

Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature

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Abstract

Mental health tribunals are responsible for making decisions about compulsory treatment for individuals considered a risk to themselves and others due to mental disorder. They are generally designed to provide safeguards for individuals subject to compulsory treatment by testing whether national legislative criteria and international human rights standards have been met. Despite this, they have been criticised for being dominated by the medical domain, focusing rigidly on legal criteria, and for restricting human rights, including the rights to liberty and access to justice. As a result, questions have arisen over the extent to which mental health tribunals are indeed operating in line with their legislative intentions and international human rights requirements. The aim of this systematic review was to synthesise international evidence on this and to assess the extent to which this is reflected in such literature. A systematic search of the literature was conducted on the 17th April 2018 for articles published between 2000 and 2018 in MEDLINE, CINAHL, PsychINFO, ASSIA, and Web of Science. All study designs were included within this review, provided they reported empirical findings. Thirty-two studies met the inclusion criteria. Eight themes were identified across the literature and these were participation, information and understanding, patient representation, the power of the medical domain, feelings of powerlessness, perceptions of fairness, risk, and the impact on relationships. The findings call into question whether mental health tribunals necessarily operate in compliance with international human rights standards. This article suggests that mental health tribunals may need to do more to safeguard legislative principles and human rights standards that promote patient autonomy.

Keywords: Mental Health, Mental Health Act, Human Rights, Systematic Reviews

What is known about this topic

- Mental health tribunals may not be fully safeguarding the maximisation of patient autonomy in care and treatment situations.
- Mental health tribunals have been criticised for denying patients' human rights through effectively legitimising coercion and restricting access to justice.

What this paper adds

- The participatory potential of mental health tribunals can be undermined by medicalised and legal cultural practices that dominate proceedings.
- A lack of meaningful patient involvement in tribunals can lead to feelings of powerlessness and perceptions about procedural unfairness.
- Cultural change is required to bring mental health tribunals in line with national legislative and international human rights standards.

Introduction

Mental disorder¹ is recognised as a global health concern and is one that has attracted significant international attention. Mental disorder includes psychosocial, intellectual and other cognitive disabilities and includes common disorders such as depression and anxiety (World Health Organisation, 2017). It is estimated that some 300 million people globally experience depression, equating to about 4.4% of the world population. Similarly, anxiety disorders are common and are experienced by about 264 million people globally, equating to 3.6% of the world population (World Health Organisation, 2017). While less common, diagnoses of schizophrenia and bipolar disorder are associated with increased premature mortality (Walker *et al*, 2015). Mental disorder is common across the regions and populations of the world and is overrepresented in specific subpopulations. This includes women, young people, people with intellectual disabilities, individuals from lower socioeconomic groups, and those who are unemployed, homeless, and have problem substance use (Semrau *et al*, 2015; Howlett *et al*, 2015; Whiteford *et al*, 2015; Winkler *et al*, 2017).

Mental disorder has significant implications for the individual, their family, and care services, and requires a strategic policy focus and service delivery systems (Reed *et al*, 2015; Andrade *et al*, 2014). Despite the high prevalence globally, it is an issue that is neglected when compared to common physical health conditions such as cardiovascular disease (Vigo *et al*, 2016). Some people may require access to specialist mental health services and treatments, which may be delivered compulsorily for a time where it is considered necessary to ensure compliance and prevent risk of harm to self and others (Owen *et al*, 2016). A range of approaches have therefore been developed in different countries across the world to respond to a perceived need for compulsory treatment, including the introduction of mental health tribunals.

Mental health tribunals are generally seen as independent forums and are responsible for making decisions about compulsory treatment in both community and hospital

¹ We recognise the importance of language and acknowledge the issues associated with terminology, particularly in relation to 'mental illness'. Whilst the authors prefer the language of mental distress or psychosocial disabilities, the term 'mental disorder' has been adopted as this is often the terminology used within mental health legislation and wider literature on mental health tribunals.

environments (Diesfield & McKenna, 2006). They ostensibly act as a safeguard for individuals subject to involuntary treatment, providing checks and balances against clinical decision-making by testing whether legislative criteria have been met (Carney & Beaupert, 2008; Ng *et al*, 2016). Tribunals are often regarded as being more participatory than court-based systems in that they actively involve individuals subject to compulsory treatment in the decision-making process (Carney & Beaupert, 2008). Moreover, multi-member, multi-disciplinary, panels are designed to strengthen the decision-making process by ensuring that a variety of expertise informs deliberations (Diesfield & McKenna, 2006).

Although tribunals may be considered a safeguard against unlawful detention, evidence has demonstrated that their limited jurisdiction may restrict their ability to do this (Carney, 2012; Carney & Tait, 2011). Furthermore, the over-reliance on clinical evidence, and the dominance of the health domain, have been cited as undermining the jurisdiction of the tribunal (Carney, 2012; Murphy *et al*, 2017). Resourcing may also impact on the availability of patient representation, such as independent advocacy (Scottish Independence Advocacy Alliance, 2017; Mental Welfare Commission for Scotland, 2018). In addition, the UN Report of the Special Rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health has condemned the use of mental health tribunals for legitimising coercion and limiting access to justice (UNHRC, 2017).

International human rights frameworks are designed to protect individuals from abuses of power and have important ramifications for mental health tribunals (Freeman, 2011: UN Human Rights Council, 2017). The European Convention on Human Rights (ECHR) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD), for example, contain a range of entitlements and protections for persons with psychosocial, intellectual and other cognitive disabilities (Bartlett, 2012). That being said, the ECHR and CRPD approaches to compulsory care and treatment differ. On the one hand, and in line with the approach traditionally adopted under other international human rights treaties, the ECHR and its case law defines the boundaries of non-consensual intervention. Whilst it increasingly emphasises the need to respect individual autonomy it accepts that, subject to safeguards, non-consensual treatment may be justified on the basis of a diagnosis of mental disorder and related mental

incapacity assessments (Flynn & Arstein-Kerslake, 2014). On the other hand, the CRPD represents a radical departure from this approach, moving away from the limitation of rights predicated on diagnosis and incapacity assessments, as such denial does not allow for the equal enjoyment of rights by all (Stavert & McGregor, 2018). Instead, it requires the provision of support to enable substantive rights to be claimed (Bartlett, 2012). Article 12 of the CRPD (Equal Recognition Before the Law) is particularly pertinent as it identifies the universal right to exercise legal capacity and access to appropriate support to achieve this (UN Committee on the Rights of Persons with Disabilities, 2014; Stavert & McGregor, 2018). This is based upon the premise that by providing a range of person-centred supports, all individuals, including those with mental distress, can exercise legal capacity (UN Committee on the Rights of Persons with Disabilities, 2014): Flynn & Arstein-Kerslake, 2014). Notwithstanding their different approaches, the ECHR and CRPD can therefore be said to have a commonality of purpose in recognising the need to maintain and enhance individual autonomy.

Domestic legislation and policy, increasingly influenced by international human rights requirements, also shape tribunal practices. In Scotland, for example, patient-centred human rights based principles were incorporated into, and underpin the operation of, the Mental Health (Care and Treatment) (Scotland) Act 2003, including participation, benefit, reciprocity, and least restrictive alternative. These principles must be applied by the Mental Health Tribunal for Scotland in its processes and decision-making deliberations.

Given the increasing international human rights focus on patient autonomy and the equal and non-discriminatory enjoyment of rights by persons with mental disorder, it is therefore timely to consider whether mental health tribunals are operating in accordance with such standards. A systematic review was conducted in 2012 but it specifically focused upon tribunal decision-making and did not include all operational aspects of mental health tribunals (Thom & Nakaranda-Kordic, 2014). The remit of the current systematic review is broader in scope and builds upon the 2012 review. It includes a range of stakeholder's views about the operation of mental health tribunals and how this is situated within the broader human rights landscape. It thus provides

an update on the existing research knowledge base whilst examining this specifically from a human rights perspective.

Methods

This systematic review was conducted as part of a wider project into the Mental Health Tribunal for Scotland (MHTS), which seeks to investigate the views and experiences of patients, Named Persons, practitioners, and tribunal members. This review sought to synthesise national and international literature to answer the following research questions:

- What are the views and experiences of patients, supporters and carers, and stakeholders of mental health tribunals?
- To what extent do mental health tribunals give effect to person-centred national legislative principles and human rights standards?

A systematic search of the literature was conducted on the 17th April 2018 using the databases: MEDLINE, CINAHL, PsychINFO, ASSIA, and Web of Science for articles published between 2000 and April 2018. This particular timescale was selected to take account of any articles published in the years that immediately preceded the Mental Health (Care and Treatment) (Scotland) Act 2003 being enacted, which is key legislation that is pertinent to the wider study. A subject librarian assisted with the search strategy.

An initial scoping exercise was completed to identify relevant MeSH and thesaurus headings and keywords. A search of abstracts and titles was conducted for terms including 'tribunal', 'hearing', 'review board', 'mental health act', 'involuntary admission', 'compulsory treatment', 'involuntary treatment', 'involuntary commitment', 'community treatment order', 'CTO', 'outpatient commitment', 'assertive outreach', 'community treatment'. This was adapted for each database in line with the relevant subject indexing terms; an example from MEDLINE is outlined in Table 1.

Inclusion and Exclusion Criteria

All study designs were included within this review, provided that they contained relevant keywords in the title or abstract, were published in English, had been subject

to peer review, and addressed at least one of the research questions. In addition, studies had to report empirical findings about mental health tribunals, thus omitting review articles and commentaries. Articles that focused upon compulsory treatment more broadly that did not include views or experiences of the tribunal were excluded.

A total of 1327 articles were initially identified, reducing to 1224 once duplicates and those not specifically focusing on the review questions were removed. One researcher (AM) reviewed the titles and abstracts and 1119 were excluded at this stage. One hundred and five articles were read in full by two researchers (AM and JS), leaving a total of thirty-two articles for inclusion. Figure 1 provides a PRISMA diagram of the process. Any articles that were assessed as borderline in meeting the criteria were discussed and agreed by consensus.

Assessment of Methodological Rigour

The Critical Appraisal Skills Programme was used in order to assess methodological rigour. Each article was assessed against a series of standards examining the aims, methodology, research design, recruitment strategy, data collection, researcher/participant relationship, ethics, analysis, statement of findings, and value of the research. Each study was allocated a score, with a maximum of two available for each domain, leaving a total out of twenty. Table 2 gives a breakdown of the scores **and Table 3 provides an overview of the studies**. Fourteen studies achieved scores of fifteen or over, indicating high methodological quality, whilst seventeen received fewer than fifteen, indicating significant gaps or weak methodological rigor. No studies were excluded on the basis of the robustness of the methodology.

Certain methodological weaknesses in the existing literature were, however, identified and the findings of this review must therefore be considered with these in mind. For example, some studies scored poorly relation to the researcher/participant relationship. Only five studies scored full marks in this category and another partially fulfilled this criterion, scoring one out of a possible two. The majority of papers failed to demonstrate adequate reflexivity, whereby reflecting upon the role of the researcher, including issues around potential bias and power dynamics. In addition, several studies either omitted discussion of the ethical issues pertaining to the

research process and/or failed to state whether ethical approval was obtained. Several studies also either failed to discuss the research design or provide an adequate justification for the design adopted.

Analysis and Results

Systematic reviews have established processes for synthesising quantitative research but these are less developed for qualitative studies (Thomas & Harden, 2008). As the current review included qualitative, quantitative and mixed methods research designs, it was important to develop a method that could accommodate these diverse approaches. The framework method (Ritchie and Lewis, 2003; Spencer *et al*, 2013) was drawn upon, which provides a structured way to manage and analyse large volumes of data (Ritchie and Lewis, 2003; Spencer *et al*, 2013). A key component involves creating a thematic framework and charting data according to themes in a matrix (Ritchie and Lewis, 2003; Spencer *et al*, 2013). The first stage of the process comprised of creating an annotated bibliography including a description of the aim, methods, key findings, strengths and limitations. The findings were grouped into themes, initially using an inductive approach to coding, and these were subsequently refined. Notes and extracts from the included studies were then placed in the thematic matrix, allowing comparisons to be made within and across the literature. Table 4 illustrates the coding framework and Table 5 provides an extract from the thematic chart for information and understanding.

The studies were undertaken in Australia, New Zealand, Canada, the United Kingdom, the United States, Ireland, South Korea and Poland. Table 6 provides an overview of tribunal activity in these countries. Eight key themes were identified across the studies and were: participation, information and understanding, patient representation, the power of the medical domain, feelings of powerlessness, perceptions of fairness, tribunal decision-making and the impact on relationships. The remainder of this article presents the key findings and discusses the implications of these for compliance with person-centred legislative principles and human rights standards.

Participation

Participation is a key legislative principle that aims to increase user involvement and is one of the key rationales for moving away from court-based systems (Ridley & Hunter, 2013). Where human rights are interpreted as promoting individual autonomy then this may be enhanced by including people in tribunal decision-making processes.

The literature highlights that whilst there is potential for meaningful participation in tribunal decision-making this is often limited in practice. Analysis of tribunal written decisions in New Zealand found that the voice of the individual was evident within these - either through direct quotations, written submissions, or indirect references to the individual's views – but only occasional references were made to treatment preferences (Diesfield & McKenna, 2006). In another study, forensic patients in New Zealand noted that the tribunal is the only mechanism available to promote voice (Ng *et al*, 2016) and **research on** forensic mental health tribunals in Canada illustrated that being able to attend the tribunal can foster a sense of involvement (Livingston *et al*, 2016). Likewise, a study in three jurisdictions in Australia revealed that some informants valued the opportunity to have their views heard, although they were limited in what they could discuss (Carney & Tait, 2011). This has led to criticisms of parochialism with mental health tribunals in Australia, focusing narrowly on the fulfilment of the legal criteria and excluding information about the social and family context and the iatrogenic effects of medication (Carney, 2012; Beaupert & Vernon, 2011). As a result, calls have been made for wider engagement with subjective experiences of treatment (Carney & Tait, 2011) and other pertinent issues that are neglected within tribunal deliberations (Beaupert & Vernon, 2011).

A perceived unsuccessful outcome may also undermine a tribunal providing opportunities for participation in decision-making (Livingston *et al*, 2016; Ridley & Hunter, 2013; Wyder, 2015). A study into the early implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 found that half of the informants felt that the outcome of their tribunal hearing was a 'foregone conclusion' and that tribunal outcomes that deviated from individuals' preferences undermined valuable mechanisms – such as advance statements, the named person provision and independent advocacy – which were designed to enhance participation (Ridley &

Hunter, 2013). The inability of individuals to shape tribunal outcomes was also evident in a survey with mental health review board members in South Korea, where individuals and carers' wishes were not factored into the tribunal's decision-making deliberations (Lee *et al*, 2014).

A range of barriers and facilitators to participation were identified within the literature. One study in Ireland found that having the opportunity to share ones' views and having these listened to reinforces that individuals' perspectives are valued (Murphy *et al*, 2017). Nonetheless, tribunal cultures have been condemned as a barrier to participation with the weighting afforded to psychiatric evidence and the use of reports perceived to be inaccurate being particular issues (Murphy *et al*, 2017). In addition, inaccessible jargon, not being able to challenge evidence as it is presented, being the last person to speak during proceedings and being discouraged from speaking altogether reduces autonomy and disrupts the participatory potential of the tribunal (Murphy *et al*, 2017; Livingston *et al*, 2016).

Some of the studies also focused on carer participation, a legislative principle that operates in some jurisdictions such as Scotland and New South Wales. The included studies revealed that carer participation is variable. In their study examining carer involvement in care planning and tribunal decision-making processes in three jurisdictions in Australia, Beaupert & Vernon (2011) found that tribunal discretion shaped carer involvement. When carers did participate they reported being treated with respect, had the opportunity to share their views and, crucially, felt they were listened to. However, many carers did not participate in tribunal proceedings. This was largely due to not being informed about tribunal proceedings and not understanding its scope and purpose (Beaupert & Vernon, 2011). In a Scottish study, Ridley *et al* (2010) found that named persons felt empowered by their formal role and felt they were listened to by professionals, although carers who were not named persons were not fully included in decision-making. Thus, whilst human rights protections and legislative principles might be designed to safeguard autonomy, their actual implementation is impeded if individuals are not fully informed and involved.

Information and Understanding

Person-centred practice requires that tribunal processes are accessible. The support for equal recognition before the law required by Article 12(3) CRPD is interpreted as including the provision of accessible information to facilitate supported decision-making (UN Committee on the Rights of Persons with Disabilities, 2014). However, people subject to compulsory treatment often receive poor information about the mental health tribunal. Quantitative studies highlight gaps in knowledge and understanding about the mental health tribunal process and accompanying statutory rights. Gallapathie *et al* (2013) observed that out of 65 evaluated cases in England, only 70% of patients were aware of at least one way that they could request a tribunal. Similarly, a study conducted in Ireland found that 73% of informants were aware that they could appeal the decision (O'Donoghue *et al*, 2010) and this percentage was found to be slightly higher, at 78%, in a Western Australian study (Rolfe *et al*, 2008). Although these indicate that the majority of individuals were aware of how to appeal decisions about involuntary treatment, a significant minority were not, underpinning the need for additional support to enable individuals to understand and claim their rights.

Impairment arising from mental distress can also act as a barrier to processing and retaining information and the withholding of information, or providing inaccessible information, can foster misunderstanding and prevent people from exercising their right to a fair hearing. A study conducted with social workers and physicians in British Columbia reported that only 39.5% had informed patients of their right to a review panel (Yip, 2003). In addition, Georgiva *et al* (2017) observed that only 34% of informants in Ireland were actually satisfied with the level of information they received.

The way in which information is presented is also pertinent to recipient understanding. The importance of receiving information at different times and in an informal way has been demonstrated (Murphy *et al*, 2017). In an Irish study, only a minority of informants received clear information and many felt that they lacked understanding about the purpose, process and outcome of the tribunal and consequently felt unprepared (Murphy *et al*, 2017).

Knowledge and understanding require the provision of clear, timely and accessible information. In a study conducted in England, for example, approved mental health practitioners reported difficulties in meeting individuals prior to tribunals taking place when they were given short notice of tribunal hearings (Banks *et al*, 2016). Whilst written information was usually provided in these circumstances, some individuals' required intensive support to understand and retain information and this was often unavailable (Banks *et al*, 2016). As a result, some service users could not recall being provided with written information and lacked understanding about the purpose of advocacy and their legal rights including the right to appeal (Banks *et al*, 2016). Issues have also been identified with individuals not remembering information in three Australian jurisdictions (Carney & Tait, 2011) as a result of the iatrogenic effects of medication (Beaupert, 2009). Another study, however, revealed that informants in Canada perceived there to be good accessible information, which was not patronising (Livingston *et al*, 2016).

Impact on Relationships

Person-centred practice is also dependent upon the development of good quality relationships. Giving evidence in support of compulsory treatment, however, can cause tensions in inter-personal relationships and relations with mental health professionals (Donnelly *et al*, 2011; Jabbar *et al*, 2010; Ng *et al*, 2016; Ridley & Hunter, 2013; Yip, 2003). In a Canadian study, around one third of social workers and physicians felt that their relationships with patients were negatively impacted by discussions about the review panel (Yip, 2003). This was higher in a survey sent to all members of the Royal College of Psychiatrists in Ireland, with 41% saying that their relationship had changed as a result of the Mental Health Act 2001, which had become more legalistic, more conflicted, less collaborative and less trusting (Jabbar *et al*, 2010). This was reinforced in a study amongst forensic patients in New Zealand who expressed that tribunals could result in a loss of trust with clinicians (Ng *et al*, 2016) and by similar findings in another study relating to tribunals in Ireland (Donnelly *et al*, 2011). The Mental Health (Care and Treatment) (Scotland) Act 2003 has been perceived as shifting the focus away from therapeutic relationships to managing compliance (Ridley & Hunter, 2013). In addition, psychiatrists have indicated that their

workload has increased as a result of the 2003 Act, which has negatively impacted on the quality of care provided to voluntary patients (Donaldson *et al*, 2008).

Studies indicate that disruptions to family relationships can also occur as a result of involvement in the tribunal (Beaupert & Vernon, 2011; Carney, 2012; Grundell, 2005; O'Donoghue *et al*, 2010). This has clear implications for recognising the right to respect for family life identified in Article 8 ECHR and Article 23 CRPD. Families are often involved in providing evidence to mental health tribunals or in instigating involuntary treatment (O'Donoghue *et al*, 2010). Tensions can arise as a result of this, particularly where there is a disagreement of views between individuals and their relatives (Beaupert & Vernon, 2009; Carney, 2012; Grundell, 2005). In an Irish study, it was reported that families instigating involuntary treatment had a negative effect in 27.5% of cases and a positive impact in 15% of cases (O'Donoghue *et al*, 2010). In Scotland, a patient may appoint a named person to support them although the named person role is to provide an independent view about care and treatment rather than advocating the patient's perspective (Ridley *et al*, 2010). Whilst named persons have reported a resultant strengthened relationship with professionals, as this legitimised their involvement, this has created tensions with the patient where the views of the patient and named person do not coincide (Ridley *et al*, 2010).

Patient Representation

Article 12 of the CRPD requires that individuals are provided with access to support so they can exercise their legal capacity on an equal basis with others. However, the evidence suggests discordance between discourse and practice here.

Advocacy can be an important means of supporting decision-making. Individuals in a large scale multiple case study conducted in England were found to be generally satisfied with advocacy support when they received it (Newbigging *et al*, 2014). However, in order to be effective, advocacy must be accessible, and over two thirds of participants who were eligible for advocacy but did not use it were unaware of its purpose (Newbigging *et al*, 2014). Whilst individuals using advocacy were often more articulate and knowledgeable about compulsory treatment, the uptake was lowest amongst those most in need (Newbigging *et al*, 2014). Indeed, reduced rates of use in inner city areas and amongst children, young people, and those from BME

communities were reported (Newbigging *et al*, 2014). Access issues were also reinforced in another English study where participants represented by independent advocates were those with the most knowledge of CTOs (Banks *et al*, 2016) .

Similarly, legal representation may facilitate the exercise of legal capacity. However, poor access to legal representation has also been highlighted in a number of studies (Carney, 2012; Swain, 2000; Beaupert, 2009). Low rates of legal representation have been reported in Australia for those who have been involuntarily hospitalised (Beaupert, 2009; Carney, 2012), and this was even lower for those on community treatment orders due to a lack of legal aid funding (Carney & Tait, 2011). In Victoria, for example, only 13% of a sample of 300 individuals had legal representation (Carney & Tait, 2011: 141) and only two out of twenty-five observed tribunals had a legal representative or advocate in another Victorian study (Swain, 2000). Of these, six were decided on the basis of paper work alone without the cross-examination of witnesses (Swain, 2000). The quality of legal representation has also faced scrutiny in New Zealand due to inadequate challenging of evidence and individuals' feeling that insufficient time was spent with a lawyer in advance of a hearing (Ng *et al*, 2016). In Poland, poor legal representation is linked to the mandatory appointment process and low remuneration of attorneys who are required to provide legal aid (Doll, 2016). Furthermore, a study found that solicitors in Ireland do not always act in the best interests of the individual (Smyth *et al*, 2017). These studies collectively demonstrate the need for further investment in advocacy and legal services to ensure individuals are fully and effectively represented.

The Power of the Medical Domain

The extent to which practices are viewed as human rights compliant is largely dependent on which treaty is being used as the measure. As indicated above, one of the distinctive features of the CRPD is its shift away from a medical model of disability towards a more socially grounded perspective (Degener, 2016) whereas the ECHR permits rights limitations on the basis of mental disorder. Despite tribunals being multi-membered and multi-disciplinary, evidence suggests that they are significantly influenced by the medical domain (Carney, 2012; Carney & Tait, 2011; Livingston *et*

al, 2016; Murphy *et al*, 2017; Ng *et al*, 2016; Ridley *et al*, 2010; & Tait, 2011). The use of medical discourse and the predominant focus on clinical expertise (Carney, 2012; Carney & Tait, 2011) perpetuate the dominance of the medical within tribunal cultural practices. This can act as a barrier to patient autonomy since technical language and jargon can prevent individuals from getting their views across (Murphy *et al*, 2017).

Studies consistently show that tribunals are dominated by medical expertise with medical evidence carrying the most weight in decision-making about compulsory treatment (Murphy *et al*, 2017; Livingston *et al*, 2016; Ng *et al*, 2016, Richardson & Machin, Ridley *et al*, 2010, Swain, 2000; Ferencz & McGuire, 2000; Ferlauto & Frierson, 2011; Player, 2015). Carers have criticised a tribunal system in Scotland that reinforces hierarchies of opinion found in the psychiatric system more broadly (Ridley *et al*, 2010). Similarly, in a qualitative study exploring the views of individuals with recent experience of a tribunal following involuntary admission in Ireland, some informants described medical evidence being afforded more importance than their perspectives, leading some to question the independence of the tribunal process (Murphy *et al*, 2017). This was also apparent within forensic settings in New Zealand where participants described outcomes being aligned with the doctor's perspective (Ng *et al*, 2016). Forensic patients in Canada have highlighted that tribunal decision making is significantly influenced by treating teams, and in particular, the psychiatrists' viewpoint (Livingston *et al*, 2016). Tribunal members in England and Wales have themselves underpinned the salience of medical evidence on tribunal decision-making (Ferencz & McGuire, 2000) and concerns have been raised that there is lack of scrutiny of medical assessments in New South Wales, Victoria, and Australian Capital Territory (Carney & Tait, 2011). Nevertheless, this view was not exclusively represented across the studies, with some informants in Canada reflecting that the review boards took an objective stance and did not accept psychiatric evidence without question (Livingston *et al*, 2016).

Feelings of Powerlessness

Feelings of powerlessness emerged as a key theme across the studies with clear implications for patient perceptions of autonomy. Individuals described feeling powerlessness in respect to both the tribunal process and outcome, exacerbated by the unequal power differentials between individuals' and professionals involved in their

care and treatment (Carney, 2012). As demonstrated above, individuals have criticised the way that they have been prevented from discussing issues that are pertinent to them, including experiences of care and treatment (Beaupert & Vernon, 2012; Carney, 2011; Carney & Tait, 2011). The narrow focus of the tribunal on the legal criteria (Beaupert & Vernon, 2012; Carney, 2011; Carney & Tait, 2011) restricts what people are able to discuss and reduces choice and control for individuals who experience compulsory treatment. Ferencz & McGuire (2000) described the tribunal as causing a 'cycle of distress', with individuals in England and Wales experiencing powerlessness, dissatisfaction and confusion. The way that the physical and symbolic space of the tribunal is structured can also reinforce power differentials (Carney, 2012). Individuals in Australia (New South Wales, Victoria, and Australian Capital Territory) experienced anxiety in advance of and during tribunals (Carney & Tait, 2011) and the adversarial nature of the tribunal process produced feelings of hopelessness for some individuals in New Zealand (Ng *et al*, 2016). The numbers of people attending the tribunal can also be intimidating, especially when individuals do not have any family, advocacy or legal support (Carney & Tait, 2011).

In conjunction with the process, the tribunal outcome can contribute to feelings of powerlessness (Carney & Tait, 2011). Livingston *et al* (2016) highlighted the emotional labour exercised by individuals in Canada in forensic settings, and their families, who experienced worry, anxiety, and stress over the outcome. Individuals perceived their detention to be disproportionate to the offence committed and felt stuck in a system that was impossible to break free from (Livingston *et al*, 2016). In another study, psychiatrists noted that the administrative review process in Victoria created feelings of distress due to raised expectations that fail to materialise (Grundell, 2005). Like the previous sections, this suggests that tribunals are not operating in the spirit of full and meaningful participation.

Perceptions of Fairness

Article 6 ECHR and Article 13 CRPD identify the right of all to a fair hearing. Several studies examined the justice implications of mental health tribunals. The aforementioned Victoria forensic mental health tribunal study noted that the tribunal enhances accountability and transparency, and provides checks and balances against decision-making about compulsory treatment (Grundell, 2005). In addition, a study

found that around two thirds of key stakeholders believed that individuals in Ireland received a fair and independent review (Georgieva *et al*, 2017). Individuals in Canada also indicated that they were treated respectfully and fairly during proceedings, though felt their voice was constrained (Livingston *et al*, 2016) since the tribunal aligned with the psychiatric viewpoint (Ng *et al*, 2016). Another study involving participants in Ireland reported mixed views about the tribunal, with some indicating that the tribunal helped to safeguard human rights, preventing detention for longer than necessary, whilst others felt that the renewal period within the legislation, rather than clinical necessity, determined the duration of detention (Smyth *et al*, 2017).

Several procedural issues have been identified that undermine the integrity of the tribunal. An issue of revoking orders for the purpose of avoiding tribunals has been reported and a minority of consultant psychiatrists (14%) admitted to readmitting a patient after a tribunal had revoked an order in Ireland (O'Donoghue & Moran, 2009). Slightly under half said this was because the decision was based on a technicality and they were concerned about the person's wellbeing, whilst a majority said this was because the person was unwilling to be hospitalised voluntarily. This is a gross undermining of the tribunal, removing accountability for clinical decision-making and eroding human rights.

Concerns about the quality of evidence presented at the tribunal have also been raised. Out-dated and inaccurate reports were identified in the above-mentioned Canadian study involving the forensic mental health tribunal (Livingston *et al*, 2016) and a lack of rigor and assessment of current presentation in a New Zealand study (Ng *et al*, 2016).

Inadequacy of community support and provision also appears to be an impediment to tribunals' ability to fully realise the rights of persons with mental disorder, particularly the right to the least restrictive option of care and treatment.² Individuals are thus perceived as being unnecessarily held in hospital in several jurisdictions. For instance, in a South Korean study, 93% of respondents stated that it would be difficult to discharge somebody whose mental health had stabilised but who lacked

² Such principle being a feature of mental health legislation in, for example, Scotland, England, Victoria and New Zealand.

appropriate supports in the community (Lee *et al*, 2014). Similarly, slightly under a quarter of probate judges in South Carolina indicated that a lack of alternatives would increase the chances of granting an order (Ferlauto & Frierson, 2011).

Therapeutic jurisprudence also emerged as a key theme within the literature and is based upon the premise that the law can work in such a way that promotes therapeutic outcomes (Beaupert, 2009). It is argued that the hearing process itself can be a therapeutic one by enabling individuals to have voice by actively involving them in the process and by treating them with dignity and respect (Beaupert, 2009). Individuals in a forensic setting in Canada expressed that the review board was compassionate, understanding, friendly, and acted fairly and impartially (Livingston *et al*, 2016). Paradoxically, others described being patronised, infantilised, and ridiculed, though these experiences were an exception rather than the norm (Livingston *et al*, 2016). Other studies report more positive findings. Thematic analysis of tribunal written decisions in New Zealand revealed that the tribunal attempted to enhance therapeutic outcomes for individuals' subject to compulsory treatment (Diesfield & McKenna, 2006). This occurred through constructive and positive comments about a person's character, and the progress they had made in their relationships, and on occasion, directing clinicians towards a particular therapeutic intervention (Diesfield & McKenna, 2006).

Risk

Human rights limitations have historically been justified on the basis of risk management. The right to liberty identified in the ECHR can, for example, be limited, subject to conditions, in the case of persons of 'unsound mind' (Article 5 (1(e))). The right to autonomy identified in Article 8 ECHR can be limited for the prevention of disorder, and to promote health or morals and public safety (Article 8 (2)). Whilst the CRPD requirement of equal and non-discriminatory rights enjoyment by all is, as already indicated, calling this approach into question (Stavert 2018) the proportionality of any rights limitation is an essential principle of the traditional human rights approach. However, assumptions about the risk posed by individuals who experience mental distress are central to tribunal decision-making. Tribunal members and clinicians have highlighted the challenging nature of risk assessment, particularly when risk assessment tools focus on static as opposed to dynamic risk factors (Trebilock &

Weaver, 2012). History has been promulgated as the best predictor of risk (Trebilock & Weaver, 2012) but this can result in one off events being taken out of context to demonstrate a pattern of behaviour that if properly scrutinised does not necessarily hold up (Freckelton, 2010).

Individuals in forensic settings in New Zealand expressed their disagreement with assessments of dangerousness, with complaints that this was overemphasised in some cases (Ng *et al*, 2016). In addition, a study based in New York found that decisions about assertive outreach treatment were based upon a history of non-compliance, clinical testimony regarding insight, the need for treatment, and histories of risk to others and self-harm (Player, 2015). Furthermore, extra-legal factors affecting tribunal decision-making in Victoria have been challenged for reinforcing stereotypical value judgments as opposed to being based on evidence (Freckelton, 2010). Indeed, examples of clinicians relying on outdated and decontextualised reports in order to demonstrate a risk of violence have been reported (Freckelton, 2010).

Discussion

This research sought to understand the extent to which mental health tribunals give effect to person-centred and human rights based national legislative principles and human rights standards. The findings suggest that, overall, mental health tribunals may not be meeting these requirements and that legislative and cultural change is required to promote patient autonomy for those subject to compulsory treatment. Although it is impossible to ascertain from the included studies whether or not violations of associated human rights have definitely occurred, it is clear that several of the findings call into question whether mental health tribunals always ensure rights compliance. For example, perceptions and concerns regarding patient participation, information and understanding, feelings of powerlessness, the weight given to medical opinion, assumptions about risk and affected relationships raise concerns about respect for patients' rights to dignity (Article 3 ECHR and Article 15 CRPD), to liberty (Article 5 ECHR and Article 14 CRPD) and respect for private and family life (Article 8 ECHR). Perceptions and concerns about patient representation and fairness, on the

other hand, raise questions about a patient's right to a fair trial (Article 6 ECHR) and access to justice (Article 13 CRPD).

Certainly, the existing body of literature suggests that, overall, the workings of mental health tribunals are not compatible with the universal right to exercise legal capacity identified in Article 12 of the CRPD. As outlined, Article 12 recognises this right regardless of decision-making capabilities and requires the provision of person-centred supports to facilitate this (Flynn & Arstein-Kerslake, 2014; UN Committee on the Rights of Persons with Disabilities, 2014). However, a general sense of powerlessness was evident amongst individuals' subject to compulsory measures (Livingston *et al*, 2016; Carney, 2012; Carney & Tait, 2011; Grundell, 2005; Ferencz & McGuire, 2000). Although some studies indicated that being able to attend the tribunal in and of itself was beneficial (Ng *et al*, 2016; Livingston *et al*, 2016), this was undermined by practices that silenced individual voice within proceedings (Carney & Tait, 2011; Beaupert & Vernon, 2011). This is exacerbated by a lack of awareness amongst individuals about their legal rights, further preventing them from actively participating in decision-making (Gallapathie *et al*, 2013; O'Donoghue *et al*, 2010). Although different jurisdictions offer a range of mechanisms to support patient representation, the current evidence demonstrates that, overall, this is inadequate in securing individual rights, with low levels of legal and advocacy representation being particularly problematic.

It would also appear that not only is this incompatible with human rights standards, it is also not in keeping with legislative principles that require participation. The apparent dominance of the medical domain within tribunal cultural practices makes meaningful patient participation all the more important. Where tribunals act as 'rubber stamps' for clinical decisions rather than representing a robust accountability measure and effective safeguard for individuals (Thom & Nakaranda-Kordic, 2014: 122) and the medical realm dominates practice and reinforces unequal power relations between individuals and 'expert' professionals, this can lead to feelings of disempowerment and subjugation (Murphy *et al*, 2017; Livingston *et al*, 2016; Ng *et al*, 2016). Although there was evidence of individuals feeling they were treated fairly, and with dignity and respect, such findings reported in the literature indicate a prevalence of powerlessness

which suggests a significant shift in practice is required if human rights and related legislative objectives are to be achieved.

The CRPD is radical in that it requires significant rights protections surpassing those offered by preceding treaties, such as the ECHR, and for this to be effective there has to be meaningful engagement with its message by state parties (Stavert and McGregor, 2018; Stavert, 2018) even where substitute decision-making arrangements for persons with mental disorder remain.

Conclusion

This review has synthesised international research evidence on mental health tribunals published since 2000. While Thom & Nakaranda-Kordic (2014) conducted a review into tribunal decision-making, the current review is novel and goes further by examining the literature from a human rights perspective. This review has highlighted important areas that require attention if mental health tribunal practice is to become compliant with international human rights standards and legislative principles designed to reflect such standards. This includes, in particular, the need to address the perceived dominance of the medical domain in shaping decisions about care and treatment and structural and cultural barriers to meaningful patient representation.

Whilst the findings of the review have important implications for legislation, policy and practice, it is limited by the weaknesses of the existing evidence base with consequences for its perceived robustness. The majority of the studies have been conducted in the global north and there are indications that several of the studies lack methodological rigour. In addition, grey literature was excluded from the review in an attempt to ensure high methodological quality, however, this may have resulted in important material being excluded from the review, which may limit the strength of the findings. Further research should therefore focus upon how best to achieve cultural change towards a more participatory and inclusive system, whilst ensuring a robust research design is utilised and transparency in the methodological reporting.

References

Andrade, L.H., Alonso, J., Mneimneh, Z., Wells, J.E., Al-Hamzawi, A., Borges, G., Bromet, E., Bruffaerts, R., De Girolamo, G., De Graaf, R. & Florescu, S., (2014). Barriers to mental health treatment: results from the WHO world mental health surveys. *Psychological Medicine* 44, 1303-1317, doi: 10.1017/S0033291713001943

Banks, L. C., Stroud, J. & Doughty, K. (2016). Community treatment orders: exploring the paradox of personalisation under compulsion, *Health & Social Care in the Community* 24, e181-190, doi: 10.1111/hsc.12268

Bartlett, P. (2012). The United Nations Convention on the Rights of Persons with Disabilities and mental health law, *The Modern Law Review* 75, 831-844, doi: 10.1111/j.1468-2230.2012.00923.x

Beaupert, F. (2009). Mental health tribunal processes and advocacy arrangements: 'Little wins' are no small feat, *Psychiatry, Psychology and Law* 16: 90-107, doi: 10.1080/13218710802169339

Beaupert, F. & A. Vernon (2011). 'Odyssey of hope': The role of carers in mental health tribunal processes and systems of mental health care, *Psychiatry, Psychology and Law* 18, 44-68, doi: 10.1080/13218711003591560

Carney, T. (2012). Australian mental health tribunals-'Space' for rights, protection, treatment and governance? *International Journal of Law and Psychiatry*, 35, 1-10, doi: 10.1016/j.ijlp.2011.11.002

Carney, T. & Beaupert, F. (2008). Mental health tribunals: rights drowning in unchartered health waters, *Australian Journal of Human Rights* 13, 181-208, doi: 10.1080/1323238X.2008.11910839

Carney, T. & Tait, D. (2011). Mental health tribunals – rights, protection, or treatment? Lessons from the ARC linkage grant study? *Psychiatry, Psychology and Law* 18,137-159, doi: 10.1080/13218719.2010.544242

Carswell, C., Donaldson, A. & Brown, K. (2007). Psychiatrists' views and experiences of the Mental Health (Care and Treatment) (Scotland) Act 2003, *Psychiatric Bulletin*, 31, 83-85, doi: 10.1192/pb.bp.106.0105979

Diesfield, K. & McKenna, B. (2006). The therapeutic intent of the New Zealand mental health review tribunal, *Psychiatry, Psychology and Law* 13, 100-109, doi: 10.1375/pplt.13.1.100

Donnelly, V., Lynch, A., Mohan, D. & Kennedy, H.G. (2011). Working alliance, interpersonal trust and perceived coercion in mental health review hearings, *International Journal of Mental Health Systems* 5(1), 29, doi: 10.1186/1752-4458-5-29

Doll, A. (2016). Lawyering for the 'Mad': Social organization and legal representation for involuntary-admission cases in Poland. In [eds] B. *Burstow, Psychiatry interrogated: An institutional ethnography anthology*, New York, NY, Palgrave Macmillan, 183-202, doi: 10.1007/978-3-319-41174-3

Ferencz, N. & McGuire, J. (2000). Mental health review tribunals in the UK: Applying a therapeutic jurisprudence perspective, *Court Review* 37, 48-52

Ferlauto, M. J. & Frierson, R.L. (2011). The probate judge and involuntary civil commitment in South Carolina, *Journal of the American Academy of Psychiatry and the Law* 39, 209-215

Flynn, E. & Arstein-Kerlslade, A. (2014). The support model of legal capacity: fact, fiction, or fantasy? *Berkeley Journal of International Law* 32,134-53, doi: 10.15779/Z38494G

Freckelton, I. (2010). Extra-legislative factors in involuntary status in (Eds.) McSherry, B., Weller, P. Rethinking rights-based mental health laws, Oxford: Hart Publishing, 203-230

Freeman, M. (2011). Human rights: An interdisciplinary approach (2nd Ed), Cambridge: Polity Press

Galappathie, N., Harsh, R.K., Thomas, M., Begum, A. & Kelly, D. (2013). Patients' awareness of the mental health tribunal and capacity to make requests, *The Psychiatrist* 37, 363-366, doi: 10.1192/pb.bp.113.042945

Georgieva, I., Bainbridge, E., McGuinness, D., Keys, M., Brosnan, L., Felzmann, H., Maguire, J., Murphy, K., Higgins, A., McDonald, C. & Hallahan, B. (2017). Opinions of key stakeholders concerning involuntary admission of patients under the Mental Health Act 2001, *The Journal of Psychological Medicine* 34, 223-232, doi: 10.1192/pb.bp.106.0105979

Grundell, E. (2005). Psychiatrists' perceptions of administrative review: A Victorian empirical study, *Psychiatry, Psychology and Law* 12, 68-87, doi: 10.1375/pplt.2005.12.1.68

Howlett, S., Florio, T., Xu, H. & Trollor, J. (2015). Ambulatory mental health data demonstrates the high needs of people with an intellectual disability: Results from the New South Wales intellectual disability and mental health data linkage project. *Australian & New Zealand Journal of Psychiatry* 49,137-144, doi: 10.1177/0004867414536933

Jabbar, F., Kelly, B.D. & Casey, P. (2010). National survey of psychiatrists' responses to implementation of the Mental Health Act 2001 in Ireland, *Irish Journal Of Medical Science* 179: 291-294, doi: 10.1007/s11845-009-0320-x

Lee, M.S., Lim, H.Y. & Lee, Y.S. (2014). How can a change in the operating system of the mental health review board promote the discharge of long-term hospitalized psychiatric patients? A Case Study of Seoul City, *International Journal of Mental Health Systems* 8, 33, doi: 10.1186/1752-4458-8-33

Livingston, J.D., Crocker, A.G., Nicholls, T.L. & Seto, M.C. (2016). Forensic mental health tribunals: A qualitative study of participants experiences and views, *Psychology, Public Policy and Law* 22, 173-184, doi: 10.1037/law0000084

Mental Welfare Commission for Scotland (2018) The right to advocacy: a review of how local authorities and NHS Boards are discharging their responsibilities under the Mental Health (Care and Treatment)(Scotland) Act 2003, Edinburgh, https://www.mwscot.org.uk/media/395529/the_right_to_advocacy_march_2018.pdf

Murphy, R., McGuinness, D., Bainbridge, E., Brosnan, L., Keys, M., Hallahan, B., Higgins, A. & McDonald, C. (2017). Service users' experiences of mental health tribunals in Ireland: a qualitative analysis, *Irish Journal of Psychological Medicine* 34, 233-242, doi: 10.1017/ipm.2017.11

Newbigging, K., Ridley, J., McKeown, M., Machin, K. & Poursanidou, K. (2014). 'When you haven't got much of a voice: an evaluation of the quality of independent mental health advocate (IMHA) services in England', *Health and Social Care in the Community* 23, 313-324, doi: 10.1111/hsc.12153

Ng, L., Friedman, S. & Diesfield, K. (2016). Checking and balancing New Zealand's mental health review tribunal: perspectives of forensic patients, *Psychiatry, Psychology and Law* 23, 135-147, doi: 10.1080/13218719.2015.1034062

O'Donoghue, B. & Moran, B. (2009). Consultant psychiatrists' experiences and attitudes following the introduction of the Mental Health Act 2001: a national survey, *Irish Journal of Psychological Medicine* 26: 23-26, doi: 10.1017/s0790966700000094

O'Donoghue, B., Lyne, J., Hill, M., Larkin, C., Feeney, L. & O'Callaghan, E. (2010). Involuntary admission from the patients' perspective, *Social Psychiatry and Psychiatric Epidemiology* 45, 631-638, doi: 10.1007/s00127-009-0104-7

Owen, G.S., Spencer, B.W. & Kanaan, R.A., (2016). The legal and ethical framework for compulsory psychiatric treatment. *Medicine* 44, 734-736, doi: [10.1016/j.mpmed.2016.09.010](https://doi.org/10.1016/j.mpmed.2016.09.010)

Player, C.T-L. (2015). Outpatient commitment and procedural due process: *International Journal of Law and Psychiatry* 38, 100-113, doi: [10.1016/j.ijlp.2015.01.013](https://doi.org/10.1016/j.ijlp.2015.01.013)

Reed, G.M., Rebello, T.J., Pike, K.M., Medina-Mora, M.E., Gureje, O., Zhao, M., Dai, Y., Roberts, M.C., Maruta, T., Matsumoto, C. & Krasnov, V.N. (2015). WHO's global clinical practice network for mental health. *The Lancet Psychiatry* 2, 379-380, doi: 10.1016/S2215-0366(15)00183-2

Richardson, G. & Machin, D. (2000). Doctors on tribunals. A confusion of roles, *The British Journal Of Psychiatry* 176, 110-115, doi: 10.1192/bjp.176.2.110

Ridley, J. & Hunter, S. (2013). Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, *Health and Social Care in the Community* 21, 509-18, doi: 10.1111/hsc.12041

Ridley, J., Hunter, S. & Rosengard, A. (2010). Partners in care? Views and experiences of carers from a cohort study of the early implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, *Health and Social Care in the Community* 18, 474-482, doi: [10.1111/j.1365-2524.2010.00920.x](https://doi.org/10.1111/j.1365-2524.2010.00920.x)

Ritchie, J. & Lewis, J. (2003) *Qualitative research practice: A guide for social science students and researchers*, London, Sage

Rolfe, T., Sheehan, B. & Davidson, R. (2008) Are consumers on community treatment orders informed of their legal and human rights? A West Australian study. *International Journal of Mental Health Nursing*, 17, 36-43, doi: [10.1111/j.1447-0349.2007.00509.x](https://doi.org/10.1111/j.1447-0349.2007.00509.x)

Scottish Independent Advocacy Alliance (2016) *A Map of advocacy across Scotland (2015-2016 edition)*, Edinburgh, https://www.siaa.org.uk/wp-content/uploads/2017/09/SIAA_Advocacy_Map_2015-16-1.pdf

Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J.L., Chisholm, D., Gureje, O., Hanlon, C., Jordans, M., Kigozi, F., Lempp, H. & Lund, C. (2015). Strengthening mental health systems in low-and middle-income countries: The Emerald programme. *BMC Medicine* 13, 79, doi: 10.1186/s12916-015-0309-4

Smyth, S., Dymrna, C., Cooney, A., Higgins, A., McGuinness, D., Bainbridge, E., Keys, M., Georgieva, I., Brosnan, L., Beecher, C., Hallahan, B., McDonald, C. & Murphy, K. (2017) Qualitative exploration of stakeholders' perspectives of involuntary admission under the mental health act 2001 in Ireland, *International Journal of Mental Health Nursing* 26, 554-569, doi: 10.1111/inm.12270

Spencer, L., Ritchie, J., O'Connor, W., Morrell, G., Ormston, R. (2013) Analysis in practice In J Ritchie, J Lewis, C McNaughton Nicholls, R Ormston (Eds), *Analysis in practice: A guide for social science students and researchers* (pp.295-346), (2nd Ed), London, Sage

Stavert, J. & McGregor, R. (2018) 'Domestic Legislation and International Human Rights Standards: The Case of Mental Health and Incapacity' 22, 70-89.

Stavert, J. (2018) 'Paradigm shift or paradigm paralysis? National mental health and capacity law and implementing the CRPD in Scotland' 7(3) *Laws* 26
<https://www.mdpi.com/2075-471X/7/3/26>

Swain, P. (2000). Admitted and detained - Community members and mental health review boards, *Psychiatry, Psychology and Law* 7, 79-88, doi: 10.1080/13218710009524973

Thomas, J. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews, *BMC Medical Research Methodology*, 8-45, doi: <https://doi.org/10.1186/1471-2288-8-45>

Thom, K. & Nakarada-Kordic, I. (2014). Mental health review tribunals in action: a systematic review of the empirical literature. *Psychiatry, Psychology and Law* 21, 112-126, doi: 10.1080/13218710009524973

Trebilcock, J. and T. Weaver. (2012). 'It doesn't have to be treatable': mental health review tribunal (MHRT) members' views about dangerous and severe personality disorder (DSPD), *The Journal of Forensic Psychiatry & Psychology* 23, 244-260, doi: 10.1080/14789949.2012.668208

UN Committee on the Rights of Persons with Disabilities. (2014) General Comment No 1 (2014) Article 12 Equal Recognition before the Law (CRPD/C/GC/1, 19 May), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

UN Human Rights Council (2017). Report of UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March) available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement>

Vigo, D., Thornicroft, G. & Atun, R. (2016). Estimating the true global burden of mental illness, *The Lancet Psychiatry* 3 171-178, doi: 10.1016/S2215-0366(15)00505-2

Walker, E.R., McGee, R.E. & Druss, B.G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry* 72, 334-341, doi: 10.1001/jamapsychiatry.2014.2502

Whiteford, H.A., Ferrari, A.J., Degenhardt, L., Feigin, V. & Vos, T. (2015). The global burden of mental, neurological and substance use disorders: an analysis from the global burden of disease study 2010. *PloS one* 10, e0116820, doi: 10.1371/journal.pone.0116820

Winkler, P., Krupchanka, D., Roberts, T., Kondratova, L., Machů, V., Höschl, C., Sartorius, N., Van Voren, R., Aizberg, O., Bitter, I. & Cerga-Pashoja, A. (2017). A blind spot on the global mental health map: a scoping review of 25 years' development of mental health care for people with severe mental illnesses in central and eastern europe. *The Lancet Psychiatry* 4, 634-642, doi: 10.1016/S2215-0366(17)30135-9

World Health Organisation (2017). *Depression and other common mental disorders: Global health estimates*. WHO: Geneva.

Wyder, M., Herriot, A. & Crompton, D. (2015). The experiences of the legal processes of involuntary treatment orders: tension between the legal and medical frameworks, *International Journal Of Law And Psychiatry* 38, 44-50, doi: 10.1016/j.ijlp.2015.01.006

Yip, S. (2003). Social workers' and physicians' experiences with review panels in British Columbia. *Social Work in Mental Health* 2(1): 71-89, doi: 10.1300/J200v02n01_05

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