The future of mental health law – the need for deeper examination and broader scope

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Abstract

Recent years have seen increasing reform of mental health law and debate, especially in relation to involuntary detention and treatment, largely stimulated by the passing of the United Nations Convention on the Rights of Persons with Disabilities in 2006. This chapter will examine these changes, surrounding challenges, and some related initiatives including moving towards capacity-based law, mental health advance-decision making, and co-production within mental health law. I will argue that, in order for mental health law to progress towards helping to realise the aspirations of the CRPD, we must direct increased attention towards associated clinical, social, and environmental considerations. In the second half of this chapter, I then examine two areas typically falling beyond the remit of discussions of mental health law and stress their importance in relation to the human rights of those with mental illness – the criminalisation of suicide, and legalising euthanasia for mental disorder or 'psychological suffering'.

Introduction

This chapter aims to outline the most prominent developments in mental health law and examine some challenges arising from these developments, while also considering areas of law rarely included within discussions of mental health law, despite their great significance for individuals with mental illness. Although a comprehensive account is not possible, I will outline major global trends, using illustrative examples, and examine how we might progress towards addressing the many remaining concerns.

The last 20 years have seen some major shifts in mental health law, both internationally and within individual countries. Central to this has been the United Nations Convention on the Rights of Persons with Disabilities (CRPD), passed in 2006 and ratified by 185 States, as of May 2022. The CRPD prioritises maximising the autonomy of those with disabilities, by instituting changes within law, healthcare, and society, which could facilitate social inclusion and a paradigm shift from substitute to supported decision-making (Doyle Guilloud, 2023). In doing so, it presents both significant challenges and opportunities in relation to mental health law.

I will begin by briefly summarising recent changes in laws and ideas discussed in great depth within this Handbook, reviewing some related difficulties and starting to think about how these might be addressed. In particular, we must acknowledge major environmental factors which may obstruct implementation of legal change and the potential unintended consequences and omissions which legal changes may themselves involve. Most important, perhaps, are the continuing lack of resources, stigma, and discrimination in mental health, outlined very powerfully within the recently launched Lancet 'Commission on ending stigma and discrimination in mental health' (Lancet, 2022b). The Lancet's most recent 'Global Burden of Disease' report identifies 'mental disorder' as the health condition with the 7th highest global Disability Adjusted Life Years (DALYs), including the 2nd highest global years of healthy life lost due to disability (YLDs) (Lancet, 2020). Nevertheless, 'worldwide, government spending on mental health is, on average, a paltry 2% of the total health budget' (Lancet, 2022a). To progress towards realising the legal and human rights aspirations of the CRPD these environmental factors must be identified and addressed.

Alongside CRPD-related issues such as decision-making capacity and supported decision-making which dominate current mental health law debates, we must also recognise legal and human rights issues beyond the usual scope of such debates, but with huge relevance for those with mental health conditions. Notably, there are recent developments in medically assisted dying or euthanasia, both generally and relating more specifically to mental health conditions. This issue, with its deeply important legal and ethical challenges, should be incorporated within mainstream ethico-legal mental health debates. Another issue rarely discussed is that attempting suicide remains illegal in multiple countries. Given that severe mental illness is a significant contributory factor in so many suicide attempts, to protect the rights of those with mental health conditions, this issue should not be neglected.

Central to all these issues is the principle of autonomy, one of the four cornerstones of medical ethics. This makes it all the more important to recognise that maximising autonomy is not a straightforward process. Efforts to modify mental health law to improve human rights and justice for those with mental health conditions can only progress effectively through considering the complexities of understanding autonomy in relation to mental illness. We must ensure that an excessively narrow focus on a particular view or element of autonomy does not result in potential harms and injustices being overlooked.

1: The CRPD as a catalyst for change

The CRPD advocates equality for those with disabilities through 'equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (Article 1). Equality, according to the CRPD, includes socio-economic factors, such as the right to 'full and effective participation and inclusion in society' and 'equality of opportunity' (Article

3). The CRPD notion of discrimination is broad, encompassing anything which obstructs full inclusion and participation in the 'political, economic, social, cultural, civil or any other field' (Article 2). Given that the human rights advocated within the CRPD itself are concise but broad in scope, a further Committee on the Rights of Persons with Disabilities, currently comprising eighteen independent experts, was created to monitor implementation of the CRPD, to issue recommendations to member states, and to publish General Comments offering a broader interpretation of the CRPD provisions. It was the first of these comments (GC1), on 'Article 12: Equal recognition before the law', which has stimulated the most intensive discussion in relation to mental health law (2014).

Article 12 calls for State Parties to 'ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law' and lays down some broad guidelines concerning such measures. GC1 interprets Article 12 as requiring governments to move from a 'substitute decision-making paradigm' to a paradigm 'based on supported decision-making' (1/3). It advocates the abolition of 'substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment' (1/7) and presents these laws as restricting the right to exercise 'legal capacity' on an equal basis with others. GC1 prioritises 'legal capacity' and 'takes the position that, while mental capacity may change and fluctuate due to factors such as a person's age, impairment or emotional state, the legal capacity of every individual is unassailable' (Doyle Guilloud, 2023). It presents mental capacity, defined as 'the decision-making skills of a person', as a flawed "highly controversial" concept, 'contingent on social and political contexts', and argues that using impaired decision-making (mental) capacity to justify denying any type of legal capacity is inherently discriminatory and contravenes the fundamental right to 'equal recognition before the law' (Gergel et al., 2021). Both the CRPD and the Committee's interpretation reflect the drive to move away from models of coercive treatment and substitute decision-making which developed during c.20 and have been central to debates surrounding mental healthcare and the law.

The CRPD is underpinned by a primarily social, rather than medical, model of disability (Doyle Guilloud, 2023), while the abolitionist position espoused within GC1 is based on an entirely social model of disability 'which views disability as being entirely created by social, attitudinal, and environmental barriers' (Wilson, 2023). The CRPD Preamble states the need to recognise 'that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'. Thus, even the CRPD and UN Committee's concept of illness and disability departs from mainstream contemporary psychiatry, which generally adheres to the 'biopsychosocial' model influential within modern medicine (Huda, 2021, Borrell-Carrió et al., 2004).

1.1: Coercion – how do things stand and how might we move forwards?

Involuntary treatment and detention have always played a major role in how society manages the care of those with severe mental health conditions (Kelly, 2023). The ethical case for GC1's calls for complete abolition of involuntary treatment can seem compelling. Undoubtedly, despite any regulatory safeguards, experiencing involuntary treatment and detention is usually disturbing and traumatic for service users and even for clinicians responsible for its implementation (Diana Paksarian et al., 2014, Butterworth et al., 2022, Borgeat and Zullino, 2004). Moreover, human rights abuses associated with coercive treatment of mental health service users remain, both under the auspices of mental health law and outside of legal frameworks. Although the CRPD is now ratified by almost all member states of the United Nations, shocking abuses still occur, due to reasons such as lack of resources, stigma, and mistaken beliefs about mental illness. For example, a 2020 'Human Rights Watch' report found 'evidence of shackling across 60 countries across Asia, Africa, Europe, the Middle East, and the Americas' (2020). Even in developed countries with legal safeguards, abuse occurs, as demonstrated by a recent exposé on abusive treatment of individuals detained under the Mental Health Act 1983 at the Edenfield Centre in Manchester, England (Lee, 2022a).

While a cluster of factors, including some progress in human rights law and understanding of mental illness and treatments, and some decrease in stigma, have led to certain improvements and safeguards and slightly decreased need for involuntary treatment, it is evident that we still have far to go.

It is interesting that near global ratification of the CRPD has brought no absolute abolition of legal provision for involuntary treatment for mental illness. As Doyle Guilloud explains, 'at the domestic level, the response has varied from complete rejection, to outright refusal, to major (if not complete) shifts in law and policy' (Doyle Guilloud, 2023). India, despite its 'best effort to give effect to the Convention in national mental health legislation', still has statutory provision for substitute decision-making (Kelly, 2023). In China, where reformed mental health law has narrowed the scope of involuntary treatment and increased provision of voluntary services, remaining legal loopholes and societal factors significantly hamper its implementation (Chen, 2023). At regional level, an additional protocol proposed by the Council of Europe Committee on Bioethics, still under consideration, which 'provides for the involuntary detention and treatment of persons with a "mental disorder" based on need for treatment or dangerousness to others' and 'also endorses the concept of legal incapacity' has created controversy and internal division (Doyle Guilloud, 2023). As Wilson explains 'even Peru, which has come close to abolitionist, allows detention and treatment in emergency situations' (Wilson, 2023).

This situation does not look set to change in the near future and most mental health law remains closer to UN 1991 Principles which constituted major legal advances pre-CRPD by allowing for involuntary

treatment, but imposing protective conditions (Kelly, 2023). So, what changes should we target for coercion within mental healthcare? Would it be realistic or ethical to move towards a zero-coercion model of mental health law, in line with GC1? Clearly, implementation of involuntary treatment and detention needs to change. However, as we consider significant reduction or even abolition, we also need to consider the validity of the abolitionist argument and the potentially negative consequences of such changes.

GC1's call for all legally sanctioned substitute decision-making to be abolished prioritises the UN Committee's model of autonomy above all else. Yet there are many reasons to question the assumption that all statutory provision for involuntary treatment necessarily constitutes a fundamental violation of human rights, especially when a lack of insight into illness and a failure to recognise the need for treatment are often features of severe mental illness (David and Ariyo, 2020). As Lewis puts it: 'This narrow type of autonomy is said to be more important than every other value: health, wellbeing, happiness, living a pain-free life and the right to non-discrimination. In some cases it may be, but in every scenario?' (Craigie et al., 2019). Significant concerns are raised that 'an interpretation precluding any involuntary interventions' may well deprive those with severe mental illness of treatment and stands to threaten or even violate 'an individual's right to health, justice, liberty, and even life', through depriving them of treatment and the 'personal, financial, reputational and occupational damage that may occur ' (Duffy, 2023, Freeman et al., 2015). Indeed, although the UN Committee present their abolitionist stance as part of realising the 'right to health', espoused in CRPD Article 14, Norwegian law actually uses Article 14 itself to justify retention of some legal provision for 'compulsory care or treatment' (Doyle Guilloud, 2023). Moreover, increasing evidence during the last fifteen to twenty years suggests that service users may well retrospectively accept that treatment was beneficial and acknowledge the necessity of involuntary treatment during severe episodes of illness (Larsen and Terkelsen, 2014, Krieger et al., 2018, Borgeat and Zullino, 2004, Craigie et al., 2019, Pathare et al., 2015).

In practical terms, reducing restrictive practices and inpatient care in mental healthcare can, in itself, have adverse consequences for health and may even cause increased reliance on involuntary treatment. Widespread reduction in provision of inpatient care is rarely offset by a corresponding increase in provision for community treatment and care, while resources allocated to mental healthcare remain vastly inadequate throughout the world (Lancet, 2022a, Kelly, 2023). Absence of care leads to increased incidence of severe episodes and, ironically, may well increase usage of coercive interventions, given that care remains unavailable until people experience a health crisis. As Carney explains, shrinking budgets for mental healthcare mean mental health law often becomes the only route for individuals to access treatment and, even then, only for short acute periods (Carney, 2023). Another risk is that raising thresholds for accessing treatment or abolishing involuntary

treatment will result in increased involvement of the criminal justice system for those with mental health conditions (Duffy, 2023). It is already true that 'figures from those detained in prisons in many jurisdictions suggest that the majority of offenders have mental health difficulties' (Peay, 2023). It would be both deeply ironic and damaging if attempts to use international law to maximise the autonomy of those with mental health conditions inadvertently resulted in their increased criminalisation.

It therefore appears that many reasons remain for retaining some statutory provision for substitute decision-making within mental healthcare. Moving forward, therefore, what can be changed to ensure that implementation of coercion maximises the rights of service users? Increasing research shows that, even when service users retrospectively accept the benefit or necessity of involuntary treatment, many still view this treatment as having been administered in ways which were, for example, unnecessarily disrespectful or abusive and made them feel unsafe (Valenti et al., 2014, Larsen and Terkelsen, 2014). There is an increasing drive towards changing how coercive treatment is practised (Krieger et al., 2018), reducing coercion where possible, giving patients more control and maximising dignity, an idea enshrined in the CRPD Article 1's statement of purpose – ' to promote respect for their inherent dignity'. Part of this drive is ensuring that blanket condemnation of coercive practices does not lead to an inability to differentiate between unethical practices and those which have the potential to be used in a way which does not violate human rights (Duffy, 2023). Another important factor is to consider patients' 'emotional safety' (Veale et al.). It is suggested that 'even in the ethically challenging context of involuntary treatment, there are possibilities to increase patient freedoms, enhance their sense of safety and convey respect' (Valenti et al., 2014, Butterworth et al., 2022, Plunkett and Kelly, 2021, Kelly, 2023).

It is also highly likely that, no matter how liberal the law and its aspirations, such goals can only be achieved through huge culture shifts bringing decreased stigma and changing attitudes towards mental illness. One shift could well be moving from the current and stigma-reinforcing legal focus on dangerousness and risk management towards provision of treatment (Kelly, 2023). Moreover, we cannot reduce coercive treatment without increased provision of community services and the type of support which maximises possibilities for moving towards a supported decision-making paradigm (Wilson, 2023).

1.2: Other options for using the law to enhance autonomy

1.2.1 – 'Fusion'

As Kelly argues, the case is strong for viewing the continuing focus on dangerousness and risk management within most mental health law as unjust (Kelly, 2023). The principal idea proposed for addressing such injustice is moving from the dangerousness criterion towards a system based on impaired mental/decision-making capacity (DMC). Widely known as 'fusion' and gaining increasing

prominence, some claim that this system would allow equality between mental and physical health by making substitute decision-making within any medical context contingent on a clinical judgement of impaired DMC in relation to specific treatment decisions (Szmukler, 2017). 'Fusion' might also reflect the increasing significance of DMC within psychiatry, even where laws are not capacity-based (Ruck Keene and Reidy, 2023).

'Fusion' may represent a way to make mental health law more equitable (Davidson, 2023). However, many questions about its practicability and potential still need to be addressed. Given that psychiatric assessment of DMC is central to 'fusion', the issue of accuracy of assessment is critical. While some evidence supports the reliability of psychiatric capacity assessment (Cairns et al., 2005b, Okai et al., 2007), other evidence suggests that major uncertainties surrounding accuracy remain (Charland, 2016, Verhofstadt et al., 2019a, Ferracuti and Parmigiani, 2023). These include great variability in assessment methods (Calcedo-Barba et al., 2020, Okai et al., 2007) and the proportion of patients judged to retain DMC in different studies (Curley et al., 2022). For example, while a 2005 British study reported that 43.8% of their inpatient participants lacked DMC in relation to treatment (DMC-T) (Cairns et al., 2005a), a 2020 meta-review based primarily on inpatient participants suggests that up to 75% of psychiatric patients, even when hospitalised for severe mental illness, may retain DMC and that '[d]ecisional capacity impairments in psychotic patients are temporal, identifiable, and responsive to interventions directed towards simplifying information, encouraging training and shared decision making' (Calcedo-Barba et al., 2020). Moreover, 'fusion' cannot offer a complete solution for proponents of the abolitionist position, insofar as GC1 would still render substitute decision-making based on impaired DMC as a denial of 'legal capacity' and therefore as a violation of human rights.

Other questions concern the feasibility of implementing 'fusion' and its potential for making a significant difference. Although Northern Ireland has introduced fusion via the Mental Capacity Act 2016, remaining difficulties and questions mean that it is not yet implemented (Davidson, 2023). Would a move towards DMC-based mental health law make a substantive difference to issues such as involuntary treatment? Given the variability and evaluative elements of DMC and its assessment, would the majority of patients who would have been treated involuntarily under risk-based laws simply now be assessed as lacking DMC-T? Is there a danger that 'fusion' could lead to longer periods of detention in those who retain DMC-T, but refuse treatment, both within the criminal justice system (Davidson, 2023), and within healthcare? For example, following a landmark case in Canada (Starson v Swayze 2003 SCC 32), where the Supreme Court upheld Starson's right to refuse treatment on grounds that he had DMC-T, Starson was lawfully detained involuntarily for many years in Ontario psychiatric hospitals without treatment.

The recent Independent Review of the Mental Health Act in England and Wales proposed five ‘confidence tests’ to evaluate feasibility of ‘fusion’. These were examining service user views, the impact of ‘fusion’ legislation in Northern Ireland, the reliability of DMC assessment, the possibility of adapting associated processes, and public interest (Ruck Keene and Reidy, 2023). However, even if DMC-based laws might come closer to exemplifying UN principles (Kelly, 2023), as with the CRPD, how much change can they initiate if socio-economic frameworks are not modified to support those with mental illness? As Ruck-Keene and Reidy argue, if no mechanisms exist supporting the CRPD’s right to independent living and social inclusion (Article 19), then ‘fusion’ debates ‘will reduce to little more than a debate about what to label the lock on the door of the institution where the person will end up in crisis’ (Ruck Keene and Reidy, 2023).

1.2.2 – Advance decision-making (ADM) in mental health

Advance decision-making (ADM) in mental health, also known as psychiatric advance directives or advance statements, are based on Dworkin’s principle of ‘precedent autonomy’, allowing that ‘an individual's preferences when autonomous trump their preferences when lacking autonomy and that this can extend self-determination to incapacity’ (Gergel and Owen, 2015). ADM can help to ensure that, despite ongoing legal provision for involuntary treatment, people have the right to contribute in advance to decisions about management of care and treatment when severely unwell, and it could be an important way of increasing autonomy within mental healthcare. ADM even appears to accord with the UN Committee to some extent, given that GC1 states that ‘all persons with disabilities have the right to engage in advance planning’, although the fact that ADM is implemented when an individual is assessed as lacking in DMC during a health crisis also appears to render ADM in violation of GC1’s prohibition of denying ‘legal capacity’ (Gergel et al., 2021, Stephenson et al., 2020).

There has been growing support for mental health ADM. While some states in the USA and the Netherlands have already had legal provision for mental health ADM for some time, countries such as India, Australia (in some states and territories), Chile, and Peru have recently introduced this (Gergel et al., 2021) Marshall and Gómez Yuri, H. 2022). The UK government has also now committed to introducing statutory provision for ADM in England and Wales, following the recent Independent Review of the Mental Health Act (Stephenson et al., 2020). Research has confirmed that key stakeholders are interested in ADM as a way to improve management of mental illness, and has produced some evidence for effectiveness in reducing coercion, including reduction in involuntary admission rates in ethnic minority populations, and improving the therapeutic alliance (Stephenson et al., 2020, Frances, 2021, Ariyo et al., 2021). In the words of Allen Frances:

> Advance directives are perhaps the only intervention in psychiatry that is without a downside. Relapses are much shorter and less harmful when treated promptly. Accepting that future

> relapses can occur provides patients with the strongest possible incentive to reduce their probability by participating fully in preventive disease management. And ideological and legal controversies about the role of coercion in psychiatry usually dissolve in the cooperation forged by jointly facing clinical reality (Frances, 2021).

Moreover, not all mental health ADM aims to reduce the use of hospitalisation or enforced treatment. 'Self-binding directives' (SBDs) or 'Ulysses contracts' are a form of ADM which 'instruct clinicians to overrule treatment refusal during future severe episodes by using involuntary treatment'. SBDs are particularly interesting, not simply in terms of potential for maximising autonomy and reducing illness-related harms, but also insofar as they depend upon acceptance and support for statutory provision of involuntary treatment. Opposition to SBDs based on GC1's abolitionist stance may well contravene the wishes of the individual themselves (Duffy, 2023). SBDs have been promoted and discussed since the 1970s and some very limited provision for SBDs has been introduced in parts of Europe, North America, and Australasia. There is now also research demonstrating patient support for SBDs, which should go some way to addressing the remaining ethico-legal concerns (Gergel et al., 2021, Hindley et al., 2019). Interestingly, qualitative analysis of reasons given by individuals with bipolar disorder for endorsing SBDs actually indicated service user support for the notion of impaired DMC, as well as involuntary treatment. Although the survey question did not mention DMC, endorsement responses were dominated by the view that their severe episodes of illness involved a 'determinate shift (from valid thinking when well) that substantially compromised decision-making abilities'.

In conclusion, there is strong support for ADM in mental health and a small, but increasing, amount of research exploring its outcomes (Stephenson et al., 2022). Nevertheless, it has also been recognised that take-up can remain low, even when law supports ADM, suggesting that introduction of statutory provision alone is not sufficient for facilitating ADM. It is also critical that education and frameworks are provided to ensure the availability and practicability of mental health ADM (James et al., 2022, Gieselmann et al., 2018, Stephenson et al., 2020).

1.2.3: Co-production and mental health law

Another way to try to ensure that mental health law reflects the priorities of service users themselves is increasing use of co-production with mental health law. Underpinned by the principle of 'nothing about us without us', 'co-production' is the active involvement of people with lived experience of illness. Co-production is expanding in many areas of mental health (Gergel and Kabir, 2017), including the development and administration of law. Innovative involvement of the disability community was central to developing the CRPD itself (Doyle Guilloud, 2023) and follow-on initiatives such as the WHO Quality Rights Initiative (Duffy, 2023). McSherry and Carney both discuss the need for co-production and recent Australian initiatives ensuring that involvement of those

with lived experience becomes a legislative requirement (McSherry, 2023; Carney, 2023). Co-production has been an important element of law reform in countries including India, England and Wales, and Northern Ireland ({Gov.uk, 2018; Davidson, 2023; Dey and Mellsop, 2023).

Going forward, development of mental health law must incorporate expertise through experience. Yet we must also be aware of some of the challenges facing service user involvement in the law and elsewhere. One problem is that the value of service user expertise may be questioned by other stakeholders, with worries that it only reflects 'personal perspectives', rather than broad areas of knowledge (Gergel and Kabir, 2017). Another issue is ensuring that co-production is truly representative, not tokenistic (Gergel and Kabir, 2017), and includes input from a broad range of service users and user organisations. Moreover, to produce practicable recommendations, it must be truly collaborative and include input from clinicians alongside service users. For example, even those who are deeply supportive of service user involvement in drafting the CRPD and General Comments, express major concerns that the extreme abolitionist position expressed in GC1 and the resultant controversies stemmed from exclusion of clinical input and failure to include a broad range of service user views (Freeman et al., 2015).

1.3: Reforming mental health law – environmental factors, unintended consequences, and omissions

As discussed above, mental health legislation does not exist within a vacuum. With mental health law dominated by a drive towards using law to realise the aspirations of the CRPD, feasibility and applicability of laws depend upon and are affected by multiple environmental factors, while legal changes and even debates can have unintended consequences or omit significant factors. To make progress, it is essential that these issues are explored and addressed.

As can be seen, for example, in the Asian subcontinent, factors such as insufficient resources, culture, social structure, and stigma can obstruct both legal change and implementation of new laws. India's new Mental Healthcare Act 2017 represents a 'bold step' away from outdated laws stemming back to colonial rule and is a 'rights-based mental health law'. Nevertheless, its implementation has been hindered through insufficient funding, while certain elements of the new law are incompatible with existing social structures. The case is similar regarding 'ongoing concerns about the gap between the legislative framework and current practice in Pakistan'. Meanwhile, poor understanding and unscientific cultural beliefs regarding mental illness mean that people still approach religious leaders, rather than seeking medical intervention (Carney, 2023; Dey and Mellsop, 2023).

Others raise concerns that the dominance of controversies surrounding involuntary treatment and mental capacity within legal debates leads to the neglect of other critical issues, particularly how to realise the CRPD's positive rights to socio-economic inclusion (Kelly, 2023). Carney suggests that, even though socio-economic exclusion is both a cause and consequence of mental illness, inclusion is

largely overlooked in relation to law due to the difficulties of measuring it, together with a shortage of resources (Carney, 2023). An excessive focus on coercion and capacity within legal debate may even be contributing to the comparative neglect of issues of inclusion (Craigie et al., 2019). Fulfilling the CRPD's principles of non-discrimination and inclusion will depend upon increasing prioritisation of socio-economic rights and dominant service user concerns, such as resources and how the law 'impacts on access to employment, housing and services generally' (Bell, 2023; Carney, 2023). Kelly suggests that we may also need to look beyond mental health legislation and that 'some rights might be better protected, and some needs better met, through mental health policy, social policy, and broader societal awareness and reform' (Kelly, 2023).

Another issue often neglected in relation to mental health law is legal equality. While Article 7 of the 1948 Universal Declaration of Human Rights states 'All are equal before the law and are entitled without any discrimination to equal protection of the law' (Nations, 1948), these rights are rarely realised within the application and even structure of mental health law. From an international perspective, although the rights advocated in the CRPD should be universally applicable, factors such as insufficient resources and prevalent cultural beliefs make implementation harder or even unattainable in many low and middle income countries (Carney, 2023; Duffy, 2023). Within individual nations, inequalities within the application and structure of law affect a number of particular populations.

Legal debate needs urgently to address the fact that coercive practices are disproportionately associated with social deprivation, male gender, and ethnic minorities, as well as particular symptoms and diagnoses (Keown et al., 2016)Ferracuti and Parmigiani, 2023). Structural racism, exclusion and prejudice towards ethnic minorities, and a lack of cultural competency amongst mental health professionals are other factors which hinder mental health equity (Michael Mensah et al., 2021, Gone and Kirmayer, 2020, Venkataramu et al., 2021) and are highly relevant to mental health law, both in terms of protecting rights and decreasing disproportionate use of involuntary treatment. Disproportionately high involuntary detention, treatment, and police involvement amongst ethnic minorities is widely recognised (Keown et al., 2016). For example, a principal aim of the recent Independent Review of the Mental Health Act in England and Wales was addressing 'the disproportionate number of people from black and minority ethnic groups detained under the Act, police involvement, admission to secure hospitals, and poorer outcomes' (Gov.uk, 2018). It remains to be seen whether the proposed changes will have a significant impact on this situation. The law also needs to do more to address the fact that the needs of older adults are not yet adequately reflected in mental health law (Weller, 2023) and to address issues of prejudice based on gender and sexuality in relation to mental health (Argüello, 2020)

Mental health law should offer protection to those who experience mental illness. Excluding certain conditions, such as personality and substance abuse disorder, from the remit of mental health law in many countries (Dey and Mellsop, 2023), can result in poorer health and social outcomes and increased criminalisation. Conditions are either explicitly excluded from detention under mental health laws, or though defining mental illness within the law in terms 'tailored to psychosis, thought disorder or mood disorders' (O'Loughlin, 2023). Some possible progress is being made in this direction, for example, in Northern Ireland, through broad changes to mental health laws (Davidson, 2023), or in New Zealand through the recent Substance Addiction (Compulsory Assessment and Treatment) Act 2017. This innovative law offers compulsory treatment for 'severe substance addiction' when necessary and when provision of treatment is available, on the grounds of impaired DMC-T (Health, 2017). However, far more must be done to ensure that particular conditions do not fall beneath the radar of mental health law.

2: Moving beyond 'mental health law' – suicide, euthanasia, mental illness, and the law.

Despite the continuing criminalisation and stigmatisation of suicide and increasing movements towards legalising physician-assisted suicide for those with psychiatric conditions, these issues are very rarely included within mainstream discussions of 'mental health law'. Given the strong association between mental illness and suicide, the case seems strong for directing more attention towards these issues going forward. Moreover, another reason for drawing these issues into broader discussions of mental health law is that the risk factors identified above in relation to mental health law in terms of environmental factors, unintended consequences, and omissions, could all potentially contribute towards causation of both suicide attempts and the type of chronic and apparently hopeless situations which might lead an individual towards requesting euthanasia. Although I cannot explore all aspects of practice or debate, I will aim to give a broad indication and consider some of the most pressing concerns.

A recent review reports that 'suicides account for 1.4% of premature deaths worldwide'. Suicide is a global phenomenon and 'the majority of suicides worldwide are related to psychiatric diseases'. It is estimated that 'half of all completed suicides are related to depressive and other mood disorders' (Bachmann, 2018). The link between severe mental illness and suicide has been well documented (Bertolote and Fleischmann, 2002, UGMH, 2021). For bipolar disorder, for example, the mental disorder with probably the highest suicide risk, it is estimated that 'about one-third to one-half of bipolar patients attempt suicide at least once in their lifetime and approximately 15–20% die due to suicide' (Dome et al., 2019, Miller and Black, 2020). Suicidal ideation and actions are viewed as key diagnostic criteria associated with multiple categories of mental disorder in both the WHO's International Classification of Diseases and the American Psychiatric Association's DSM-V, and high suicide rates are also linked to psychotic, eating, personality, substance abuse, and other mental

disorders (Bachmann, 2018, Bertolote and Fleischmann, 2002). It is also highly likely that both suicide rates and the links to mental illness are under-reported, given the stigma and even, in some countries, illegality of suicide, combined with the fact that suicide often occurs in early episodes of illness and may well occur before diagnosis. For bipolar disorder, for example, the average delay between onset of illness and diagnosis is estimated to be close to a decade (Fritz et al., 2017, Scott and Leboyer, 2011, Lublóy et al., 2020). Suicide risks are intensified by the global phenomenon of lack of resources for healthcare; lack of inclusion; stigma, discrimination, and abuse associated with mental illness.

Clearly this relation between suicide and mental disorder should be carefully considered in any matters relating to law and suicide. Yet it is frequently overlooked or downplayed in debates surrounding both euthanasia and the criminalisation of attempting suicide. Surely a key question in relation to both issues must be, given that suicidaility is a core feature of mental illness, could it ever be just for the law either effectively to aid illness by facilitating suicide or to punish and stigmatise individuals for their illness, through criminalisation of suicide?

2.1 Criminalisation of suicide

Historically, suicide has been stigmatised from both cultural and religious viewpoints and viewed, for example, as a criminal act of selfishness and cowardice. While most countries have now reformed laws criminalising attempted suicide, such laws do still exist (Mishara and Weisstub, 2016), and calls for reform are complicated by cultural and religious sensitivities. A 2021 report by the International Association for Suicide Prevention together with United for Global Mental Health was part of working towards the 'United Nations Sustainable Development Goal: Good Health and Wellbeing's target to reduce suicides globally'. It details the current state of affairs, outlines key concerns, and calls for decriminalisation. Efforts towards decriminalisation are being made - 'in recent years legislation criminalising suicide has been successfully repealed or superseded by new legislation in the Cayman Islands, Cyprus, Singapore and India' (UGMH, 2021, Lancet, 2014). Nevertheless, as of 2021, attempting suicide is a criminal offence in at least 20 countries worldwide, with a further 20 countries prosecuting suicide attempts under sharia law (UGMH, 2021).

Laws criminalising suicide are usually part of a penal or criminal code which often dates back to laws imposed by colonial powers, when 'suicide or attempted suicide was considered a crime against the state, as well as against religion'. They were written ' when mental health was grossly misunderstood and human rights abuses regarding mental health were commonplace' and one obstacle facing reform is that this situation still remains in many of these countries (UGMH, 2021). In Pakistan, for example, both factors still influence law and practice, with suicide and attempted suicide still 'deemed criminal offences under section 309 of the Pakistan Penal Code', and a 2018 amendment to mental health law decriminalising attempting suicide yet to be practically implemented. Such is the stigma and fear

surrounding disclosure of suicide that Pakistan has only included suicide among annual mortality data since 2017 (Khan and Khan, 2020).

Failure to collect accurate data concerning suicide and suicide attempts is one major harm which results from such laws, with suicide prevention initiatives hampered by underrepresentation or even concealing of suicide prevalence rates. This remains the case, even in many countries where suicide is no longer illegal. Despite suicide being a worldwide epidemic, 'only 87 countries have quality data concerning suicide' (Mishara and Weisstub, 2016, UGMH, 2021, Wu et al., 2022). Criminalising suicide also contributes to perpetuating stigma and stops people from seeking help (Khan and Khan, 2020), with research suggesting that laws penalising suicide were associated with higher national suicide rates (Wu et al., 2022, UGMH, 2021). At the World Health Assembly in 2019, all health ministers agreed that decriminalising suicide was an effective way to reduce deaths by suicide when they approved the World Health Organization (WHO) Mental Health Action Plan for 2021-2030. Moreover, legal procedures and even imprisonment of those who attempt suicide have severe adverse effects on their mental health.

It is also important to note that, even in countries where suicide is no longer deemed a criminal offence, ongoing stigma and prejudice can result in criminalisation of suicidality. In the US, for example, there have been cases of a pregnant woman attempting suicide being prosecuted for murder, or where military personnel attempting suicide face criminal charges and even imprisonment (Mishara and Weisstub, 2016). In the UK, there has been considerable recent controversy over the now withdrawn SIM (Serenity Integrated Mentoring) scheme which involved the police in 'mentoring' of those who had experienced police involvement during a mental health emergency and, effectively, resulted in criminal sanctions as a response to suicidality (Thomson et al., 2022, House, 2022). Even outside of SIM, however, criminalisation of those who are suicidal has been longstanding and still continues, using mechanisms such as 'antisocial behaviour orders, community protection notices and criminal behaviour orders'. Although suicide was decriminalised fully in the UK 55 years ago, there are examples of people being charged with 'breach of the peace for causing alarm to a police officer by disclosing suicidal thoughts, criminal damage for dislodging fencing while jumping from a bridge, or wasting police time for calls made by healthcare staff to police' (Thomson et al., 2022). As Thomson and others argue, these practices are both unethical and damaging, and need urgently to be addressed.

The criminalisation of suicide does not typically fall within the remit of mental health law debates and is also an area which must be approached with cultural awareness, especially given that many calls for reform come from ex-colonial nations, historically responsible for the initial criminalisation. Nevertheless, given the associations between mental illness and suicide, ongoing stigma and lack of resources for healthcare and societal inclusion, and the harms engendered by criminalisation of

suicide, we must devote more attention towards campaigning for the remaining laws which criminalise suicide to be overturned (Mishara and Weisstub, 2016). We must also direct attention towards preventing criminalisation of suicidality through other legal avenues, in countries where attempting suicide is officially no longer a criminal offence. Looking beyond the law, an important part of this is to prioritise increasing our understanding of suicide, allowing us to address continuing stigmatisation and misconceptions. We must work towards a future where those who are suicidal can request and receive help without fear of reprisal, legal or otherwise.

2.2 What price 'autonomy'? Euthanasia and mental illness.

2.2.1 Physician-assisted suicide (PAS) and mental illness – how things stand

While five US states and Switzerland have already legalised euthanasia for terminal medical conditions, the BeNeLux countries Belgium, Luxembourg, and the Netherlands have, since 2002, legalised physician-assisted suicide (PAS) for both terminal and non-terminal medical conditions (Verhofstadt et al., 2019b, Verhofstadt et al., 2017). Canada joined these countries in March 2021, with Bill C-7 amendments to their 2015 MAiD (medical assistance in dying) Laws, removing the 'foreseeable death requirement' (Whitelaw et al., 2022, Webster, 2022).

As Lemmens reports about the law in Belgium and the Netherlands: 'Generally, patients can request euthanasia if all of the following criteria are fulfilled: (1) they have a medical condition; (2) which causes unbearable (physical or psychological) suffering; (3) the situation is medically hopeless (Belgium) or there is no prospect of improvement (Netherlands); and (4) the suffering cannot be alleviated (Belgium) or there is no reasonable alternative solution (Netherlands)' (Lemmens, 2018). The inclusion of conditions which cause unbearable *psychological* suffering allows those with chronic mental health conditions the possibility of requesting physician-assisted suicide (PAS) (Kelly, 2017, Lemmens, 2018). In March 2023 Canada's 2021 revisions to the MAiD laws will expand to include patients with mental illness. Although final reviews are still ongoing, Canada's MAiD laws are more 'permissive', with less safeguards, than their BeNeLux counterparts (Webster, 2022).

Instances of euthanasia-assisted suicide (EAS) in Belgium and the Netherlands have increased dramatically, with such deaths now accounting for a far greater percentage of overall deaths in Belgium and the Netherlands than in US states which have legalised PAS only for terminal conditions (Lemmens, 2018). EAS accounted for 4.5% of all deaths (7666) in the Netherlands in 2021 (Euthanasie, 2021), with rates going as high as 14.43% in some districts (Groenewoud et al., 2021), while Belgium had its highest ever number in 2021, with 2699 euthanasia-related deaths (l'euthanasie, 2022).

A major increase in requests for PAS amongst psychiatric patients has generated growing opposition to the inclusion of mental illness as a basis for PAS (Verhofstadt et al., 2019b, Lemmens, 2018). In

the Netherlands psychiatric cases have steadily increased from 1% of all EAS in 2016 to 1.5% in 2021 and EAS for dementia accounts for 2.8% (Euthanasie, 2021).

In Belgium, some recent controversies have seen a slight decline (Lemmens, 2018), with psychiatric cases accounting for 0.9% of 2699 total EAS deaths in 2021 compared to 2.3% of 1928 deaths in 2014 (l'euthanasie, 2022). One high-profile controversy was the case of Tina Nys, a 38 years old woman, who suffered a relapse after a very long period of stability and was then diagnosed with autism, but not treated, two months before being 'euthanized in the presence of her traumatized family members' (Lemmens, 2018). This case, in which 'the patient was euthanized without it having been substantiated that her psychiatric illness had no prospect of improvement and that her suffering could not be alleviated' became the first criminal trial in Belgium of PAS clinicians, although they were not convicted (De Hert et al., 2022). Alongside this came controversies raised by a 2015 study published by the Belgian psychiatrist, Thienpont, who admits to a very flexible approach towards granting euthanasia requests and was revealed to be responsible for approving almost 50% of Belgian cases of PAS for mental illness in the period leading up to publication (Lemmens, 2018).

In Canada euthanasia rates are now increasing even faster than in Belgium and the Netherlands and have far less stringent safeguards, in general and, especially in relation to the upcoming inclusion of mental illness as a sole or primary criterion in MAiD laws (Webster, 2022, Guly, 2022). Numbers have already increased from 2838 in MAiD's first year (2017) to '10,064—accounting for more than 3 percent of all deaths in Canada that year' in 2021 (Subramanya, 2022). Concerns have been raised over a number of controversial cases such as Alan Nichols, who died via MAiD in July 2019, after being detained involuntarily under the Mental Health Act in June 2019 (Nichols, 2020), or recent reports of MAiD being suggested unprompted by Veteran Affairs Canada to a Canadian armed forces veteran seeking help for post-traumatic stress disorder and a traumatic brain injury (Lee, 2022b). The impending addition of mental illness to MAiD criteria, following a Senate amendment which pressured parliament to overturn its original exclusion of mental illness, remains deeply controversial (Guly, 2022). Even those who advocate for the inclusion of mental illness have expressed deep concerns about the lack of adequate safeguards and insufficient impartiality within Canada's expert panel on MAiD and Mental Illness, who were commissioned to review and issue recommendations concerning the upcoming legislation (Kirby, 2022, Guly, 2022).

Expansion of PAS/MAiD to include non-terminal conditions and disabilities, both physical and psychiatric, has been justified on the basis of prioritising equality and autonomy, insofar as restriction to those suffering from terminal conditions is presented as discriminating against those who suffer from chronic health conditions/disabilities. In Canada, for example, the 2021 expansion of MAiD laws was due to a ruling following a constitutional challenge, which stipulated that 'the restriction to a reasonably foreseeable death is an unjustifiable impingement on the right to life, liberty, and security

of the person and the right to equality' (Whitelaw et al., 2022). However, given the numerous legal and ethical concerns about this expansion, we must consider whether, ironically, it actually risks abusing the autonomy and equality it supposedly protects. Might it be the case, as Charland suggested, that 'nascent science, inadequate regulations, economic pressures and incentives, and an overly zealous commitment to autonomy and individualism at all costs, make us worry whether autonomy may actually be turning on its own and is poised to devour its most vulnerable subjects' (Charland, 2016)?

2.2.2 Problems and challenges facing euthanasia for mental illness

The legalisation of euthanasia based on a sole or primary reason of mental illness or 'psychological suffering' faces significant legal, ethical, and practical challenges, while strong evidence suggests that we currently lack sufficient knowledge and resources relating to mental illness to allow a safe and ethical clinical and social environment for this practise. Here is a brief summary of key concerns relating to euthanasia for mental illness or 'psychological suffering' and an account of how many concerns seem to be substantiated by increasing evidence of abuse and controversy within the countries which have legalised this practice (Charland, 2016).

One factor underpinning all concerns relating to PAS for mental illness is a comparative lack of knowledge. Compared to many physical disorders mental disorder is poorly understood and unpredictable (Kelly, 2017, Naudts et al., 2006, Nicolini et al., 2022). We lack, or are severely limited in, our ability to understand and measure what would constitute irremediable suffering, to establish that all options and hope of future improvement have been exhausted, and, accordingly, to make informed decisions about the validity of this practice. An additional factor relevant to all concerns is the global lack of resources devoted both to care and support for those with mental illness and to research into mental illness which could expand our understanding. Given that this shows no immediate signs of being significantly alleviated, how could we ever be justified in saying that we have considered all clinical and socio-economic interventions which could potentially improve outcomes? Insufficient knowledge and resources must constitute critical factors to consider in relation to all euthanasia-based concerns.

One of the greatest concerns about PAS for mental illness is the fact that suicidality is itself an intrinsic feature of many types of severe mental illness, as explained above in relation to the criminalisation of suicide. Suicide prevention, through treating illness and protecting individuals from harming themselves, is central to mental healthcare. So, could we ever truly overcome concerns that PAS is responding to a symptom of illness instead of aiming to find alternative interventions to help recovery or improvement (Kelly, 2017; Verhofstadt, Van Assche, et al., 2019)?

Medical evidence suggests that psychiatric illness is usually treatable, episodic, and transient, meaning that there can never be certainty regarding the absence of possible improvement or recovery

(Verhofstadt et al., 2019b, Nicolini et al., 2022). As Kelly argues, ‘with mental illness there is no point at which can say that a person’s illness is untreatable or that their suffering cannot be alleviated, either now or at some future point’ (Kelly, 2017). A recent review of PAS cases involving ‘treatment resistant depression’ concludes that ‘[o]ur findings suggest that the objective standard for irremediability in psychiatric EAS cannot be met, raising implications for policy and practice around the world’ (Nicolini et al., 2022), while others discuss the potential complexities of establishing irremediability in relation to personality disorders, a common diagnosis in PAS requests (Nicolini et al., 2020). The Canadian Mental Health Association has now made an about-turn in relation to MAiD, by accepting the proposed inclusion of mental illness, albeit with numerous safeguards which do not actually look feasible. However, a main reason for their initial strong opposition to its inclusion was the episodic nature of mental illness and uncertainties regarding prognosis, stating ‘Mental illness is very often episodic. Death, on the other hand, is not reversible. In Dutch and Belgian studies, a high proportion of people who were seeking MAID for psychiatric reasons, but did not get it, later changed their minds’ (Webster, 2022).

Another major concern is that, according to the generally accepted biopsychosocial model of mental illness, socio-environmental factors can be a major contributory factor in its onset, deterioration, and continuation. Given the lack of resources currently allocated to mental healthcare and the major socioeconomic challenges facing so many people with mental illness, many factors which contribute to ‘psychological suffering’ may well be alleviated through better provision of resources (Kelly, 2017, Verhofstadt et al., 2019b). It is deeply disturbing to recognise that, for both mental illness and other health conditions and disabilities, death might become an alternative to providing improved resources or treatments. The reality of these concerns is borne out by existing evidence. The controversial Belgian psychiatrist Thienpont admitted ‘accepting social determinants of health as sources of unbearable suffering’ when approving PAS requests (Lemmens, 2018), while a recent qualitative study examining the concept of ‘unbearable suffering’ through the testimonials of 26 psychiatric patients requesting PAS in Belgium, found that socio-economic factors, including financial issues like the unaffordability of paying for continued treatment, were major contributory factors (Verhofstadt et al., 2017). This study also reported ‘the experience of solitude or loneliness because of a lack of social support from “society in general”’ as reasons for requesting PAS, while a review of 66 Dutch PAS cases concluded that ‘most of the patients had personality disorders and were identified as socially isolated and lonely’ (Kim et al., 2016). As Verhofstadt states, ‘Some correlates of suffering (such as low income) indicate the need for a broad medical, societal and political debate on how to reduce the burden of financial and socioeconomic difficulties and inequalities in order to reduce patients' desire for euthanasia. Euthanasia should never be seen (or used) as a means of resolving societal failures’ (Verhofstadt et al., 2017).

A connected concern is the issue of normalisation, whereby, as PAS becomes increasingly accepted and repeated, death is more readily considered or offered as a solution (Lemmens, 2018, Whitelaw et al., 2022, Naudts et al., 2006). The increasing numbers of PAS cases for mental illness in Belgium and the Netherlands suggest that this a very real phenomenon rather than some theoretical 'slippery slope' concern. In Canada, the situation regarding MAiD for mental illness seems potentially even worse, since there will be no requirement for the physician to pursue other treatment options with patients and it is even the case that 'physicians and nurse practitioners would have a "professional obligation" to initiate conversations about MAiD if they believe a patient might be eligible' (Benson, 2022, Kirkey, 2022).

Alongside normalisation comes the very legitimate concern that increased provision for PAS for disabilities including mental illness will result in devaluing the life of those with disabilities, with euthanasia increasingly becoming a substitute for failing to provide adequate resources, support, and treatment (Lemmens, 2018) – in the words of a recent UN report 'life-ending interventions are normalized for people who are not terminally ill or suffering at the end of their lives, such legislative provisions tend to rest on – or draw strength from – ableist assumptions about the inherent 'quality of life' or 'worth' of the life of a person with a disability' (Mulligan, 2022). This is a particular concern for people with severe mental illness, who are already often amongst the most disadvantaged and disenfranchised members of society (Whitelaw et al., 2022). Research found that being a burden to family, friends, or society was given amongst reasons for requesting PAS by psychiatric patients in Belgium (Verhofstadt et al., 2017), where such guilt is not necessarily viewed as a legally invalid reason for this request (Verhofstadt, Van Assche, et al., 2019). As Naudts says, 'Patients who primarily have a mental disorder are at substantial risk of judging themselves to be a burden on their carers' (Naudts et al., 2006) and it seems that legally sanctioned provision of PAS is already reinforcing this view.

Further concerns are the risk of undue influence, either from family or clinicians, pushing people towards seeking PAS and the increased risk and complexity relating to particular patient populations (Kirkey, 2022). Clinical opinion regarding PAS varies greatly and there is a risk that clinical endorsement of PAS in itself suggests a lack of hope of recovery or alleviation of suffering to patients (Kelly, 2017). Moreover, the controversies surrounding Thienpoint show that 'change in practice can be driven by a small number of medical practitioners, and in a direction that arguably moves away from the original intent of the regulatory regime' (Lemmens, 2018).

There are particular issues surrounding dementia, PAS, and rising numbers. In the Netherlands, for example, numbers have risen from 12 cases in 2009 to 215 cases in 2021 (2.8% of all euthanasia cases) (Lemmens, 2018, Euthanasie, 2021). There are concerns about an 'expansion of the access criteria' for dementia cases and worries about imposing euthanasia on an elderly population, many of

whom might not be able to fully comprehend what is happening and whose 'unbearable suffering' is difficult to establish, given the lack of awareness associated with severe dementia. It is also feared that expansion of PAS in dementia cases may lead to devaluing 'quality of life in the context of dementia' and have an 'impact on societal perception of cognitive disabilities more broadly' (Lemmens, 2018). There have already been many controversial and shocking cases, especially in relation to administering treatment according to an advance directives requesting euthanasia (Lemmens, 2018, Groenewoud et al., 2022, Miller et al., 2019).

Particular concerns have been raised about PAS amongst the prison population, especially given the prevalence of mental disorders, an extremely insufficient provision of treatment and care, and the proliferation of 'external factors' which can contribute to suffering. In the words of Franke et al., 'strong safeguards are necessary to prevent a slippery slope toward AD (assisted death) becoming the preferred method for ending suffering from untreated or incurable mental disorders in detention because other options (e.g., sufficient mental health care) are lacking' (Franke, Urwyler, & Prüter-Schwarte, 2022).

Finally, there are major procedural concerns that adequate safeguards regarding assessment of eligibility for PAS are either currently lacking or actually not possible. The most significant questions concern the difficulties of measuring 'psychological suffering' and assessing decision-making capacity (DMC) in relation to PAS. It is argued that there is insufficient understanding of the type and level of suffering which would prompt psychiatric patients to consider PAS, as well as no clear consensus regarding multiple clinical issues (Verhofstadt et al., 2019a, Nicolini et al., 2022, Nicolini et al., 2020). As van Veen and others write in relation to MAiD and mental illness: 'Challenges regarding the definition, diagnosis and treatment of irremediable psychiatric suffering complicate the process of establishing it in the context of MAiD. Development of consensus clinical criteria for irremediable psychiatric suffering in this context and further research to understand "treatment fatigue" among patients with psychiatric disorders may help address these challenges' (van Veen et al., 2022).

Assessing whether someone has capacity to consent to PAS in relation to mental illness is particularly complex. Yet DMC, despite its centrality, is rarely discussed in relation, for example, to MAiD, where discussions 'tend to be very general and ideological and conveniently overlook practical details' (Charland, 2016). Assessment of DMC in mental illness in general is still a relatively new area with many uncertainties and remains 'a matter of considerable controversy among many researchers and clinicians' (Charland, 2016). There are significant difficulties in establishing whether DMC is 'affected by a psychiatric disorder' (Verhofstadt et al., 2019b, Naudts et al., 2006) and major concerns about how clinicians' personal values might influence capacity assessments, so that a ' "sliding

standard of competence" poses the risk of further paternalistic, non-voluntary euthanasia' (Naudts et al., 2006, Charland, 2016, Lemmens, 2018)

Such concerns are substantiated by evidence from Belgium and the Netherlands suggesting that safeguards are insufficiently observed (Verhofstadt et al., 2019b, Lemmens, 2018, Kim and Lemmens, 2016) As Kim and Lemmens report: 'there is a gap between the idealized basis upon which MAID is advocated for patients with psychiatric conditions and the reality of its practice.' (Kim and Lemmens, 2016). Analysis of Netherlands PAS cases shows that DMC assessment was often superficial, was subject to disagreement both in relation to DMC and irremediability, and that low thresholds for DMC may 'reflect the normative position of the review committees' (Doernberg et al., 2016, Kim et al., 2016). Although many cases of PAS in the Netherlands and Belgium do involve a second consultation with a specialist clinician, this second consultation is not legally binding and PAS often proceeds despite clinical disagreement (Lemmens, 2018).

In conclusion, the numerous concerns, many based on worrying evidence from current practice in countries where PAS for mental illness is legal, suggest that there are strong arguments for prohibition or abolition of such legalisation and that current knowledge and resources are, indeed, insufficient to facilitate safe and ethical practice. Nevertheless, numbers of PAS cases for mental illness in Belgium and the Netherlands have increased and this practice will soon be legalised in Canada. Moreover, there is a strong possibility that these existing models might impel other countries towards considering this practice, especially as people become more sympathetic to euthanasia in general. It is imperative, therefore, that during the next decade, this issue receives increased attention and resources, and becomes a major element of debate within mental health law and ethics.

Conclusion

There is still much to be done to address the constitution, application, and debates surrounding mental health law, especially relating to the prevalence and practice of involuntary treatment. Moreover, progress towards realising the CRPD's aspirations for justice, autonomy, equality, and inclusion, will also depend upon prioritising the multiple interconnected environmental factors and considering legal issues beyond the traditional remit of mental health law, such as criminalisation of suicide and euthanasia. It is also critical that the dominance of a particular libertarian view of autonomy manifest, for example, in assumptions about rights to abolition of all involuntary health interventions or euthanasia, does not inadvertently produce harmful outcomes or even threaten the autonomy of people with mental illness.

Nevertheless, there may be some grounds for optimism about addressing stigma, increasing resources, and legal reform. While certainly true, as the Lancet Commission reports, that stigma and discrimination surrounding mental health is an ongoing global issue, the very existence of high profile initiatives such as the Lancet Commission demonstrates the increasing prioritisation of the rights and

well-being of those with mental health conditions (Lancet, 2022b). While resources for mental health research remain vastly insufficient, it is heartening to note, for example, that the Wellcome Trust, one of the world's largest funders for medical research, has recently identified mental health as one of three core health challenges and priorities for health research alongside infectious diseases and climate and health (Wellcome). Moreover, as we have seen, considerable progress is also being made in mental health law itself. Recent years have seen the introduction of new mental health laws, reforms to existing laws, increasing safeguards, and movements towards change, largely motivated by the passing of the CRPD in 2006. Initiatives such as growing recognition and provision for mental health advance decision-making and coproduction within law have great potential for maximising the autonomy of people with mental illness and ensuring relevance to their concerns. There has been some progress towards decriminalisation of suicide, together with increased awareness and campaigns. Despite the enormity and urgency of the remaining challenges, these recent changes and initiatives suggest a growing global recognition of the importance of mental health law and the human rights of people with mental health conditions.

Acknowledgements

TG is funded by the Wellcome Trust, UK (grant number 203376/Z/16/Z), as part of the Mental Health and Justice project. I am grateful to Trudo Lemmens, Scott Kim, and Niall Boyce for providing information in relation to euthanasia and criminalisation of suicide, and to Brendan Kelly and Mary Donnelly for their guidance and support in the preparation of this chapter.

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