Measuring the impact of revised mental health legislation on human rights in Queensland, Australia

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Abstract

The Convention on the Rights of Persons with Disabilities (2006) (CRPD) has been instrumental for initiating and shaping the reform of mental health legislation in many countries, including the eight Australian jurisdictions. Multiple approaches have been proposed to assess and monitor the compliance of States Parties' mental health legislation with the CRPD, and to evaluate its success in protecting and promoting the human rights of people with disabilities. This article reports an effort to index the impact of legislation on human rights by measuring changes in the prevalence of compulsory treatment orders applied to people with mental illness after the introduction of CRPD influenced mental health legislation in the Australian state of Queensland. We found that despite reforms intended to enhance patient autonomy, the prevalence of compulsory treatment orders increased after implementation of the new legislation. Possible reasons behind this unintended consequence of the legislative reform may include a lack of systematized voluntary alternatives to compulsory treatment, a paternalistic and restrictive culture in mental health services and risk aversion in clinicians and society. We recommend that the reforms in mental health policy as well as legislation need to go further in order to achieve the goals embodied in the human rights framework of the CRPD.

Keywords: Mental health legislation, compulsory treatment, human rights, autonomy, forensic orders, mental illness, CRPD

1 Introduction

Mental health legislation and its implementation in policies and practice can either protect or adversely affect human rights (Gostin & Gable, 2004). While improvements in the care and support provided for people with mental illness are mediated by the systems and frameworks within individual states, the structure and ongoing refinement of these

systems are influenced by the moral suasion of academic and international opinion (Callaghan & Ryan, 2012; Donoho, 1992). The United Nations and the World Health Organization have a prominent role in gathering information about the determinants of health and wellbeing across the world and lead the debate on desirable and acceptable practice in the clinical and legal frameworks for the management of mental illness. As a result, efforts to protect and promote the human rights of people with mental illness in any region must consider not only local legal, social, and administrative features of mental health care, but also the international environment within which they occur. This article will argue that the successful translation of principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) into improvements in the health and wellbeing of people requires systematic empirical verification of the effects of the CRPD-inspired legislation, alongside analysis of the compliance of States Parties' legislation with the Convention. We discuss these issues within the legislative framework of the Australian state of Queensland.

1.1 The CRPD and the Australian Mental Health Laws

The CRPD was adopted by the United Nations in New York on 13 December 2006 after a process of negotiations among various stakeholders including UN representatives, mental health professionals, organizations working in the field and service-user and carer bodies, spanning approximately five years (United Nations, 2006). Article 4 of the CRPD requires States Parties to adopt appropriate legislative, administrative and other measures for the implementation of the rights recognized in the Convention. As per article 34, a 'Committee on the Rights of Persons with Disabilities' (hereafter called the CRPD Committee or the Committee) has been established to monitor implementation of the CRPD. States Parties are obliged to submit periodic reports about implementation of

the Convention to the CRPD Committee. Furthermore, the countries which ratified the optional protocol of the CRPD are, as a result, subject to inquiry by the CRPD Committee, following communication from individuals or groups indicating serious or systemic violations of the Convention (United Nations, 2006).

Australia ratified the CRPD in July 2008 and the optional protocol in 2009. The CRPD entered into force for Australia on 16 August 2008 (Australian Law Reform Commission, 2013). Australia has a dualist legal system in which the international conventions do not become part of Australian law until incorporated into domestic legislation (Australian Law Reform Commission, 2014), rather than a monist system, where the international conventions become part of the domestic law once the State ratifies the convention (Series, 2019). While signing the CRPD also made it obligatory for Australia to amend domestic legislation and develop frameworks sufficient for its implementation and maintenance, enforcement of breaches of these obligations is problematic. At the time of signing the Convention, Australia made an interpretative declaration, which included (Australian Law Reform Commission, 2013) –

> *Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards; and*
>
> *Australia further declares that the Convention allows for 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 CRPD Committee has repeatedly urged Australia to withdraw the interpretative declarations on articles 12, 17 and 18 of the Convention (United Nations Committee on the Rights of Persons with Disabilities, 2013, 2019). Australia has maintained the positions adopted by these interpretative declarations, and retained substitute decision-making and compulsory psychiatric treatment in guardianship laws as well as mental health legislation.

Australia is a federation comprising six states and two territories. While ratification of international instruments like the CRPD is enacted by the Commonwealth Government representing the national interests of the federation, mental health legislation is enacted at state or territory level, with the result that each jurisdiction has a different Mental Health Act. At present these eight Acts are broadly similar, including in the influence of the CRPD on their most recent revisions. Each jurisdiction's legislation includes provisions that establish the conditions under which compulsory psychiatric treatment may be required of patients experiencing mental illness, which may include periods of compulsory admission to hospital as well as periods of adherence to treatment while living in the community.

By world standards, community treatment order (CTO) use in Australia is high and rising, with considerable variations across states (Light, 2019; Light, Kerridge, Ryan, & Robertson, 2012). For example, in Queensland the percentage of community mental health contacts in the public sector which were compulsory increased from just under 9% in 2005-6 to 22% in 2016-17 (Figure 1) (Kisely, Moss, Boyd, & Siskind, 2020). By contrast, the proportion of compulsory community contacts in Western Australia over the same period never exceeded 4% (Figure 1). Studies of the effectiveness of compulsory

treatment have been limited to CTOs as opposed to forensic orders. A Cochrane systematic review of the impact of CTOs on the outcomes for patients with mental illness found only three randomised controlled trials, two from the United States and one from Great Britain (Kisely, Campbell, & O'Reilly, 2017). CTOs did not reduce health service use or improve social functioning, psychiatric symptoms, quality of life or satisfaction with care. Studies in Australia have been restricted to analyses of administrative data comparing people on CTOs with voluntary controls using matching or multivariate techniques to adjust for confounding. Results have been mixed with any benefit requiring a minimum of two years' use (Burgess et al., 2006; Harris et al., 2019; Kisely et al., 2020; Kisely et al., 2013; Kisely, Xiao, & Preston, 2004; Segal, Hayes, & Rimes, 2017). The effectiveness of compulsory inpatient treatment has never been formally assessed, given the practical and ethical difficulties of finding suitable controls for a study.

Insert Figure 1 here

1.2 Queensland Mental Health Legislation

Queensland has had a series of laws legislating the treatment of mental illness since the Lunacy Act of 1869 which instituted reception houses which would accommodate people who were, or were likely to be, committed to an asylum.[1] Major revisions in 1962, 1974, 1985, and 2000 expanded access to services, and added safeguards such as a Mental Health Tribunal which determined a criminal offender's suitability for a mental health

[1] *Lunacy Act 1869* (Qld).

defense.[2] Replacing the 1974 Act, the Mental Health Act 2000 (MHA 2000) added a definition of mental illness;[3] the concept of capacity and the need for immediate assessment or treatment in a 'no less restrictive way'.[4] It also allowed ambulance officers to transport persons to a mental health facility for an involuntary assessment where it was previously restricted to police officers.[5] The MHA 2000 introduced involuntary treatment in the community,[6] provided a statement of rights which was to be made available to patients and enshrined regulations on prohibited treatments, seclusion and restraints.[7] This Act permitted involuntary treatment orders (ITOs) both where patients lacked the capacity to make decisions about their own health-care, and where they had unreasonably refused care without reference to capacity.[8]

The Queensland Mental Health Act 2016 (MHA 2016), which replaced the Mental Health Act 2000 (MHA 2000), was intended to improve the human rights of patients, including by minimizing compulsory treatment (Queensland Health, 2017). Section 3(2) states that '*the main objects (of this Act) are to be achieved in a way that safeguards the rights of persons and is least restrictive of rights and liberties of a person who has a mental illness.'* We aimed to explore if the MHA 2016 has been successful in that objective, by measuring the prevalence of compulsory treatment orders.

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[2] *Mental Health Act 1974* (Qld) s 28b.

[3] *Mental Health Act 2000* (Qld) s 12.

[4] Ibid s 9, 14.

[5] Ibid s 33.

[6] Ibid s 109.

[7] Ibid s 344, 162.

[8] Ibid s 14(1f).

The MHA 2016 has three categories of compulsory treatment order – Forensic Order (FO), Treatment Support Order (TSO) and Treatment Authority (TA). Patients who have been diverted from the criminal justice system before trial as a result of unsoundness of mind or unfitness for trial due to a mental illness may be managed under a FO or a TSO. These orders are initiated by a specially constituted mental health court, presided over by a judge assisted by two psychiatrists. Most patients subject to compulsory treatment are not involved with the criminal justice system. For these patients a third type of order called a 'Treatment Authority' (TA) is used when a psychiatrist determines that the person has a mental illness, lacks capacity to consent to treatment and there is an imminent risk of harm to self or others or risk of serious mental or physical deterioration in the absence of involuntary treatment. Each type of order can be in place during inpatient or community episodes of care. All are subject to periodic review (every six or twelve months) by a Mental Health Review Tribunal (MHRT) comprising a psychiatrist, a lawyer, and an appointed community member. A TA can be revoked by the treating psychiatrist, whereas an FO or TSO can only be revoked by the MHRT. The following tables describe the requirements for compulsory treatment under each type of order.

Insert Table 1 here

Insert Table 2 here

The TSO was created by the MHA 2016 as a step-down from a FO (Queensland Health Office of the Chief Psychiatrist, 2020a, 2020b). Both the FO and TSO can be either

inpatient- or community-based,[9] but the TSO is considered to be less restrictive[10] because it is presumed that it will be of the community category unless the Mental Health Court believes it necessary for the patient to be in hospital, while it is presumed that a FO will be inpatient unless the Mental Health Court is satisfied that there is not unacceptable risk to the community. Furthermore, the treating psychiatrist can change the category of TSO from inpatient to community, whereas for FOs, the treating psychiatrist has to apply to the MHRT to request a change of category from inpatient to community.

While the intention of introducing TSOs was to reduce the time spent under the most restrictive category of compulsory treatment, moving from an FO to a TSO may not have a significant impact on a patient's experiences or perceived level of autonomy. Table 3 shows that the clinical criteria for FOs and TSOs are identical, and the main differences between the orders are procedural. For example, FO hearings before the MHRT require a representative of the Attorney General (AG), but TSO hearings do not. Furthermore, FOs require regular six-monthly reviews by an ad-hoc Acute Risk Management Committee (ARMC) comprising key members of the treating team and senior representatives of the clinical governance framework of the local mental health service; but ARMC review is required for TSOs only if there is a significant risk issue, a change of circumstances, or a plan to revoke the Order (Queensland Health Office of the Chief Psychiatrist, 2020a, 2020b). As the major difference between an FO and a TSO is that under a FO the decision whether to treat a patient in an inpatient facility or in the community is removed from the psychiatrist, introduction of the TSO has increased the clinical discretion of

[9] *Mental Health Act 2016* (Qld) s 138, 139, 140, 145.

[10] Ibid s 130.

psychiatrists without necessarily increasing patient autonomy. As the legislative criteria as well as the patient experiences under FOs and TSOs are essentially identical, we consider them together.

The Mental Health Act 2016 (Qld) (MHA) Schedule 3 defines a forensic patient as 'a person subject to a forensic order' and lists three types of forensic order (FO): 'mental health', 'disability' and 'criminal code', which have been described in the Table 3.

Insert Table 3 here

2 Interpretation of the CRPD article 12

The extent to which Queensland legislation complies with international standards is significantly influenced by how the CRPD is interpreted. Of central importance are article 12 - 'persons with disabilities have the right to equal recognition before the law'; article 14 - 'the existence of a disability shall in no case justify a deprivation of liberty'; and article 17 - 'every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others' (Callaghan & Ryan, 2014; United Nations, 2006). General comment 1 (GC 1) on article 12 issued by the CRPD Committee interprets article 12 as proscribing compulsory treatment in all circumstances (United Nations Committee on CRPD, 2014). As noted above, the Committee has repeatedly stated that Australia's interpretative declaration and Australian mental health laws violate the CRPD by allowing substitute decision-making (United Nations Committee on the Rights of Persons with Disabilities, 2013, 2019). The CRPD Committee argues that when a patient with limited capacity is faced by a health decision, efforts should focus on optimizing their

capacity to decide by providing meaningful information at an appropriate level of detail with adequate cognitive and social supports (supported decision-making) rather than identifying the best person or institution to make a decision on their behalf (substitute decision-making).

The practical, legal, and ethical implications of GC 1 have received considerable attention. The CRPD Committee asserts that individual autonomy, will and preferences must be respected for all people, with supported decision-making implemented in place of substituted decision-making in all circumstances (United Nations Committee on the Rights of Persons with Disabilities, 2014). Others have argued that for people with varying degrees of mental capacity, full access to the right to refuse treatment may sometimes disrupt the right to access optimal health care. As a result, failing to account for decision-making capacity in some cases may jeopardize the right to the highest attainable standards of physical and mental health, social inclusion and adequate standard of living (Callaghan & Ryan, 2014; Freeman et al., 2015; Gill, 2019). While there appears to be general agreement that supported decision-making should be the standard in almost all circumstances, this debate remains unresolved in situations where an individual completely lacks decision-making capacity. The CRPD Committee argues that these situations should be managed by a "best interpretation" of the person's will and preferences, while critics note that this appears to be a form of substitute judgement, with the corollary that the CRPD cannot be interpreted as completely prohibiting substitute judgement (Craigie et al., 2019). The debate is complicated by inconsistencies between the CRPD and other international instruments and UN entities (Guilloud, 2019).

Given this background, one approach acknowledges the crucial importance of patient autonomy, by minimizing constraints on both the right to refuse treatment and the right

to receive treatment. Consistent with article 12(4) of the CRPD, this approach highlights that measures limiting the exercise of legal capacity must be tailored to the person's circumstances, free of conflict of interest or undue influence and subject to safeguards and independent monitoring. They must also respect the person's rights, will and preferences, and apply for the shortest possible time. This is consistent with the compromise suggested by Dawson (2015) and others, that while supported decision-making should be the default approach, substitute decision-making, including compulsory treatment, must be available as a last resort, under exceptional circumstances, with strong safeguards (Callaghan & Ryan, 2014; Dawson, 2015; Freeman et al., 2015; Gill, 2019). This empirical analysis of MHA 2016 is based on this interpretation of the CRPD.

Freeman et al. (2015) have argued that an insistence on the immutable presence of legal capacity is particularly problematic for the management of those who commit legal offences while lacking capacity. This position would prevent diversion of mentally ill offenders from the criminal justice system to mental health and welfare systems (Freeman et al., 2015). The MHA 2016 does not adopt this position, but seeks to balance the rights of autonomy and wellbeing by encouraging supported decision-making where possible, by limiting the instances in which compulsory treatment can be ordered, and by imposing stringent safeguards in its use. This includes the use of the least restrictive conditions for the shortest time, with frequent review by the MHRT, independent of the treating team and service.

2.1 Compliance of Queensland mental health legislation with the CRPD

A strong criticism of the MHA 2000 was that it allowed compulsory treatment where a patient who retained full mental capacity had 'unreasonably refused' treatment in the judgement of a psychiatric doctor, with no definition of unreasonable refusal (Gill, Allan, Clark, & Rosen, 2020). In evaluating this criticism, it is useful to compare the application and consequences of relying upon "unreasonable refusal" as opposed to "lack of capacity" to justify substitute judgement in treatment decisions. While under the MHA 2000 both criteria were based upon the judgement of a qualified doctor, the former refusal was unrelated to established clinical or legal practices, precedents, or theories and was therefore subjective. By contrast, the assessment of capacity is a specific clinical skill that is a standard component of medical curricula, as well as a well-established legal concept routinely applied in criminal and civil law. Perhaps more importantly, unreasonable refusal did not specify a lack of capacity but that the patient's decisions were unacceptable to an individual doctor at a particular point in time.

Decisions about compulsory treatment in the context of mental illness are often made in emergency situations, with incomplete information, and may be associated with serious harm to patients and others. A clause which allowed compulsory treatment despite capacity based entirely on a subjective opinion led to conflicts of interest by allowing doctors the discretion to prioritize immediate risk reduction over patient's right to autonomous action.

While the "unreasonably refused" criterion unequivocally violated patients' right to refuse treatment, it also could not be justified by the compromise approach described above, as a patient with mental capacity has both the legal right and the mental ability to

determine what constitutes optimal care, so neither supported nor substitute judgement can apply.

Responding to this line of criticism, the MHA 2016 removed the "unreasonably refused" clause[11] and emphasized patients' ability to understand the nature of the illness and treatment, the consequences of not receiving treatment, and the ability to make and communicate a decision. In limiting the instances that justify compulsory treatment, the MHA 2016 therefore took a welcome step towards recognizing the principle of individual autonomy (Gill, Allan, Clark, & Rosen, 2020). Furthermore, the MHA 2016 gave people with disabilities the right to be assisted by another person in achieving the understanding necessary to have capacity under the Act. This represents a shift towards supported decision-making as advocated by the CRPD Committee through the General Comment 1 on article 12 (United Nations Committee on the Rights of Persons with Disabilities, 2014).

The MHA 2016 increased the emphasis on treating patients in the least restrictive manner. Less restrictive options than compulsory treatment include treating according to an advance health directive and administering treatment with the consent of a guardian or attorney, where available.[12] While these provisions do not achieve the move from substitute to supported decision-making for all patients lacking mental capacity required by the CRPD, they do expand the group of patients for whom supported decision-making is feasible, and attempt to increase all patients' control over their treatment. They explicitly require treating doctors to consider and use in their reasoning

[11] *Mental Health Act 2016* s 12(1b).

[12] Ibid s 13(1).

the impact of clinical and legal decisions including compulsory treatment on patients' and others' rights to safety, autonomy and best possible treatment. The Act's recognition of supported decision-making is enhanced by the appointment of nominated support persons.[13] All these options expand the autonomy of the patient — by permitting the patient to have a direct say in their treatment and through the effective creation of an agency that acts in accordance with the will and preference of the patient.

Another novel feature of the MHA 2016 is the express recognition of the rights of patients and others. These include patients' rights to be visited by nominated support persons and family,[14] and by their health practitioner or legal advisors.[15] The Act also gives patients a right to a second opinion about their treatment. Furthermore, the Act requires the Chief Psychiatrist to prepare statements of rights that are widely available.[16]

The MHA 2000 required a mandatory psychiatrist report regarding unsoundness of mind and fitness for trial whenever any patient subject to compulsory treatment was charged with an offence, in order to allow for the diversion of patients from the criminal justice system to appropriate treatment.[17] While diversion was intended to improve patient access to care, and avoid legal and ethical dilemmas arising from involving patients with limited mental capacity in legal processes such as advising counsel, making a plea, and participating in a trial, diversion can also have negative consequences for patients. Most

[13] Ibid s 223, 224.

[14] Ibid s 281.

[15] Ibid s 282, 283.

[16] Ibid s 277, 278, 279, 290.

[17] *Mental Health Act 2000* (Qld) s 238.

fundamentally, patients diverted to treatment after being accused of an alleged offense are never subject to the processes of investigation and trial that might establish their innocence. Many patients diverted to forensic psychiatric treatment from the criminal justice system prefer the certainty of a jail sentence to the open ended timeframe of admission. MHA 2016 removed the mandatory request for a psychiatrist report, and returned the decision whether to request such a report to patients and advocates, should they prefer to access a 'mental health defense' (unsoundness of mind at the time of the alleged offence or unfitness for trial), instead of resolving matters through the criminal justice system.[18] By removing the mandatory psychiatrist's report, MHA 2016 has increased patients' influence over whether they should be diverted from the criminal justice system to treatment. The only exception is that MHA 2016 allows the Chief Psychiatrist to request a psychiatrist report to protect public safety.[19]

Together, the reforms of the MHA 2016 attempted to improve compliance with the CRPD by removing the option to initiate compulsory treatment for "unreasonable refusal" of treatment, facilitating supported decision-making, requiring the least restrictive means of treatment possible, and increasing autonomy regarding diversion from the criminal justice system. The MHA 2016 mechanisms enhancing the human rights of people with mental illness are outlined in Table 4.

A qualitative study that interviewed patients and their advocates as well as clinicians and other stakeholders about the impact of MHA 2016 on experiences of care and caring

[18] *Mental Health Act 2016* (Qld) s 20.

[19] Ibid s 92, 93.

reported that while all parties had positive responses to the intended effects of the legislative changes, their experiences were not consistent with significant changes in service practice or patient outcomes. Participants speculated that the limited impact of legislative change on lived experiences might include: a) barriers to implementation, such as a risk averse culture within the tribunals with oversight of compulsory treatment, a lack of relevant expertise or training in staff expected to implement the legislation, and unanticipated procedural problems leading to adjournments and other delays; and b) a lack of specific safeguards in the legislation, such as limited mechanisms for advocates to challenge physical and chemical restraint of patients (Giuntoli et al., 2019).

Insert Table 4 here

3 Measuring the impact of legislation on human rights

Implementation of principles embodied in human rights treaties may be illusory and not automatically achieve the intended ends. (Posner, 2014). In addition, Guilloud (2019) has highlighted the inconsistency between the CRPD Committee's position on the compulsory treatment of those with disabilities and that of the Human Rights Committee, which appears to have endorsed compulsory treatment as the last resort where disability is accompanied by risk (Guilloud, 2019). Although Guilloud notes that the principle of *lex specialis derogat legi generali* ('special law repeals general laws') suggests the CRPD should have primacy in the area of disability, these inconsistencies may be used by States Parties to justify non-implementation of the Convention's more challenging aspects including the proscription of compulsory treatment. As the impact of international law on individual outcomes is complicated not just by the fidelity of implementation, but by

contested areas of the law itself, we argue that empirical data are required to evaluate how changes to legislation motivated by the CRPD affect human rights outcomes. In the absence of data, reform will be driven purely by theoretical considerations which do not guarantee improved access to human rights. To this end we assessed the impact of MHA 2016 on the human rights of patients in Queensland managed under compulsory psychiatric treatment.

We specifically investigated if the legislative changes of the MHA 2016 resulted in a shift away from substitute decision-making in clinical practice, as required by the CRPD. We conducted an observational study design comparing the number of FOs, TSOs and TAs in the three years before the implementation of the Act in March 2017, i.e. the period from 1st of July 2013 to 30th of June 2016, to the corresponding numbers in the three years subsequent, from 1st of July 2017 to 30th of June 2020. The financial year of 2016 to 2017 was not included in this study as both the MHA 2016 and MHA 2000 were in effect for different parts of this year. For each financial year during this period, the following numbers were recorded:

- the number of FOs and TAs made during the year;
- the number of FOs and TAs ended during the year;
- The number and proportion of MHRT hearings that resulted in revocation of FOs and TAs by the MHRT; and
- the total number of FOs and TAs at the end of the financial year.
- Since the MHA 2016 introduced the new category called Treatment Support Orders (TSOs) as described above, the total number of TSO's at the end of financial years after the implementation of MHA 2016 were also recorded (i.e. on 30 June 2018, 2019 and 2020).

- The number of TSO's at the end of each financial year after the implementation of the MHA 2016 was added to the corresponding number of FO's, given the criteria of TSO and FO are identical, as described above.

All data were sourced from the Chief Psychiatrist Annual Report and the MHRT Annual Report published for each financial year by the Office of the Chief Psychiatrist Queensland and the MHRT respectively. Prevalence of FOs and TAs at the end of each financial year was calculated using Queensland population data sourced from the Queensland Government Statistician's Office.

Forensic Orders:

Table 5 outlines the number and prevalence of FOs and TSOs during six financial years (2013-2020). One financial year (1 July 2016 – 30 June 2017) has been omitted owing to the implementation of the Mental Health Act during this year on 5 March 2017.

Insert Table 5 here

There was an increase in the number of FOs in the three years before the implementation of the MHA 2016, however this increase was not statistically significant. In the three years following the implementation of the MHA 2016, confidence intervals reveal a significant increase in the total number of FOs and TSOs, considered together. Whilst the total number of FOs decreased in the years 2018-2020 compared to the previous year, the larger increase in the number of TSOs continued the upward trend.

Treatment Authorities

Table 6 outlines the number and prevalence of TAs during six financial years (2013-2020). One financial year (1 July 2016 – 30 June 2017) has been omitted again as explained above.

Insert Table 6 here

Table 6 demonstrates a continued upward trend in the number of TAs made, total TAs and prevalence of TAs despite the introduction of many less restrictive practices in the MHA 2016. The number of new TAs made consistently increased from 2013 to 2016 in the three years preceding the MHA 2016. In the year subsequent to the enactment of the MHA 2016, there was a slight decrease in the new TAs issued, however, there was a greater decrease in the TAs ended, leading to an overall increase in the total number and prevalence of TAs. In 2018-2019 and 2019-2020, the new TAs as well as TAs ended increased but the trend of an overall increase in total numbers and prevalence of TAs continued. The increase in prevalence of TAs has been more significant after the introduction of the MHA 2016, than the years preceding it.

Insert Table 7 here

As evidenced by Table 7, approximately 1% of TA reviews by the MHRT resulted in revocation in the last three financial years after the introduction of the MHA 2016. There has been a steady decrease in the revocations resulting from MHRT reviews, from 2.35% in 2013-2014, to between 1.01% and 1.08% in 2017-2020. With respect to the FOs, between 3.45% and 4.66% of the Forensic Orders were revoked by the MHRT per year before the introduction of MHA 2016. The introduction of the MHA 2016 did not

significantly change the number of revocations of FOs (4.06% to 4.54%) after the introduction of MHA 2016. Before MHA 2016, revocation of a FO resulted in discharge from the forensic psychiatry system. With the introduction of TSOs in the MHA 2016, most revocations of FOs led to institution of a TSO. As a result, the introduction of the "step-down" category of the TSO has paradoxically increased the amount of time spent by patients within the forensic psychiatry system.

4 Discussion

We found that compulsory treatment in the form of FOs, TSOs and TAs is on the rise in Queensland in spite of a number of mechanisms to promote less restrictive treatment in MHA 2016, consistent with a qualitative study of patient and carer experiences of compulsory treatment following its implementation (Giuntoli et al., 2019). The gap between the legislation's intentions and outcomes illustrates the need for empirical verification of the effects of legislation and the limits of what can be achieved by legislation alone. Having identified this unintended consequence of MHA 2016, it is now possible to look for remedies and systemic reforms. Future legislative changes can then be guided by evidence on the practicalities of implementation and their impact on patients' rights. Causes of this unintended consequence of rise in compulsory treatment may include a lack of systematized and well-resourced voluntary alternatives, a paternalistic and restrictive culture in mental health services, and risk aversion in clinicians and society (Gill, Allan, Clark, & Rosen, 2020). In addition, poor understanding of the concept of capacity to consent to treatment may contribute to the fact that legislative reform does not appear to be translating into increased access to rights (Ryan, 2019). Further systematic inquiry is required around the possible determinants of the

rise of compulsory treatment and effective ways to reduce compulsory treatment and promote voluntary and less restrictive care. It is likely that despite introducing some less restrictive ways and supported decision-making provisions, the changes in Queensland legislation do not go far enough. We recommend that the reforms in mental health policy as well as legislation need to go further in order to achieve the goals embodied in the human rights framework of the CRPD.

The increase in FOs that we found is of concern and has several implications for individual rights. For instance, MHA 2016 allows the Mental Health Court to impose a non-revocation period on a FO of up to 10 years, ostensibly for the purpose of protecting the community.[20] This is a compromise between the right of patients not to be subject to an indefinite period of detention in the absence of responsibility for a crime, and the right of the community to safety, but raises the question how FOs balance the goals of therapeutic and criminal justice systems. As noted by Guilloud (2019), the CRPD Committee found in *Noble v. Australia* that the compulsory treatment of an Aboriginal Australian with a mental and intellectual disability including incarceration without trial for more than a decade was a violation of the CRPD.[21] It was estimated that had he been found guilty of the charges made, Mr Noble would likely have received a sentence of around three years, and therefore loss of the right to trial had significantly affected his wellbeing. This illustrates the extremely serious effect of a non-revocation period of up to 10 years on

[20] *Mental Health Act 2016* (Qld) s 137

[21] Committee on the Rights of Persons with Disabilities, Views adopted by the Committee under article 5 of the Optional Protocol, concerning communication No 7/2012 *Noble v. Australia*, CRPD/C/16/D/7/2012 (2 September 2016).

the rights of patients who by that fact lose the right to defend their innocence as well as the other procedural rights to reviews of detention during that period.

FOs differ significantly from TAs in that basic clinical decisions including inpatient versus community treatment and adequate risk management are routinely imposed by the Mental Health Court or MHRT based on the assessment whether there is 'an unacceptable risk to the safety of the community'.[22] This framework can lead to extended periods of hospitalization or on the community category of a FO, based on risk categorization, often in the absence of psychopathology, particularly where patients engage in periodic substance abuse. With the rationale that greater attention to and comprehensive management of the sources of risk would reduce the need for Forensic Orders for some patients, an additional step was introduced to the review process, called the Assessment and Risk Management Committee (ARMC). Involving more professionals on more occasions appears more likely to slow the progress towards greater patient autonomy than to materially improve risk reduction or clinical care. Extended periods of compulsory treatment in such cases violate patients' individual autonomy, liberty and integrity as identified in the CRPD articles 12, 14 and 17. Furthermore, whereas a TA can only be ordered if someone lacks mental capacity, a FO may be continued even after the individual has regained that capacity, as revocation requires the MHRT to conclude that the patient is not an unacceptable risk to the safety of the community. While the risks associated with patients managed under FOs may arise in part from mental illness, for many patients there are also risk factors unrelated to illness, including premorbid and

[22] *Mental Health Act 2016* (Qld) s 138(2).

persisting personality traits, learned behaviors, substance abuse, and social circumstances predisposing to high risk activities.

As a result, risk assessment of patients managed under FOs can be highly uncertain and psychiatrists and MHRT working in a risk-averse system may be biased against assuming responsibility for revoking the FOs. A qualitative study by Giuntoli et al. (2019) reported that FO patients with a dual diagnosis of mental illness and intellectual disability had prolonged periods of compulsory treatment due to a lack of appropriate forensic beds (Giuntoli et al., 2019). A consequence is that certain patients remain on FOs for much longer than the time they would have served had they gone through the normal legal process after an alleged offence. This underlies several complaints made by patients under FOs: that in the absence of a trial the claim that they have committed an offence is never tested and guilt is assumed; that diversion from the criminal justice system prevents them from accessing discounted sentences by pleading guilty (New South Wales Law Reform Commission, 2013); and that they would prefer the certainty of a prison sentence to the uncertainty of admission under a FO. Such criticisms are consistent with the CRPD Committee's interpretation of article 12 in the context of criminal proceedings. While we do not agree that this calls for a complete ban on diversion from criminal system to mental health system as argued by the CRPD Committee, our findings point towards the need for further legislative and policy reform to protect and promote the human rights of people in the mental health care system as well as criminal justice system.

5 Conclusion

The ultimate goal of international legal instruments like the CRPD is to materially improve the human rights and wellbeing of people, including people living with disabilities. Success depends on the specifics of the legislation used by States Parties to implement the international instruments, which must accommodate prevailing tensions between maximizing the autonomy of people with disabilities, ensuring the equity of access to care, and the practical difficulties of ending substitute decision-making for people with severely affected judgement. Inconsistencies in international law complicate the implementation of legislation, and may provide States Parties with greater discretion to avoid difficult requirements such as a move to supported decision-making.

This article has shown that legislation intended to improve the human rights of people with disabilities in Queensland has been associated with an increase, not a decrease, in the number of people subject to compulsory psychiatric treatment. Possible reasons behind this increase could include lack of systematized voluntary alternatives, restrictive culture of mental health services and high risk-aversion in mental health services as well as society at large. It is also likely that the legislative reform has not gone far enough and hence there is a need for further legislative and policy reform. We have observed that some patients remain under Forensic Orders for longer, and sometimes much longer, than would be justified by their clinical illness or alleged infractions alone, due to sources of risk such as substance misuse and learned behavior.

We recommend further empirical research, qualitative as well as quantitative, into the increase in compulsory treatment and forensic orders in Queensland. The uptake of other less restrictive measures should also be evaluated. The intersections between human rights legislation, mental health services, and systems of justice are complex and

extremely variable. We argue that the implementation of any legislation intended to improve human rights should always be assessed using empirical indices such as those considered here, as well as qualitative research, alongside compliance with relevant international instruments including the CRPD. Ideally, the indices would be developed at the same time as legislation, with a plan for periodic review to ensure that the legislation has achieved its goals, and to facilitate resolution of inconsistencies in international laws and their interpretation.

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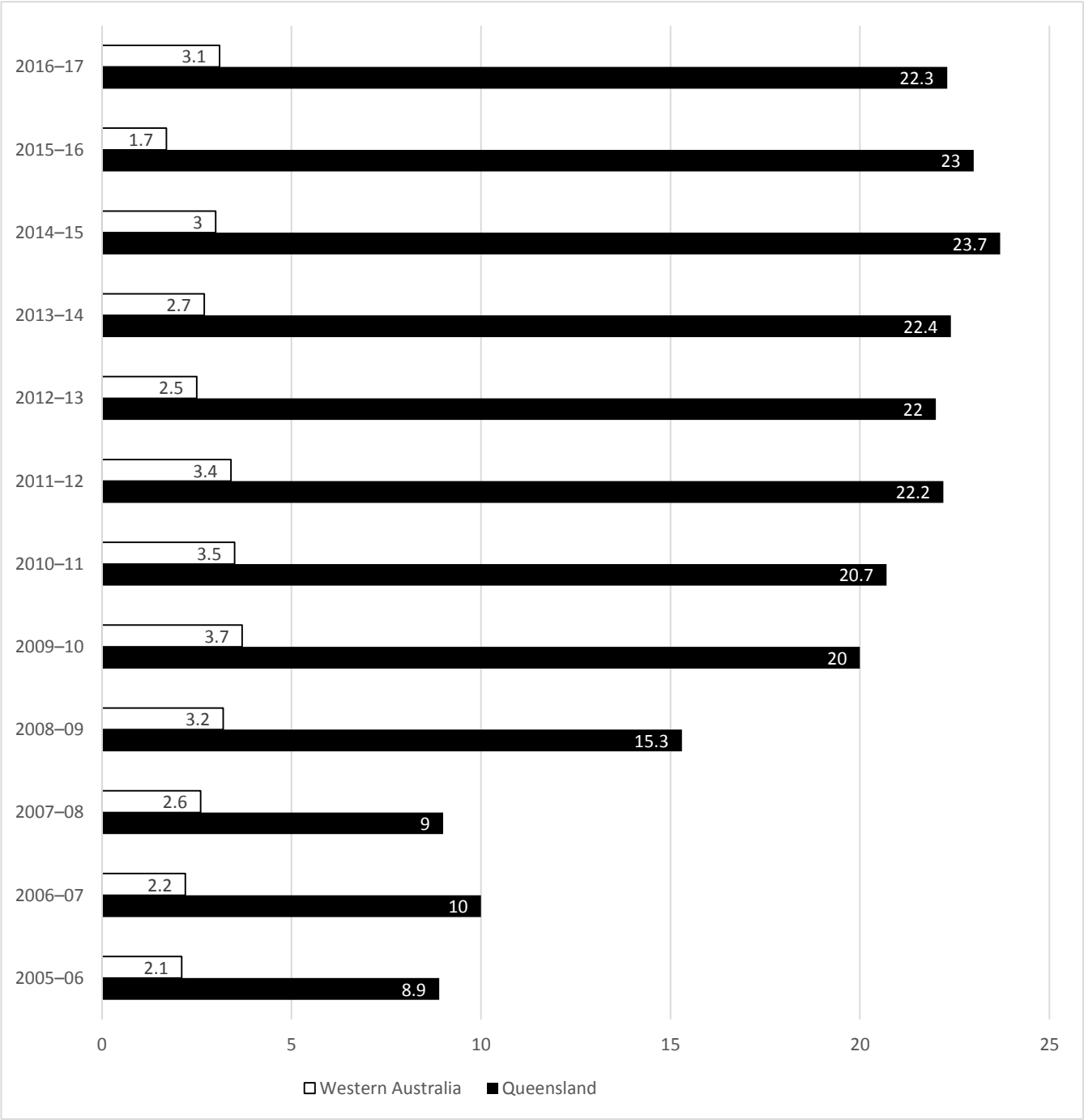

Figure 1: Involuntary visits as a percentage of community contacts. (Source: AIHW)

Requirements for a Treatment Authority under the Mental Health Act 2016 (Qld)		
Treatment Criteria: Includes the adjacent three requirements:	**Mental Illness**	The person has a mental illness. [s12(1)(a)]
	Lack of Capacity to Consent	The person does not have capacity to consent to be treated for the illness. [s12(1)(b)]
	Harm/Risk	Because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in: imminent serious harm to the person or others; or the person suffering serious mental or physical deterioration. [s12(1)(c)]
AND **No Less Restrictive Alternative**		There is no less restrictive way for the person to receive treatment and care for the person's mental illness. [s18(2)]

Table 1: Requirements for a treatment authority in the *Mental Health Act 2016* (Qld).

Criteria for Involuntary Treatment	Under a **TA**	Under a **FO**	Under a **TSO**
Current mental illness	Yes	––	––
Lack of capacity to consent to treatment	Yes	––	––
No less restrictive way for treatment	Yes	––	––
Unsoundness of mind at the time of the alleged offence Or **Unfitness for trial**	––	Yes	Yes
Risk	Imminent risk of serious harm or mental/physical deterioration.	Unacceptable risk to the safety of the community, including risk of serious harm to other persons or property.	Unacceptable risk to the safety of the community, including risk of serious harm to other persons or property.

Table 2: Criteria for compulsory treatment under Treatment Authority (TA), Forensic Order (FO) and Treatment Support Order (TSO).

FO (criminal code)	**FO (disability)**	**FO (mental health)**
Orders made by the Supreme Court or District Court under the Criminal Code 1899 (Qld) [s645(1), s647(1)]:	Orders made by the Mental Health Court under the MHA [s134(3)(b)]:	Orders made by the Mental Health Court under the MHA. [s134(3)(a)]:
If the jury find that the person is not of sound mind… the court is required to order the person to be admitted to an authorised mental health service to be dealt with under the Mental Health Act 2016. Note: The registrar of the court that made the forensic order (Criminal Code) must, within 7 days after the order is made, give notice of the order in the approved form to: a) The Chief Psychiatrist b) The MHRT (MHA [s190])	The person's unsoundness of mind was, or unfitness for trial is, because of an intellectual disability; and the person needs care for the person's intellectual disability but does not need treatment and care for any mental illness.	The person's unsoundness of mind was, or unfitness for trial is, because of a mental condition other than an intellectual disability; or the person has a dual disability and needs involuntary treatment and care for the person's mental illness, as well as care for the person's intellectual disability.

Table 3 – The types of forensic order under the *Mental Health Act 2016* (Qld).

Mechanism	Explanation
Patient rights advisers	• Each health service is required to appoint an independent patient rights adviser who is not an employee of the mental health service • The adviser informs the patient and their support persons of their rights and responsibilities • The adviser works with the patient and support persons to communicate the patient's views, wishes and preferences to the healthcare team
Statement of rights	• The Chief Psychiatrist is required to prepare a written statement on the rights of patients and their support persons, and information on the procedure for making complaints • The statement is explained to the patient upon admission. A copy is also given to the patient or their support person
Defining capacity	• A person is presumed to have capacity to make decisions for their treatment unless proven otherwise • A person has capacity if they can understand in general terms: that they have a mental illness; the nature and purpose of the treatment for the illness; the benefits, risks and alternatives to the treatment; and, the consequences of not receiving treatment • Assistance from others in achieving the understanding necessary to have capacity is permitted. This enables supported decision-making
Less restrictive treatment	• A treatment authority can only be issued if there is no less restrictive way of treatment • Less restrictive ways of treatment include consent from a minor's parents, an advanced health directive which states the patient's views, consent from an attorney appointed by the patient or consent from a guardian appointed to the patient
Responsibilities for treatment and care	• Doctors must discuss with the patient the treatment and care they are to be provided under a treatment authority • Doctors must consider the views, wishes and preferences of the patient in deciding treatment under a treatment authority • A treatment authority must be reviewed by a doctor at least every 3 months
Right to information	• It is required that the patient be informed of when a recommendation for assessment has been made, the treatment and care to be provided under a treatment authority and the regular assessment of a treatment authority
Rights as an inpatient	• The MHA 2016 enshrines the rights to be visited by a support person at any reasonable time, to be visited and examined by a health practitioner and to be visited by a legal or other adviser • It also enshrines the right to communicate with others
Complaints and second opinions	• A patient may request a second opinion on treatment and care from an independent health practitioner
Nominated support persons	• A person may nominate support persons for when they are an inpatient • The support person can participate in the decision's regarding treatment and care, and will receive information about the patient's treatment
Mental Health Review Tribunal	• The Tribunal reviews a treatment authority within 28 days of it being made, at regular intervals and on the application of a patient or on a patient's behalf • The Tribunal similarly reviews forensic orders and treatment support orders • Authorisation for use of electroconvulsive therapy in patients without capacity can only be provided by the Tribunal

Table 4: MHA 2016 Mechanisms for protecting and promoting human rights of people with mental illness, adapted from 'Guide to patient rights under the *Mental Health Act 2016*' (State of Queensland (Queensland Health), 2017).

	FOs Made	FOs Ended	Total FOs	Total TSOs	Total FOs + TSOs	Prevalence FOs + TSOs (per 10,000)	95% CIs
1 July 2013 - 30 June 2014	104	82	741	-	741	1.57	1.46 – 1.68
1 July 2014 – 30 June 2015	132	95	770	-	770	1.61	1.50 – 1.72
1 July 2015 – 30 June 2016	118	90	792	-	792	1.63	1.52 – 1.74
1 July 2017 – 30 June 2018	105	113	811	126	937	1.84	1.72 – 1.96
1 July 2018 – 30 June 2019	93	95	795	187	982	1.93	1.81 – 2.05
1 July 2019 – 30 June 2020	78	94	778	221	999	1.94	1.82 – 2.06

FOs – Forensic Orders; TSOs – Treatment Support Orders; CIs – Confidence Intervals

Table 5: The number and prevalence of Forensic Orders from 2013 to 2020.

(Adapted from – Office of the Chief Psychiatrist. Annual Reports (2014 to 2020)

(State of Queensland (Queensland Health), 2019, 2020)

	TAs Made	TAs Ended	Total TAs	Prevalence (per 10,000)	95% CIs
1 July 2013 - 30 June 2014	6601	6423	3828	8.11	7.86 – 8.36
1 July 2014 - 30 June 2015	7468	7191	4100	8.58	8.33 – 8.84
1 July 2015 - 30 June 2016	8152	8024	4200	8.67	8.42 – 8.93
1 July 2017 - 30 June 2018	8016	7561	4764	9.44	9.17 – 9.71
1 July 2018 - 30 June 2019	8764	8187	5333	10.47	10.11 – 10.76
1 July 2019 – 30 June 2020	9146	8801	5676	10.99	10.71 – 11.28

TAs – Treatment Authorities; CIs – Confidence Intervals

Table 6: The number and prevalence of Treatment Authorities from 2013 to 2020. (Adapted from – Office of the Chief Psychiatrist. Annual Reports (2014 to 2020) (State of Queensland (Queensland Health), 2019, 2020)

	No of FO reviews	FOs revoked	Percentage of FO reviews resulting in revocation	TSOs Made by MHRT	TSOs revoked	No of TA reviews	TAs revoked	Percentage of TA reviews resulting in revocation
1 July 2013 - 30 June 2014	1637	69	4.22%	-	-	9237	217	2.35 %
1 July 2014 - 30 June 2015	1630	76	4.66%	-	-	9878	162	1.64 %
1 July 2015 - 30 June 2016	1943	67	3.45%	-	-	10466	149	1.42 %
1 July 2017 - 30 June 2018	2182	99	4.54%	95	4	9322	95	1.02 %
1 July 2018 - 30 June 2019	1969	80	4.06%	70	23	10111	102	1.01 %
1 July 2019 – 30 June 2020	1889	82	4.34%	72	49	10965	119	1.08 %

Table 7: Number of Forensic Order (FO) and Treatment Authority (TA) reviews and revocations, as well as the number of Treatment Support Orders (TSO) made/revoked by the Mental Health Review Tribunal from 2013-2020. Adapted from: (Queensland Government. Mental Health Review Tribunal, 2020)

03 October 2020

To

Professor Mary Donnelly

Associate Editor

International Journal of Law and Psychiatry

Re: Ethical statement for Manuscript Number: IJLP-D-20-00173

Measuring the impact of revised mental health legislation on human rights in Queensland, Australia

Dear Professor Donnelly

All the data for this research were obtained from the information available in public domain, on the government websites, and hence, no ethics approval was required.

Thanking you.

A/Prof Neeraj S Gill

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