Application of Rights Analysis Instrument to
Australian Mental Health Legislation

Report to Australian Health Ministers' Advisory Council Mental Health Working Group
Application of Rights Analysis Instrument to Australian Mental Health Legislation

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on behalf of the National Rights Analysis Instrument Assessment Panel

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Foreword

Under the National Mental Health Strategy in 1992 Health Ministers agreed to enact legislation consistent with the United Nations Principles for the Protection of and for the improvement of Mental Health Care, as well as the National Mental Health Statement of Rights and Responsibilities.

This Report shows that there has been improvement in State and Territory mental health legislation since the 1993 Burdekin Report, both in terms of human rights protection, as well as consistency across jurisdictions. Although the relative success of contemporary legislation is heartening, there is still a need to be vigilant in order to maintain and further improve compliance - not only in the letter of the legislation measured by the Rights Analysis Instrument, but also its actual enforcement in practice.

The Rights Analysis Instrument was developed through targeted consultations, for the purpose of assessing compliance with the international and national norms and standards. In 1999 multidisciplinary groups applied the Instrument in seven jurisdictions. Consistency in scoring the Instrument was promoted by the formation of a National Panel who considered the self-assessments and adjusted them if necessary.

This Report shows that the process of applying the Rights Analysis Instrument has been a successful one in terms of quality assurance. It comprehensively documents the application of the thirteen Indicators in the Instrument. The Report is designed as a resource, to highlight good legislative practice that can be emulated in other jurisdictions. It also notes areas requiring improvement, such as informed consent to general mental health treatment.

The methodology attempts to be as transparent and accessible as possible, and is unique in refining accountability for compliance with these international and national legislative performance benchmarks. However, when the Instrument was developed and applied in Australian jurisdictions, the United Nations Principles were found to be lacking in a number of areas. One important area is community treatment, which is an evolving area of mental health not sufficiently anticipated in the United Nations Principles. The National Panel has sensibly recommended that it should be included in a future version of the Instrument, with Australia enhancing the Principles rather than being tied to current aspects of international standards.

I would like to thank all the jurisdictions for their commitment to making these improvements, which vitally affect the lives of people affected by a mental illness.

Dermot Casey
Assistant Secretary
Mental Health and Special Programs Branch
31 October 2000
I Introduction

(A) History of Rights Analysis Instrument

1. In December 1996 a Rights Analysis Instrument was prepared to evaluate State and Territory mental health legislation for the Australian Health Ministers’ Advisory Council (AHMAC) National Mental Health Working Group. The Instrument was designed to measure compliance by legislation with the 1991 United Nations Principles for the Protection of and for the Improvement of Mental Health Care, and also the National Mental Health Statement of Rights and Responsibilities. It consists of thirteen indicators measured in four quadrants (substantial, significant, partial and minimal). It enables qualitative laws to be methodically classified with an overt rating along this compliance dimension.

2. The National Inquiry into the Human Rights of People with Mental Illness (the “Burdekin Report”) reported in October 1993 and was critical of the lack of compliance by State and Territory legislation with the UN Principles. Health Ministers agreed under the National Mental Health Strategy to enact legislation consistent with the UN Principles and the National Statement. In 1993 AHMAC commissioned a project to develop model legislation and a Report was released for public comment. In 1995 a draft Rights Analysis Instrument was developed and applied to all Australian jurisdictions, but was released for information only. The draft was not acceptable to stakeholders and jurisdictions principally, it is understood, because of the lack of transparency of the methodology, and the inadequate distinction between core and subsidiary rights in the analysis. A fresh consultative process involving a new draft commenced in 1996. Targeted consultations were held in all jurisdictions with relevant stakeholders, including members of consumer advisory groups, peak mental health non-government organisations, academics, professionals, service providers, advocates, carers, members of mental health tribunals and guardianship boards, and officers from relevant State and Territory Departments. A revised Rights Analysis Instrument that took into account comments from these groups was endorsed by AHMAC in 1997.

(B) Process of applying the Rights Analysis Instrument

3. During 1998 to 1999 seven (Tasmania, New South Wales, Victoria, Western Australia, South Australia, the Northern Territory, and the Australian Capital Territory) out of eight jurisdictions applied the Instrument to their legislation. In this self-assessment process multi-disciplinary panels were formed in most jurisdictions, as recommended in the 1996 Report on the Rights Analysis Instrument. The panels broadly consisted of the following members: a consumer; a human rights expert; a lawyer familiar with mental health legislation; an NGO service provider; a clinician; an advocate; a carer; and a government official from the mental health area. Queensland was in the final processes of drafting a Mental Health Bill and did not wish to apply the Instrument to old legislation – the Queensland Health Department has undertaken to apply the Instrument once the new legislation is passed in Parliament.

4. In October and December 1999 the National Rights Analysis Instrument Assessment Panel (“the National Panel”) convened twice to consider the application of the Instrument to these jurisdictions with a view to promote consistency in scoring, and to report on areas of good practice which might serve as a valuable example for other States to emulate, and to identify problem areas where improvement was required. A third meeting was held in March 2000 to discuss a draft of this Report. The panel consisted of members from Victoria, Queensland, Western Australia and the Commonwealth. Membership attempted to follow the structure of the local panels convened to
conduct the individual assessments – they included a member of a Mental Health Review Board, a Chief Psychiatrist, a lawyer with specialist skills in mental health, an independent human rights expert, a representative from the Mental Health Council of Australia, the Royal Australian and New Zealand College of Psychiatrists, and the Australian Medical Association, and officers from the Commonwealth Health and Attorney-General’s Departments. Unfortunately a representative of the Human Rights and Equal Opportunity Commission was unable to attend any of these meetings. The Commission’s specific expertise in human rights would have made a valuable input, and they will be invited to provide comments on this draft report.

(C) Methodology

5. It is the first time this methodology of refining accountability through clear performance standards has been used in the mental health area of international human rights. Having an accessible and transparent methodology was important to legitimise not only the data outcome, but also the process of applying the Instrument. The limitation, as well as specific value of the Instrument is that it measures the content of legislation, as opposed to implementation in practice of formal legal provisions. It gives a representative picture of legislation at the precise time in the particular jurisdiction when the Instrument was applied. Where this application of the Instrument is repeated over time, it should give some indication as to whether compliance has improved or deteriorated between the time of the first and subsequent applications, eg legislation is repealed or amended.

6. The unit of analysis is the jurisdiction in which the mental health and other legislation (such as child protection, therapeutic goods, drugs and criminal law) applies. The mental health legislation in force at the time of the application in each jurisdiction was: Mental Health Act, 1990, as amended, (NSW), Mental Health Act, 1996 (WA), Mental Health Act, 1986, as amended, (Victoria), Mental Health Act, 1996 (Tasmania), Mental Health Act, 1993 and Guardianship and Administration Act, 1993 (SA), Mental Health and Related Services Act, 1998 (NT) and Mental Health (Treatment and Care) Act, 1994, as amended (ACT). The questions in the Instrument attempt to be as objective, structured and specific as possible, so that subjective judgments about scoring is minimised. However, as the response variables are the characteristics of legislation, some latent analysis requiring interpretation of their effect, as opposed to merely recording their manifest or superficial content, is inherent in the process. Balancing the membership of the assessment panels with government and independent members was designed to make interpretation and scoring as fair as possible, rather than being artificially inflated or deflated. Having multiple evaluators in each jurisdiction can affect the reliability of the results of assessment (ie replicability of the evaluation), but the national evaluation panel assisted in promoting consistency of scoring. The sub-questions in Indicators were not numbered which made scoring more difficult to administer – the National Panel recommends that this be remedied.
II Report on findings

(A) Key themes

7. The National Panel’s overriding impression of the application of the Instrument in the seven jurisdictions was that there had been major improvements in terms of compliance in nearly all areas since the Burdekin Report in 1993. The actual process of self-assessment had been productive in all jurisdictions as an impetus for best practice, through focussing attention on strengths, anomalies, gaps and weaknesses in existing and even proposed legislation. The Instrument was able to provide concrete guidance for responsive legislative reform, as demonstrated by some jurisdictions using it to develop Drafting Instructions for new legislation. It is important to recognise that the identification of good legislative practice is not prescriptive. Often there is a range of good practices that fully implement the obligations in the UN Principles in various ways.

8. Involving stakeholders in each jurisdiction in the process was effective in highlighting the importance and meaningfulness of the task, as well as generating some ownership of the results. Such participation was valuable not only in terms of real consultation, but also in making the most of local expertise and knowledge of detailed and often complex legislation.

9. Individuals from NGOs in two jurisdictions contacted the National Panel about problems in scoring, and their views were taken into account where relevant. There was inconsistency in scoring with some States and Territories being over-generous in their scoring, and others being too strict. The National Panel therefore adjusted such scoring to promote fairness and consistency, but often the adjustment was not sufficient to change the ultimate quadrant of scoring in Indicators. One of the principal errors was a jurisdiction assessing full compliance for administrative practice, as opposed to legislative provision. As explained at the outset, the Instrument was only designed to measure the latter, and this was the specific undertaking given by Health Ministers under the National Mental Health Strategy.

10. Another recurrent problem was that although legislation guaranteed substantive rights for consumers, often there was no obligation to inform them of the existence of such rights. In such a vulnerable situation it is unreasonable to place the entire onus on claiming rights with the individual concerned. This could make such rights meaningless in practice, if they were not exercised due to lack of information. Without a legislative obligation to inform consumers, such rights become empty rather than protective. Therefore the Instrument reflects the full substantive and procedural obligations in the UN Principles.

11. There was debate in the National Panel about the role of the law in promoting and protecting rights in the mental health area. While all members recognised that substantive rights should be enshrined in legislation, there was no consensus on whether including large objects clauses in accordance with the UN Principles was useful in practice. There was also disagreement about whether good administrative practice should be specified or codified in legislation, making it less amenable to changing community needs.

(B) Controversial areas

12. Many of the deficiencies in the UN Principles outlined in the 1996 Report on the Rights Analysis Instrument were still viewed as problematic by the National Panel. These were characterised by the Principles not anticipating future developments and improvements in practice, and therefore
being somewhat out of date. This is not surprising, given that the document was developed globally and its framework must accommodate differing levels of social change and developments between countries. However, this does not mean that Australia is absolutely tied to out of date wording, but instead can extend the human rights protections beyond those required, as long as they are in keeping with the intention of the original Principles. The inadequacies identified by the National Panel were:

- the need for greater recognition of community treatment;
- specifying the various requirements to protect minors and forensic patients, as well as secure confidentiality;
- defining a minimum period before involuntary admission cases are reviewed;
- requiring review bodies to observe the rules of natural justice;
- broadening the criteria for exercising inspection powers and dispensing with notice to the facility before inspection occurs;
- their limited scope in that they did not cover facilities that bore the impact of de-institutionalisation, such as residential facilities;
- clarifying the status of electro-convulsive therapy;
- granting consumers the right to a second opinion when voluntary admission is refused, and acknowledging rights of carers; and
- emphasising positive human rights, such as codifying national standards, rather than merely providing negative protections against abuse.

Additional areas identified by the National Panel include:

- requiring tribunals to be bound by the rules of natural justice;
- giving greater weight to the rights of forensic patients; and
- clarifying the requirements relating to guardianship proceedings.

Many of these issues are dealt with in recommendations by the National Panel throughout this Report to amend the Instrument before any future application.

13. One area of controversy that was not satisfactorily resolved by the National Panel was the issue of voluntary patients. Some jurisdictions only cover involuntary patients in their mental health legislation, and voluntary patients are regarded the same as any patient in mainstream medical facilities. These jurisdictions argued that this mainstreaming approach could reduce stigma for voluntary patients. Other jurisdictions were concerned that voluntary patients in facilities also approved to detain involuntary patients, could be subject to the overt or covert threat of being made an involuntary patient. The UN Principles do not adequately address this issue, except to provide for an active right of discharge, and preference for voluntary admission. For this reason, it is recommended that the questions in Indicators relating to these rights remain, so that the Instrument can measure any diminution in their protection. In areas of the Indicators where voluntary patients are guaranteed rights under legislation that does not specifically deal with mental health, eg common law relating to consent, then scoring reflects this, rather than penalising jurisdictions that do not specifically include voluntary patients in their mental health legislation. However, it is important to distinguish between the issues of capacity for admission and assessment purposes, and ability to consent to treatment.

14. Another area of controversy was the issue of detention for a “short” period of time that is not specifically defined in the UN Principles. The National Panel decided to use the criteria of up to 14 days, which was not met in a number of jurisdictions. These jurisdictions felt that this was unfair given logistical difficulties in organising hearings so quickly, especially in geographically dispersed
areas where consumers often requested adjournments because they were not ready to proceed. The National Panel strongly believed that administrative difficulties should not diminish the substance of this important right. One jurisdiction complained that this human right had been double-counted by being included in two Indicators, 4B and 5B. However, on closer analysis the National Panel found that the first question related to allowing observation and preliminary treatment (as opposed to doing nothing to reasonably assist the person) pending review by a tribunal, whereas the latter related to the time taken to review the decision to involuntarily admit a patient.

15. A further area of controversy was the determination of “mental illness” under Indicator 3A in accordance with internationally accepted medical standards. Some jurisdictions had overly broad definitions which included concepts, such as mental disturbance or dysfunction, that were not in accordance with internationally acceptable medical standards. If jurisdictions were not in lower compliance for having an overly broad definition in the determination process, then this would be counter to questions in Indicator 3B requiring specific matters to be excluded from the determination, such as moral non-conformity or other reasons not relevant to mental health status. The National Panel believes that concepts outside the area of mental health should be dealt with under other specific legislation. This would provide a mechanism for dealing adequately with people who have social/behavioural problems that threaten community safety, by diverting them from the criminal justice system where it is not responsive or appropriate to their needs. Such laws, for example those enacted in the United Kingdom, should have general human rights protections relating to issues of preventative detention for the protection of the community that are at least be equal, if not superior, to rights in the criminal law.

16. In several Indicators the issue of the actual content of a right of review/appeal to a tribunal/court was relevant. The National Panel decided that this question should be split - half should apply to merits review, and the other half to appeals limited to questions of law. Therefore, full compliance could only occur if appeals were possible for both the merits of the case (a de novo hearing) and points of law. Such an approach recognises the importance of comprehensive, rather than merely technical, review/appeal rights.

(C) Overall assessment patterns

17. Assessments were made within four basic quadrants – substantial, significant, partial and minimal. Where assessments are made on the border of two quadrants, then this is specified, eg significant/substantial compliance. Where all requirements are met then this is referred to as total compliance. Two jurisdictions were assessed as being in total compliance in at least one of three Indicators. The majority of assessments were in the significant and substantial quadrants. Only one jurisdiction had any Indicator assessed in the minimal quadrant, and several jurisdictions had some Indicators in the partial quadrant. The Appendix sets out a pictorial representation of how an assessment is made, using the example of one Indicator.

18. The six Indicators that most fully met the criteria in the UN Principles when assessed were 12, 13, 6, 7, 8 and 11. Indicators 3, 6, and 11 all had one jurisdiction that was assessed to be in total compliance. The Indicators with the most consistently high assessment, ie substantial compliance by at least five jurisdictions, were 12 and 13. These are obviously the areas where legislative reform has been the most active, and represent good examples of compliance with the UN Principles.

19. The six Indicators that least met the requirements in the UN Principles were 2, 9, 10, 4 and 3. The Indicators that some jurisdictions were assessed in the partial quadrant were 1, 2, 3, 9, 10 and 11. The fact that Indicator 1 (dealing with general and aspirational human rights) was assessed highly by most jurisdictions, highlights the inadequacy of the objects clauses in the legislation of the jurisdiction that was assessed in the partial quadrant. Indicator 2 (dealing with human rights in
mental health facilities) mainly measures the objectives of legislation, and one jurisdiction was in the minimal quadrant, with another in the partial quadrant, making it the Indicator with assessments that least met the criteria in the UN Principles. Indicator 3 (dealing with the substantive issue of determination of mental illness) had a large divergence of assessments, from total compliance in one jurisdiction, to one jurisdiction in the partial quadrant and another with partial/significant compliance. Indicator 9 (dealing with consent to general mental health treatment) had the highest number of jurisdictions in the partial quadrant – four. Indicator 11 (dealing with treatment and medication) was assessed highly by most jurisdictions, but one jurisdiction was in the partial quadrant making its legislation appear anomalous in this regard. It is clearly in these areas with assessments in the partial and minimal quadrants that legislative reform is most urgently needed, particularly Indicators relating to substantive rights rather than objects of legislation.

20. Indicators 2, 5, 6, 7, 10 and 13 were assessed somewhat inconsistently and therefore needed to be adjusted the most by the National Panel. This was due to general misunderstanding of criteria, the tendency of some jurisdictions to gloss over limitations in their legislation, or counting administrative practice rather than legislative provision for compliance purposes.

21. The next section contains details on the assessments of jurisdictions in each of the thirteen Indicators. It gives examples of good legislative practice, then generic descriptions of legislation in other jurisdictions with an explanation of what elements were missing against the criteria required in the UN Principles.
III Details of assessment of individual indicators

Indicator 1 – General and aspirational human rights

22. Victoria’s and the Northern Territory’s legislation were assessed in the substantial quadrant in this Indicator. Their objects clauses are the best examples of nearly full implementation of the UN Principles. The Northern Territory specifically referred in its objects clauses to consistency with the UN Principles and the National Statement. New South Wales and South Australia were also assessed in the substantial quadrant. The Australian Capital Territory was in significant/substantial compliance. Western Australia was assessed in the significant quadrant as its objects clauses were relatively brief. Similarly, South Australia was assessed in the partial quadrant as its legislative objects were not comprehensive.

23. Most jurisdictions were assessed well on Indicators 1A and 1B, with four jurisdictions completely fulfilling the requirements in the UN Principles. Indicator 1A requires the legislative objective of community care, treatment and enabling people with mental illness to live and work in the community, as far as possible, eg by the use of community treatment orders. The National Panel recommends that greater comparative weight is given to Indicator 1A, and also that structured criteria be included which are additional to the UN Principles. Some jurisdictions referred to the principle of treatment in the least restrictive environment – this criterion is already included in Indicator 11A.

24. All jurisdictions fulfilled the open-ended criteria in Indicator 1C relating to confidentiality of personal information. Privacy and/or public service secrecy legislation and the common law covers all patients, but the specific protection for involuntary patients is in mental health law provisions that prohibit disclosure of such information outside the administration of the Act. This question is not specific enough in the protections required and allowable exceptions (eg public interest) - it should be more structured, rather than merely replicating the broad requirement in the UN Principles.

25. The National Panel considered that Victoria had the best legislative practice in relation to Indicator 1D by fully meeting the criteria in the UN Principles. Its legislative objects require that four relevant special needs factors be taken into account for treatment purposes: age; cultural/linguistic background; gender; and disability. Many jurisdictions did not provide for several of the specific factors, especially disability, and therefore did not fully meet the criteria. One jurisdiction only required these factors to be taken into account before treatment can be given under guardianship legislation (ie a smaller proportion of cases), rather than mental health legislation. The Northern Territory had an interpretation principle that went beyond the requirements of the UN Principles - assessment, care, treatment and protection of Aboriginal or persons from a non-English speaking background is appropriate to and consistent with the persons’ cultural beliefs, practices and mores.

26. Tasmania and the Northern Territory had the best legislative practise in relation to Indicator 1E – the former met the requirements positively by preferring voluntary to involuntary admission, and the latter negatively by the legislative principle of making every effort to avoid involuntary admission. Both positive and negative versions of the right were referred to in the question in the Indicator. A number of jurisdictions only had the legislative aim of early and timely treatment.
Indicator 2 – Human rights in mental health facilities

27. The Northern Territory and Victoria were assessed in the substantial quadrant for this Indicator. Tasmania and New South Wales were assessed in the significant quadrant. The Australian Capital Territory was assessed in partial/significant compliance. Western Australia was assessed in the partial quadrant and South Australia in the minimal quadrant due to similar factors reported in Indicator 1, ie the brevity of objects clauses. Indicator 2 was the Indicator that least fulfilled the requirements in the UN Principles on assessment.

28. The National Panel considered that Victoria and the Northern Territory had the best legislative practice for Indicator 2A by fully meeting the requirements in the UN Principles. It requires the legislative objective of securing patient’s rights to be treated in a facility near home (their own, friend’s or relative’s, subject to the consumer’s choice) wherever possible. Some jurisdictions did not have this specific objective, but rather had a general obligation to have accessible services with provision of support in the community and community treatment orders. The National Panel recommends that such obligations be included in a detailed question on community treatment suggested below. Some jurisdictions only had the substantive right of transfer to another facility.

29. The National Panel considered that the Northern Territory had the best legislative practice for Indicator 2B by fully meeting the requirements in the UN Principles. It requires the legislative objective of positively respecting the privacy of people with mental illness. The Indicator attempted to distinguish privacy as being in the sense of physical space and lack of unnecessary intrusion, as opposed to information privacy which is already covered by Indicator 1C (confidentiality). A negative version of this right in one jurisdiction (ie restricting interference to a minimum) did not fully meet this requirement. Many jurisdictions referred to planning regulations that required facilities to have certain amounts of space per bed. Although such regulations are important to prevent overcrowding, it was decided by the National Panel that such broad provisions applicable to all jurisdictions did not fulfil the requirement, as they only guaranteed overall, rather than personal space. However, general legislative objectives requiring the minimum interference with rights and least restrictive environment was considered to be in half compliance with the requirement.

30. No jurisdiction fully met the criteria in Indicator 2C. The principal difficulty was the legislative requirement to provide separate facilities for minors, with only two jurisdictions partially fulfilling this criterion. There was some debate in the National Panel as to whether this requirement for separate facilities would be better fulfilled in administrative, rather than legislative provisions, especially since it related to the allocation of finite resources. All jurisdictions were in half compliance by having general child protection legislation, and common law recognition of the best interests of the child, as well as capacity to consent and make decisions that evolved with maturity. Additional compliance was found for special provisions in mental health legislation. However, in one jurisdiction the provision only related to voluntary patients under the age of 18 years and was subject to being “appropriate and possible”. Tasmania had a valuable provision that in the case of admission to persons under the age of 14 years required the consent of the parent, as well as that the person does not resist admission. In the case of persons over 14 years of age, their consent to admission is required. Provisions that required age-related special needs to be taken into account for treatment and care purposes were not counted, as this was already provided for in Indicator 1D. However, a provision that required services to be established for age-related special needs was counted towards partial compliance (this did not equate, however, to requiring separate facilities).

31. No jurisdiction had an explicit legislative requirement to secure the right of the consumer to return to the community as soon as possible. Legislative provisions relating to community treatment orders and support were assessed to be in substantial compliance. However, provisions requiring community participation in disability services legislation, or the obligation to revoke involuntary
admission orders and the right of discharge (which are already contained in Indicator 4) were not counted towards compliance. The National Panel recommends that this question should focus explicitly on the content of community orders, rather than the vague right of return to the community without requiring any support. This question could be combined with Indicator 2A. The current formulation of Indicator 2D merely repeats the requirement of the UN Principles without updating them in line with best legislative practice.

32. The National Panel considered that the Northern Territory had the best legislative practice by fully meeting the requirements in Indicator 2E relating to freedom of lawful communication. The National Panel decided that the current wording of the Indicator relating to positive protection of rights should be retained, rather than requiring the lesser standard of lack of limitation or interference with communication rights. Specifically, only the Northern Territory provided for access to information through the media. The National Panel recommends that this part of the requirement be deleted, as it is better provided for administratively rather than legislatively. Many jurisdictions provided for freedom of correspondence. The Australian Capital Territory had a practical provision that additionally required supply of the necessary equipment, such as paper and sealable envelopes. Commonwealth legislation prohibiting interference with the mail (incoming or outgoing) applied in all jurisdictions. Only a few jurisdictions provided for access to telephones. Personal contact through visitors was often subject to administrative policy, rather than legislative protection.

Indicator 3 – Determination of mental illness

33. New South Wales was assessed to be in total compliance in this Indicator. Victoria and the Northern Territory were assessed in the substantial quadrant. Western Australia and Tasmania were assessed in the significant quadrant. The Australian Capital Territory was assessed to be in partial/significant compliance. South Australia was assessed in the partial quadrant due to similar factors reported in Indicators 1 and 2.

34. Five jurisdictions fully met the requirements for Indicator 3A that the determination of “mental illness” is in accordance with internationally accepted medical standards. Most jurisdictions required that qualified mental health practitioners undertake the determination. Where the Tribunal makes a determination itself, rather than a mental health practitioner, this was considered to be in half compliance, if the determination is informed by such a medical assessment. Two jurisdictions had an overly broad definition that included the concept of mental disturbance or dysfunction - this is not in accordance with internationally acceptable medical standards. The National Panel recommends that the misleading words in parentheses “including generic terms such as disorder or dysfunction” in the question should be deleted. As recommended above, such concepts outside the area of mental health should be dealt with under other specific legislation. If points were not deducted for having an overly broad definition in the determination process, then this would be counter to Indicator 3B below that requires specific matters to be excluded as being determinative of mental illness per se.

35. New South Wales, Victoria and the Northern Territory fully met the criteria in Indicator 3B of factors excluded as being determinative of mental illness. Although full compliance could be assessed under Indicator 3B for generic exclusion, most definitions in legislation were not comprehensive enough to cover these factors, except the factor relating to reasons that are irrelevant to mental health status. Some jurisdictions used these criteria for concepts outside the scope of mental illness, i.e. determining mental dysfunction and appointing a guardian. However, this is not relevant to the determination of mental illness and did not count towards compliance.

36. The wording of Indicators 3C and D were difficult to interpret because they followed the wording of the UN Principles too closely. The requirement to specifically exclude past history of treatment/hospitalisation as being determinative of present mental illness was only met indirectly
in two jurisdictions. Victorian legislation requires a personal examination of the patient to be made by the medical practitioner, with his or her recommendation being based on facts observed within the last 28 days. New South Wales legislation requires the current presence of symptoms that fulfil the relevant criteria. The National Panel recommends that the wording of Indicator 3C be changed to require both a personal examination of the person in respect of whom a determination is being made by a medical practitioner, as well as that symptoms be current or based on facts observed within a limited time beforehand.

37. All jurisdictions fully met the requirements for Indicator 3D, as compulsory medical examinations/assessments can only occur with legislative authorisation. Without consent, such action would constitute assault under the common law. Given this generic protection, it may be better to incorporate this requirement in an existing indicator and lessen its weighting.

**Indicator 4 – Criteria for admission to a mental health facility**

38. Victoria, the Northern Territory and New South Wales were assessed in the substantial quadrant for this Indicator. Tasmania and South Australia were assessed in the significant quadrant. Western Australia was assessed to be in partial/significant compliance, due to only fulfilling about half of the requirements in this Indicator.

39. The requirement in Indicator 4A to restrict the determination of mental illness for the purpose of involuntary admission to two grounds was met by the majority of jurisdictions. The National Panel considered that the best legislative practice was in Victoria where the criteria were fully met. A typographical error was discovered in the wording of the second ground – the word “or” should be replaced by “and”. As with Indicator 3, in jurisdictions where the criteria for involuntary admission were overly broad and included the concepts of mental disturbance or dysfunction, this was assessed to be in half compliance. Some jurisdictions did not fully meet the criteria because of a missing element, such as immediacy or imminence of harm. Although some jurisdictions did not fully cover the second ground of deterioration, it was incorporated in the definition of “harm”. The National Panel considered whether having additional irrelevant criteria, eg property damage, should result in an assessment of lower compliance. It was decided that this penalty should only operate where both authorised grounds exist. Otherwise it would operate as a double penalty where jurisdictions only had one authorised ground and a different unauthorised ground.

40. Most jurisdictions met the requirement to have the determination confirmed by a second mental health practitioner before involuntary admission. Limitations, such requiring the second opinion only where “practicable”, resulted in lower compliance. Similarly, where merely a “further” examination is required rather than a second opinion, this was assessed as lesser compliance. The fact that in some jurisdictions the second opinion is sought of the authorised psychiatrist is not a disqualifying factor. The UN Principles limit the requirement to have a second opinion to cases involving only the second ground of involuntary admission – the National Panel recommends that the requirement apply to any involuntary admission.

41. The National Panel considered that the best legislative practice was in Victoria and the Northern Territory for Indicator 4B. They fulfilled the requirements for preliminary observation/treatment being limited to a short period before being reviewed by a tribunal, as well as grounds and fact of admission being communicated to the person, the tribunal and others nominated, such as personal representative or relative/friend. Other jurisdictions were not in full compliance because the right to information was only triggered by a request, limited to an “adequate opportunity” to notify, or not extended to acceptable third parties. Some jurisdictions mentioned the existence of general written statements of legal rights. This issue is already covered in Indicator 8A, whereas Indicator 4B is only concerned with the specific grounds of detention relevant to the individual concerned.
42. The National Panel considered that the Northern Territory had the best legislative practice in Indicator 4C by fulfilling the requirement that voluntary patients are informed of their substantive right to leave a facility, unless they fulfil the criteria for involuntary admission. Other jurisdictions merely had the specific right without it being communicated to the patient. In one jurisdiction a negative version of the right exists – nothing in the Act prevents a person from discharging himself or herself where there is no involuntary admission order in force. In jurisdictions where voluntary patients have no legislative status, they retain the right (as do non-mental health patients) to leave a facility at any time under the common law. All jurisdictions met the requirement in Indicator 4D to confer a right of discharge on involuntary patients if they no longer fulfil the criteria for involuntary admission.

Indicator 5 – Involuntary review/appeals body

43. The Australian Capital Territory, the Northern Territory and Victoria were assessed in the substantial quadrant for this Indicator. New South Wales, Tasmania, Western Australia and South Australia were assessed in the significant quadrant. There was debate about whether the Australian Capital Territory had the best legislative practice by going beyond the requirements of the UN Principles, as the review body makes the initial involuntary admission order, except in emergency cases. Independently of this issue, the Australian Capital Territory most fully met the requirements in the UN Principles for this Indicator.

44. All jurisdictions fully met the requirement to establish a mental health review body in Indicator 5A. New South Wales, Tasmania, the Northern Territory and the Australian Capital Territory also fully met the criteria for Indicator 5B. It requires the review body’s jurisdiction to include initial and periodic review, as well as applications at reasonable intervals. Other jurisdictions were in lesser compliance when review periods were too long or not available at these various junctures. Six jurisdictions were in full compliance for Indicator 5C, which requires the mental health review body to have the assistance of qualified mental health practitioners independent of the facility, but including members of the Tribunal. One jurisdiction made the point that as its Tribunal was bound by the rules of natural justice, a member who had been previously involved in the treatment of a person could not determine that person’s case.

45. There was variation in the extent to which jurisdictions fulfilled the requirements of Indicator 5D - to make a decision in writing with copies being given to the consumers and his or her representative, as well as informing consumers of their right to request and receive written reasons. The National Panel considered that Victoria had the best legislative practice by advising applicants of this right at the end of a hearing, rather than on admission, and fully met the requirements in the UN Principles. Other jurisdictions were in lower compliance for only having oral decisions (unless they were recorded and copies given), limiting their distribution so as not to include representatives, and failing to inform consumers of their substantive right to request reasons. One jurisdiction only had an automatic right to be provided with an audiotape record of proceedings of the hearing. Some jurisdictions fulfilled the criterion relating to reasons for decisions, but not in respect of the decision itself as this was an administrative rather than legislative requirement. The National Panel queried whether a right relating to reasons might incorporate the decision itself, if it could be inferred from the reasons. However, it decided that it was preferable to have clear provisions relating to both the decision and reasons for it. This right to reasons was not required to be automatically exercised under the UN Principles. The National Panel did not recommend its extension, as this might be too onerous to administer.

46. The National Panel considered that the Northern Territory had the best legislative practice by fully meeting the requirements for Indicator 5E. It requires four criteria to be considered when
deciding whether review body’s decisions can be published. Automatic decisions about publication could never satisfy the criteria relating to the consumer’s wishes. However other factors were variously satisfied. Both non-publication, and publication of de-identified decisions could satisfy privacy. Public interest in the open administration of justice was only satisfied by publication. Preventing serious harm should be achieved by non-publication, but may also be satisfied by publication of de-identified decisions. One jurisdiction did not publish decisions in practice, despite the ability to do so.

47. Six jurisdictions, fully met the criteria for Indicator 5F that required a right of appeal to a higher court against the decision of the mental health review body. In the other jurisdiction the right was limited to points of law, rather than full merits review.

**Indicator 6 - Involuntary review/appeals process**

48. The Northern Territory was assessed to be in total compliance by fully meeting the requirements in this Indicator. Victoria and New South Wales were assessed in the substantial quadrant. Western Australia was in significant/substantial compliance. Tasmania, South Australia and the Australian Capital Territory were assessed in the significant quadrant. Indicator 6 was the Indicator that third most fully met the criteria in the UN Principles on assessment.

49. Four jurisdictions fully met the requirement in Indicator 6A. In the other jurisdictions lesser compliance was assessed because of limitations on the right of appearance of consumers at their hearing – it was subject to not being detrimental to applicants’ health, risking serious harm to others or disrupting proceedings. All jurisdictions fully met the requirements for Indicator 6B - it relates to the right to request and produce independent evidence at the hearing. Five jurisdictions fully met the criterion for Indicator 6C that requires the right to request the presence of a nominated person in the review process. One jurisdiction limited the right to the “person responsible”, ie next of kin. Another jurisdiction automatically limited the right to appear and give evidence to other designated persons, such as the community advocate and the discrimination commissioner, but enabled other persons to appear and give evidence with the leave of the tribunal. One jurisdiction queried the use of the term “expressly or impliedly” in the question in this Indicator – it refers to practice of open courts where, by implication, there would be no limitation on any person attending a hearing.

50. The National Panel considered that the Northern Territory had the best legislative practice for Indicator 6D. It fully complied with the requirement that consumers be advised of their right to request and receive copies of records/documents for the hearing, and went beyond the UN Principles, by automatically giving information to consumers (ie dispensing with the need for them to be informed of the right to request). Other jurisdictions at least recognised the substantive right, but often failed to inform consumers of it, or did not make it operate practically by granting access through giving or allowing copying of the documents. One jurisdiction allowed the right to inspect or otherwise have access – in practice this was interpreted as taking copies, so were in substantial compliance. In other jurisdictions there were no express rights, however there was separate legislative provision under Freedom of Information (FOI) legislation which is already referred to in Indicator 8D. To be consistent, in the absence of specific protection and promotion of these rights, this did not count towards compliance. However, the presence of a specific requirement in mental health legislation to follow the rules of natural justice, which include knowing the case against oneself, was assessed as being in half compliance in this Indicator. The National Panel recommends that a specific question be added to the Instrument regarding the application of the rules of natural justice in review hearings, even though this goes beyond the obligation in the UN Principles.

51. Three jurisdictions fully complied with Indicator 6E which requires three criteria to be taken into account when deciding to have closed or open hearings, as well as requiring reasons for such
decisions and judicial review. The format of the Northern Territory legislative provision was the simplest to understand and implement. Automatic decisions about closed or open courts can never fully satisfy the relevant criteria. For this reason pre-determined compliance ratings were allocated for closed or open hearings, but with the ability to increase compliance by including these additional factors in the process. Some jurisdictions added flexibility to a presumption of closed or open hearings with the ability to rebut, by having regard to the specified factors.

Indicator 7 – Appointment of a personal representative

52. South Australia, followed by the Northern Territory and Tasmania were assessed in the substantial quadrant in this Indicator. Western Australia was assessed as being in substantial/significant compliance. Victoria, New South Wales and the Australian Capital Territory were assessed in the significant quadrant.

53. Six jurisdictions fully met the criteria for Indicator 7A. It requires the establishment of a tribunal to determine a person’s lack of capacity due to mental illness and appoint a personal representative. A limitation in one jurisdiction on the tribunal’s jurisdiction that only covered people with chronic mental illness resulted in an assessment of half compliance.

54. No jurisdiction fully satisfied the requirements in Indicator 7B, and there was significant variation in the extent of implementation. The National Panel considered that the Northern Territory had the best legislative practice by appointing legal representatives automatically without cost, as other jurisdictions merely enabled legal representation. The requirement for the legal representative not to have a conflict of interest was not specifically provided for in any legislation, but was more a matter of professional ethics. However, some jurisdictions did have the power to require separate representation for the person and his or her family. The National Panel recommends that the question be changed to enable separate representation, rather than the present general question on lack of conflict of interest. There would also be benefit in having a requirement that the proposed personal representative, rather than the counsel in proceedings, not have a conflict of interest. The requirement to have regular reviews of decisions at least six monthly was partially met in one jurisdiction which only had such a requirement in respect of residence orders. Other jurisdictions tended to have reviews, either annually, or every three to five years which clearly is beyond the requirement in the UN Principles. Few jurisdictions had a full right of appeal against decisions. In some jurisdictions appeals were either limited to questions of law, or merit review was only granted by leave of the court. Where the legislation clarified that the jurisdiction of the Supreme Court to consider guardianship matters was preserved, this was assessed as half compliance.

55. Most jurisdictions fully met the criteria for Indicator 7C. It requires that the guardian have the power to give substituted informed consent for general mental health treatment. Legislation that only covered voluntary patients was assessed as being in half compliance. One jurisdiction was assessed as not being in compliance as there was a prohibition on guardians or the guardianship tribunal, as opposed to the mental health tribunal, giving informed consent to any mental health treatment. The UN Principles may not be as protective of human rights as this provision that takes powers away from guardians. The National Panel queried whether this issue of consent was double counted under Indicator 9A and therefore should be deleted.

56. All jurisdictions fully met the criteria for Indicator 7D. It requires the tribunal to protect the interests of persons unable to manage their own affairs. The question could perhaps be incorporated into Indicator 7A.

57. The wording of Indicator 7E was problematic, in that it followed the wording of the UN Principles too closely. Most jurisdictions complied with the substantive requirements of the right to have a personal representative other than a family member in their child protection, guardianship,
probate or Supreme Court (in respect of appointing a next friend) legislation. However, one jurisdiction provided that guardianship orders only took effect from the age of majority, ie eighteen years. The National Panel recommends that the question be reworded to require that the tribunal have the power to appoint a personal representative for a minor who is not required to be a family member. At least two additional requirements in making such a determination should be included based on the Rights of the Child Convention – the best interests and expressed wishes/preferences of the minor.

Indicator 8 – Procedural safeguards in mental health facilities

58. The Northern Territory and New South Wales, followed by Victoria and Tasmania were assessed in the substantial quadrant for this Indicator. South Australia, the Australian Capital Territory and Western Australia were assessed in the significant quadrant.

59. There was some confusion because of the wording in the UN Principles as to the breadth of the requirements in Indicator 8 – questions A and D refer to rights exercised generally by patients, whereas B and C seem to be limited to the review process. To avoid confusion, this should be clarified or Indicators 8B and C should be incorporated into Indicators 5 or 6.

60. The National Panel considered that both the Northern Territory and Tasmania had the best legislative practice for Indicator 8A. They fully complied with the requirements to communicate patient rights. Most jurisdictions supplied such information in an understandable format to the patient as soon as possible after admission, but varied in the extent to which this information was given to other nominated persons who represented their interests.

61. The National Panel considered that New South Wales had the best legislative practice for Indicators 8B and 8C. It fully complied with the requirements regarding entitlement to free legal representation and interpretation in proceedings. Other jurisdictions varied in the extent to which they allowed legal representation or interpretation, or merely did not prohibit it. One jurisdiction had the power to appoint legal representation and interpretation, together with notice of this latter fact. In another jurisdiction the tribunal must appoint a legal representative where a person is not represented unless it is not necessary in the circumstances. Free interpretation is provided “so far as is reasonably practicable” both in preparation for and the actual hearing. The Northern Territory had useful provisions that went beyond the requirements in the UN Principles. For the purposes of involuntary treatment, health service providers who are from the same non-English speaking background as the patient are to be used where possible. Treatment and care of a person of Aboriginal or Torres Strait Islander background is to be provided in collaboration with an Aboriginal health worker.

62. Indicator 8D was one of the Indicators with the greatest extent of compliance with the UN Principles. The National Panel considered that the Northern Territory had the best legislative practice with its specific provisions in mental health legislation. The majority of other jurisdictions had freedom of information, medical records or privacy legislation containing the required rights to request information. Some jurisdictions did not contain the right to add comments to a file - however, the right to correct misleading information, or alter/amend records alleviated this.
Indicator 9 – Consent to general mental health treatment

63. Tasmania, followed by Victoria, were assessed in the substantial quadrant for this Indicator. The Australian Capital Territory was assessed in the significant quadrant. New South Wales, South Australia, the Northern Territory and Western Australia were assessed in the partial quadrant, which is the highest number in any Indicator. Indicator 9 was the Indicator that second least met the requirements in the UN Principles on assessment. This is a serious concern, given that the Indicator relates to the central issue of informed consent to treatment. The main reason for lack of compliance with the UN Principles was that several jurisdictions had no provision for seeking consent from involuntary patients, who were automatically assumed (or required as a criteria) incapable of consent.

64. The National Panel considered that Victoria and Tasmania had the best legislative practice for Indicator 9A. They fully met the requirement to obtain informed consent of patients or their personal representatives prior to general mental health treatment. The fact that such protection was contained in the common law in other jurisdictions, rather than mental health or other legislation (eg guardianship) was not counted against compliance. There was inconsistency in jurisdictions’ understanding of the scope of Indicator 9A. The National Panel recommends that the question be clarified to emphasise that there is an obligation to obtain informed consent from both voluntary and involuntary patients in all situations, except as outlined in Indicator 9D. The issue of whether jurisdictions who have broader exceptions than those contained in Indicator 9D should be assessed as being in lower compliance was considered. The National Panel decided that the assessment should be divided, with half being allocated in respect of voluntary, and the other half for involuntary, patients who do not fit the exceptions in Indicator 9D.

65. The National Panel considered that Tasmania had the best legislative practice for Indicator 9B by fully meeting the requirements regarding the procedures for obtaining informed consent. Most jurisdictions did not meet the criteria enabling a patient to request the presence of another person. The National Panel considered that Victoria had the best legislative practice for Indicator 9C by fully meeting the requirement regarding the information given to the consumer when obtaining consent.

66. The National Panel considered that Tasmania had the best legislative practice for Indicator 9D by fully meeting the criteria limiting general mental health treatment without consent to two cases. Other jurisdictions had overly broad grounds, but not additional grounds. As noted above, several jurisdictions bypassed the issue of consent by involuntary patients, which is in breach of the UN Principles. The National Panel recommends that such cases be assessed as being only in half compliance. This is less confusing than the current instruction in the Indicator to take away points for additional grounds. Some jurisdictions queried whether emergency situations, as authorised under the common law would be covered. This is already incorporated in the second ground of the question that requires urgency, harm and strict necessity of treatment. A serious concern in one jurisdiction was the ability to treat persons who are not mentally ill, but fulfil the broader criteria for mental disturbance. This resulted in an assessment of no compliance, as this additional ground was deducted from an existing half compliance assessment - the criteria in the two relevant grounds were also somewhat broader than those contained in the UN Principles.

67. The National Panel considered that Tasmania also had the best legislative practice for Indicator 9E by fully meeting the requirements of the UN Principles in this area. Victoria and the Northern Territory fulfilled the criteria regarding the involvement and provision of information to consumers in the process of non-consensual treatment. Limitations, such as the right only being exercised “where practicable”, resulted in an assessment of lower compliance. Several jurisdictions met the requirement of a right of appeal against a decision to perform non-consensual treatment. Where such jurisdiction was limited, eg time-limited patients or only decisions made by a board, as opposed to a medical practitioner, this also resulted in an assessment of lower compliance.
Indicator 10 – Consent to special procedures

68. Tasmania and the Northern Territory were assessed in the substantial quadrant for this Indicator. Victoria, New South Wales and the Australian Capital Territory were assessed in the significant quadrant. South Australia was assessed in partial/significant compliance. Western Australia was assessed in the partial quadrant. Indicator 10 was the Indicator in the Instrument that third least met the requirements in the UN Principles on assessment. The principal difficulty is in the areas of mechanical restraint and involuntary seclusion, as there is a real need for legislative, rather than purely administrative, provisions to prevent abuses occurring.

69. The majority of jurisdictions were assessed as being in half compliance for Indicator 10A, and the remaining two jurisdictions were not in compliance at all. The main reason for lower compliance was the lack of appropriate criteria, or inclusion of additional criteria for mechanical restraint and involuntary seclusion. Of particular concern was the use of additional grounds such as destruction of property. The use of common criteria was not always appropriate, eg an additional ground of medical treatment may be understandable (but still beyond compliance with the UN Principles) in the case of restraint, but not seclusion. Another problem was the use of separate registers for such procedures, without a requirement to include them in individual patient records, or at least make a cross-reference.

70. The National Panel considered that the Northern Territory had the best legislative practice for Indicator 10B by fully meeting the requirements relating to consent to clinical trials and experiments. Some jurisdictions met all or several of the criteria by the use of generic provisions. Other jurisdictions only covered the case of guardianship, or relied on the common law. The existence of ethical review committees for which there was only an administrative, eg funding, rather than legislative requirement for approval was not sufficient to fulfil this Indicator.

71. Tasmania, New South Wales and the Northern Territory had the best legislative practice for Indicator 10C by completely fulfilling the criteria relating to consent to major medical procedures (ie non-psychiatric). The question should be clarified to ensure that it relates to both voluntary and involuntary patients. Many jurisdictions did not specifically regulate voluntary patients, but relied on the common law. In the case of involuntary patients, jurisdictions that did not provide for an independent body to give substituted consent were assessed to be in lower compliance. Limitations on the class of patients who were considered by the body, eg only patients over 45 days, resulted in an assessment of lower compliance. There was a query whether the authorised psychiatrist could be considered an independent review body, as in Indicator 4A he or she could give a second medical opinion – the National Panel did not support this interpretation. However, this should not detract from the need for such review to be conducted quickly where treatment is urgently required.

72. The National Panel considered that Victoria and New South Wales had the best legislative practice for Indicator 10D. They met the criteria relating to psychosurgery and other intrusive or irreversible treatments that required prohibition for involuntary patients, consent by voluntary patients, and also review by an independent and external body. Other jurisdictions were assessed as only being in half compliance because of limitations in their provisions, such as allowing these treatments for involuntary patients with substituted consent. The prohibition required in the Indicator may be too onerous, as not permitting such treatment for involuntary patients would also satisfy the requirement in the UN Principles of “never” carrying out such treatment. An anomaly existed in one jurisdiction, whereby psychosurgery was banned for the purpose of permanently altering the thoughts, emotions or behaviour of a person, but not any other irrelevant or improper purposes, eg eugenics.

73. The National Panel considered that the Northern Territory had the best legislative practice for Indicator 10E. It fulfilled the requirements relating to appeals in cases of voluntary psychosurgery
or other intrusive, irreversible treatments, and substituted consent for major medical/surgical procedures or clinical trials and experimental treatments. One jurisdiction had appeal provisions to both a specialist committee and the Supreme Court, but they related to involuntary as well as voluntary patients. Other jurisdictions had limitations on these rights. Most jurisdictions provided for appeals against guardianship matters.

74. Six jurisdictions only authorised sterilisation on medical/physical grounds as required in Indicator 10F. In one jurisdiction limitations were placed on guardians giving substituted consent to sterilisations, which resulted in an assessment of half compliance. The wording of this question could be improved by requiring that sterilisation is not permitted on grounds of mental health.

**Indicator 11 – Treatment and medication**

75. The Northern Territory was assessed as being in total compliance with this Indicator by fully meeting the requirements, and therefore provides the best legislative model for complying with the UN Principles in this area. Victoria, South Australia and Tasmania were assessed in the substantial quadrant. New South Wales and Western Australia were assessed in the significant quadrant. The Australian Capital Territory was assessed in the partial quadrant as it only had minimal regulation of medication.

76. Four jurisdictions completely fulfilled the legislative objectives in Indicator 11A relating to providing the least restrictive treatment and enhancing autonomy. The Panel considered Victoria and the Northern Territory had the best legislative practice for Indicator 11B. They fulfilled the legislative objectives relating to the administration of medication to serve the best health needs of consumers and for therapeutic purposes. Most jurisdictions were assessed as being in only half compliance because parts of these objectives were missing, or for the existence of different substantive provisions, such as prohibiting the excessive or inappropriate use of medication or limiting treatment that is primarily used to control behaviour. Two jurisdictions were not in compliance at all as they had no relevant provisions.

77. The majority of jurisdictions’ poisons or therapeutic goods legislation fully complied with Indicator 1C that required only medication of known efficacy to be administered. Most jurisdictions fully met the requirement in Indicator 11D that administration of medication is as prescribed by mental health practitioners authorised by law. This would not prevent nurses giving patients their medication, as long as it had been properly prescribed and the dosage recommended was followed. In one jurisdiction the requirement related merely to the initial prescription, rather than the actual administration of medication, resulting in an assessment of lower compliance.

78. Three jurisdictions fully complied with the basic requirement in Indicator 11E that details of treatment and medication be recorded in patients’ medical files. In one jurisdiction this was met indirectly as there is a right of patients/representatives to request details of medication, and records are therefore maintained in order to meet this potential obligation. The Panel considered that the Northern Territory, Western Australia and South Australia had the best legislative practice by meeting the additional requirement to record whether the treatment was voluntary or not. In Western Australia and South Australia an additional requirement beyond that required in the UN Principles was included – authority for the treatment was recorded, ie details of orders made.
Indicator 12 – Accountability, standards and monitoring

79. Indicator 12 was the Indicator that most fully met the criteria in the UN Principles on assessment. Five jurisdictions (Victoria, Tasmania, and New South Wales, followed by Western Australia and the Northern Territory) were assessed in the substantial quadrant for this Indicator. The Australian Capital Territory was in significant/substantial compliance. South Australia was assessed in the significant quadrant.

80. Six jurisdictions fully met the criteria for Indicator 12A that related to inspection of facilities. In the other jurisdiction the provisions relating to official visitors are not operational as no relevant regulations have been made. Five jurisdictions fully satisfied the requirement to have complaints mechanisms in Indicator 12B. Lower compliance was assessed for limitations in jurisdictions, eg only public but not private practitioners are covered, or only internal but not external complaints bodies are established.

81. All jurisdictions fully met the requirements in Indicators 12C that relate to professional disciplinary procedures. Six jurisdictions fully satisfied the criteria for Indicator 12D that relates to licensing of facilities. The other jurisdiction merely gave the Minister the discretionary power, as opposed to a requirement, to approve facilities in certain circumstances, ie emergency detention or involuntary treatment.

82. No jurisdiction fully met the requirements for Indicator 12E that relates to standards of care. New South Wales, Victoria and Tasmania satisfied most of the criteria. The Northern Territory had good legislative practice by requiring the involvement of consumers in treatment and care plans, including discharge. The Northern Territory legislation also requires that treatment and care is to be based on an individually developed plan that is discussed with the person, reviewed regularly, and revised as necessary by qualified health professionals.

Indicator 13 – General legal provisions (not usually found in mental health law)

83. The Northern Territory, Western Australia, Victoria, Tasmania and New South Wales were assessed in the substantial quadrant in this Indicator. The Australian Capital Territory was in significant/substantial compliance. South Australia was assessed in the significant quadrant. Indicator 13 was the Indicator that second most fully met the criteria in the UN Principles on assessment.

84. Six jurisdictions fully met the criteria for Indicator 13A that requires protection from discrimination. The other jurisdiction had a limitation in State anti-discrimination legislation that did not fully cover disability.

85. Six jurisdictions fully met the requirements in Indicator 13B that relate to the power to order the admission of forensic patients. In the other jurisdictions the power of the court to refer a person to the tribunal where they have been acquitted on the ground of mental illness resulted in an assessment of half compliance. All jurisdictions fully met the criteria for Indicator 13C that relate to the right of forensic patients to have consideration given to their ability to comprehend and take responsibility for their actions. This issue is not given sufficient weight or detail in the UN Principles and could be improved upon in the Instrument.

86. There was variation in the extent to which jurisdictions satisfied the requirements of Indicator 13D. The National Panel considered that the Northern Territory had the best legislative practice by having a specific legislative protection for freedom of religion. Most jurisdictions partially complied in their Constitution or anti-discrimination legislation. There was some debate as to whether this question was necessary, given the alleged lack of problems in practice in mental health facilities.
and the adequate protection of these generic provisions. Also Indicator 3B already requires the exclusion of religious belief as a ground for determining that a person is mentally ill. The National Panel recommends that Indicator 13D be deleted.

87. No jurisdictions fully satisfied the requirements of Indicator 13E. It requires protection of people with a mental illness from economic, sexual and other forms of exploitation or abuse. There was variation in protection under sexual offences laws, labour laws, disability services, consumer protection, guardianship and specific mental health provisions. An example of good legislative practice was in Tasmania that has an offence for ill-treating people with a mental illness.

88. There was variation in the way jurisdictions fulfilled the criteria in Indicator 13F that requires no limitation on the right to recognition as a person, as manifested in areas such as the right to vote or sue in a legal action. The National Panel recommends that this question be more structured. Some State legislation explicitly enables the cancellation of the right to vote, in addition to section 93 of the Commonwealth Electoral Act, 1918, which provides that persons who by reason of unsound mind are incapable of understanding the nature and significance of enrolment and voting are not entitled to be enrolled. Most jurisdictions had Supreme Court Rules that recognised the standing of persons, and enabled representation by appointing personal representatives, guardians or next friends on their behalf. There was some query about whether the ability to hold office was included in this issue of legal status, eg company directorships. In the view of the National Panel the competency to perform certain tasks goes beyond the requirement of recognition before the law. However, such provisions because of their automatic nature are unnecessarily discriminatory and add to the stigma associated with mental illness and therefore should be reviewed.
IV Conclusion

89. The application of the Rights Analysis Instrument methodology to the area of mental health is unique in the area of human rights. The existence of a codified set of norms, such as the United Nations Principles for the Protection of and for the Improvement of Mental Health Care simplified this exercise of refining accountability through measurable performance standards. It is particularly compelling as a quality improvement mechanism in a Federal system. This is because it can accommodate States and Territories’ concern with maintaining their sovereignty through involving them in self-assessment, whilst also recognising the universal application of international human rights norms that cannot be compromised and upholding the consistency of their interpretation through the use of a National Assessment Panel. The use of multi-disciplinary panels involving stakeholders at both these levels has been critical to balance the assessment process. By comprehensively documenting and stimulating best practice, as well as highlighting areas of deficiency, this has led ultimately to increasing compliance with the UN Principles beyond that reported by Burdekin in 1993. It is hoped that the relative success of this project over its five-year period will serve as a model for applying the methodology to other areas of human rights concern.
## Appendix

### Example of Indicator Assessment

<table>
<thead>
<tr>
<th>A. Does the legislation provide for protection for people who are mentally ill against..........?</th>
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<tbody>
<tr>
<td>If yes, score 2</td>
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<table>
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<tr>
<th>B. Does the legislation provide redress for people who are mentally ill against..........?</th>
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<tbody>
<tr>
<td>If yes, score 2</td>
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<tr>
<th>C. Does the legislation contain the following substantive features:</th>
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<tbody>
<tr>
<td>Score 1 for each affirmative answer.</td>
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<tr>
<th>D. Does the legislation provide for the following administrative features:</th>
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<td>Score 1 for each affirmative answer.</td>
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<tr>
<th>E. Does the legislation provide for body to have the following functions:</th>
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<tr>
<td>Score 1 for each affirmative answer.</td>
</tr>
</tbody>
</table>

**Total out of 20** | 17/13/7
Scoring procedure

The above representation attempts to show how three typical assessments in the substantial, significant and partial quadrants are made in a sample Indicator. Question A relates to a core right and has the highest weighting. In the first and second case the jurisdictions’ legislation fully complies with the requirements. In the third case, the jurisdiction only half complies. Question B relates to a right, which is important, but has half the weighting of a core right. The first and second jurisdictions again fully comply with the requirements, but the third jurisdiction only half complies. Questions C, D and E concern subsidiary rights, of which each element has a quarter of the weight of a core right. All the jurisdiction’s legislation does not fulfil all the necessary requirements, but vary in the extent to which they do. In the first case, the jurisdiction fulfils a majority of the criteria. In the second case, the jurisdiction is only in half compliance. In the third case, the jurisdiction only fulfils half or a minority of the criteria. Set out below is an outline of the features of the four quadrants in terms of the three cases in the above sample Indicator.

1. **Substantial compliance** Overall assessment in the first case is in the substantial quadrant, with the fulfilment of all core and important rights, but some small gaps in regard to subsidiary rights. Without the protection of core and important rights, it should not be possible to be assessed in the substantial compliance quadrant, even if all subsidiary rights are protected.

2. **Significant compliance** In the second case assessment is in the significant compliance quadrant. This indicates that core and important rights are present, but there are larger gaps in the provision of protection of subsidiary rights.

3. **Partial compliance** In the third case there are gaps in all areas and an assessment is made in the partial compliance quadrant. In both the significant and partial compliance quadrants it would be possible for core and important rights not to be protected to varying degrees, if subsidiary were fully or largely fulfilled. However, this is unlikely in practice, as usually the subsidiary rights follow on from the core and important rights.

4. **Minimal compliance** If the gaps in all areas were even larger than the third case, then an assessment would be made in the minimal compliance quadrant. If the core and important rights are fully protected it should not be possible to be assessed in the minimal compliance quadrant.