on Mental Health Legislation' (the Checklist),[6] to assist operationalising human rights in legislation (Freeman & Pathare, 2005; Kelly, 2011).[7] The Checklist was not intended to be absolutely comprehensive in its operation, nor to act as a set of absolute rules (Kelly, 2011). Governments could use the Checklist when drafting or reviewing mental health legislative compliance with human rights norms (Freeman & Pathare, 2005).[8] An

[4] The United Kingdom engages an Equality Impact Assessment (EqIA) to assess how disadvantaged or vulnerable persons may be affected by proposed actions or decisions through a policy, project or scheme (Dhand, 2016). This developed out of the Race Equality Impact Assessment, which was a tool that was used in assessing various pieces of mental health legislation in 2004 and 2006. See also https://www.gov.uk for examples of EqIAs conducted across Government. Completion of an EqIA is intended to influence the policy or project by identifying, removing, or mitigating any negative impacts identified through the assessment. See the Scottish Government website for guidance of EqIAs under the *Equality Act 2010* (Scotland) http://www.gov.scot/Topics/People/Equality/Equalities/EqualFramework/EvidencePSED/EQIA accessed 11 February 2017. Due to the resource intensive nature of the process while an EqIA may be used as a means of ensuring the public-sector equality duty is met under the *Equality Act 2006* (UK), they are not mandatory for Government decisions in the UK. The Scottish Recovery Indicator tool is also another tool designed to assist mental health services in Scotland to assess and design services supporting recovery focused practice. As the tool is not primarily a tool for measuring legislation, it is not explored further. For further information see the Scottish Recover Indicator at http://www.sri2.net available as at 9 June 2017.In Canada, the Cultural Analysis Tool (CAT) has been developed for health practitioners to address issues of culture and equity for ethno-racial people who have a mental illness and are subject to Ontario's civil mental health laws (Dhand, 2016). CAT provides practitioners with questions (guided by key factors) to use when addressing culture and equity issues for persons with mental illness who are from different ethno-racial backgrounds.

[5] The RAI was later developed into an audit tool that was adapted to audit Australian legislation in relation to protection and promotion of human rights in the area of HIV/AIDS.

[6] The Checklist is comprised of 175 individual standards grouped into 27 categories.

[7] See Annex A.

[8] The WHO recommended that a committee be used to conduct the assessment, preferably comprised of persons with broad experience in mental health, and general law to foster debate in reaching a consensus (Freeman et al., 2015; Kelly, 2011). This could include legal practitioners familiar with the relevant national laws, mental health representatives from government, service users and families or carers, practitioners and non-government organisations, overseen and mediated by an independent human rights and/or legal expert (Freeman et al., 2015).

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