

BEST INTERESTS OR LEGAL RECTITUDE?: AUSTRALIAN MENTAL HEALTH TRIBUNAL STAKEHOLDER & CASE-FLOW IMPLICATIONS.

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This paper draws on a multi-year Australian collaborative study of mental health review tribunals in three jurisdictions (Victoria, New South Wales and the Australian Capital Territory) undertaken in conjunction with the NSW Law and Justice Foundation, using qualitative and quantitative methods to examine the role of mental health tribunals in advancing goals of fairness, legality and treatment. In recognition of shrinkage of state resources available for treatment and care of the mentally ill in many jurisdictions, and limited time and resources for review bodies, the paper reflects on stakeholder and consumer concerns about access to quality treatment and associated support services, review of treatment adequacy and drug regimes, and their 'participation' or dignity of engagement in review processes. Building on earlier arguments in favour of equipping tribunals to adequately engage the clinical and social domains in addition to the domain of legal rectitude, and for 'flexibility' of process more characteristic of case-conferencing modes, this paper will also examine the contexts and supports for the work of mental health tribunals, such as advocacy and dispute resolution machinery.

A. INTRODUCTION

1. Background

Diversity of approaches within federal legal systems such as Australia provide expanded opportunities for socio-legal researchers not only to study the

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The material reported here reflects the contributions to the ARC project of Professor David Tait (UWS), the co-chief investigator, along with Partner Investigators Professor Duncan Chappell (Sydney and Wollongong) and Dr Christine Coumarellos (NSW Law and Justice Foundation), and key researchers including Fleur Beaupert (PhD scholar), Dr Terry Beed, Dr Michael Cain & Ms Maria Karras (all from the Foundation), and Julia Perry and Alikki Vernon (project staff). While acknowledging my debt to my colleagues, I accept full responsibility for the content of this paper.

comparative merits of different ways of doing things, but also glean an understanding of the deeper institutional and other processes ‘really’ at work.²

Mental health laws take various forms across Australia in terms of the balance between clinical concerns to promote individual wellness, individual or public safety, and legal rectitude in the exercise of state power.³ Thus NSW (and the ACT and Queensland) favour obtaining rapid or prior legal blessing (sanction) for involuntary inpatient detention (‘ITO’) or involuntary community treatment (‘CTO’) orders, while Victoria, along with Tasmania, South Australia and Western Australia, provide clinicians with up to an 8 week block of time in which clinical decisions are sufficient authority for involuntary interventions, prior to subsequent review by mental health tribunals (‘MHTs’). MHTs have been the ‘gatekeepers’ in Australia since the 1980s, following trends in Britain. Apart from the (as yet unproclaimed) 2009 South Australian mental health reforms, this means that clinical discharges prior to the hearing date are not reviewed.⁴

During 2006-07 there was a turnover of 122,000 mental-health cases in specialised psychiatric care institutions across Australia with just under 8000

² This has been demonstrated in studies of mental health in the UK (Peay, 1989; Perkins, 2003a), Australian adult guardianship tribunals (Carney and Tait, 1997) and community treatment orders (Dawson, 2005; 2006).

³ Legal rectitude at its narrowest concerns *technical* satisfaction of the *legal* criteria for making an order, without consideration of substantive issues (such as the weight of evidence or merits of treatment needs). Indeed in Victoria, the Supreme Court has ruled that the focus should be on satisfaction of the legal criteria: *In the matter of XY* unreported decision of the Victorian Supreme Court, 6 March 1992, (1992) 2 MHRBD (Vic) 501 (Fullagar, Brooking, Marks JJ).

⁴ The yet to be proclaimed South Australian legislation extends review to cover both the making and the *revocation* of otherwise unreviewed orders; but it also appears designed to allow more latitude for a gap between clinical admission (to be *notified* to the Board within 1 business day) and actual Board review in the case of *initial*, or ‘level 1’, CTOs (though this may later be clarified either by regulations or by Board policies about its discretions to conduct other reviews): *Mental Health Act 2009* (SA) (subsequently ‘SA MHA 2009’) ss 22 [1 business day notification period], 79 [requirements regarding reviews]. Otherwise ‘as soon as practicable’ or ‘not exceeding 7 days’ time limits apply.

beds (AIHW, 2009: 34). This represented an average turnover of 5.78 patients a year per bed in public psychiatric hospitals and 19 patients a year per bed in private hospitals or psychiatric wards in acute care public hospitals⁵. One-third of these were involuntary patients. Both inpatient care capacity and its duration are tightly rationed to serious/acute mental illness episodes. Community-based psychiatric care for its part is incredibly popular by world standards: there are approximately 15 CTOs for every 100,000 Australians, compared to 5 in Canada or 3 in the USA (Kisely, Campbell, Preston and Xiao, 2006: 511). This three- to five-fold greater usage of CTOs alters the ‘mix’ of residential and community-based care (and the case-loads and ‘functions’⁶ of MHTs). It arguably leaves much greater scope for the medical default rule of ‘when in doubt treat/continue treatment’ to lead to such orders being renewed rather than discharged, resulting in significant ‘return business’ for MHTs from this quarter. Likewise, the rationing of residential care increases the likelihood of detained consumers appearing before MHTs being seriously or chronically mentally ill.

This paper reports further findings⁷ from an empirical study of MHTs in three Australian jurisdictions: New South Wales (NSW), Victoria and the

⁵ Of these, 122,132 (58.3% of 209,356) were separations with specialised psychiatric care and 87,224 were separations without specialised mental health care (AIHW, 2009: 64).

⁶ In the absence of the time or powers to review and change CTO orders, or legal representation of consumers on reviews of such orders, Australian MHTs may become complicit in the enterprise of longer than necessary management, or larger than desirable cohorts of CTO clients.

⁷ Earlier papers reported on procedural fairness and therapeutic jurisprudence of MHT review (Carney, Tait, Chappell and Beaupert, 2007); the (very modest) extent to which tribunals ‘leverage’ client access to treatment (Beaupert, 2007; Carney, Tait and Beaupert, 2008); variation in the degree, style and impact of representation at MHTs (Carney, Beaupert, Perry and Tait, 2008; Beaupert, 2009); the potential of ‘charters of rights’ and of well resourced multi-member panels (Carney and Beaupert, 2008); and pre June 2009 NSW paternalism in presuming incapacity to manage property by those on involuntary orders (Beaupert, Carney, Tait and Topp, 2008). The presumption was subsequently reversed by reforms contained in the *NSW Trustee and Guardian Act 2009* (NSW), ss 43 [notice prior to mental health inquiry], 44 [MHRT jurisdiction], 47 [power to make interim orders]. However the NSW legislation continues to grant the MHRT jurisdiction to deal with matters arguably better handled by the Guardianship Tribunal.

Australian Capital Territory (ACT).⁸ The study methodology involved observations of hearings, in-depth interviews with mental health consumers and other stakeholders, focus group discussions, and sampling of approximately 300 files (and associated tribunal data) over a five year period in both NSW and Victoria. With the exception of elevated ACT rates of community care, baseline data on inpatient and outpatient care rates in the three study jurisdictions appear quite similar.⁹ Other than in Victoria and the ACT, there are no human rights constraints on tribunal operations anywhere in Australia (Carney and Beaupert, 2008).

It is argued in this paper that neither best interests nor therapeutic jurisprudence is a sufficient or sufficiently *sound* basis for shaping tribunal practice, which instead should be informed by a more nuanced rebalancing of interests across the domains of law (fairness, participation and accuracy of decisions), medicine (best practice treatment) and social relations (sound planning for preservation of relationships, housing and employment).

2. Clinical and legal perspectives

The tension between clinical and legal perspectives of mental health care and review of involuntary measures is legendary. As in Australia, the *Irish Mental Health Act 2001*, operative from November 2006, established for the first time

⁸ The study was undertaken between 2005 and 2009 funded by an Australian Research Council 'Linkage Grant', as a collaboration between the universities of Sydney and U Canberra and partner organisations, the *Law and Justice Foundation of New South Wales*, the *New South Wales Mental Health Review Tribunal*, the *ACT Mental Health Tribunal* (from February 2009, part of the *ACT Civil and Administrative Tribunal*) and the *Victorian Mental Health Review Board*.

⁹ Thus for 2003, involuntary separations per 1,000 population ranged from 1.2 for NSW to 1.8 in Victoria (1.5 in the ACT), but from 5.8 (Vic) and 6.6 (NSW) to 13.1 in the ACT. The community figure is for 'unique patients' as defined by service agencies, whereas with separations people could be counted twice. So, the number of people treated involuntarily in the community at least once in the year is at least three times higher than the number treated as inpatients: data derived by Professor Tait from AIHW data cubes as at Wednesday, August 26, 2009.

multi-disciplinary tribunals to automatically review involuntary orders, in place of the administrative or clinical admissions model of its 1945 Act.

The new Act was required to bring Irish mental health law into compliance with European and international human rights standards, but Ireland took the opportunity to introduce a multi-strand rather than unitary governance and accountability structure for mental health, much as occurred recently in Victoria in relation to review of access to disability services.¹⁰ Whereas Australia relies mainly on the check and balance provided by MHTs, in Ireland the MHT is one of three bodies, including the Mental Health Commission and an inspectorate: the Office of Inspector of Mental Health Services. The Commission, among other things, is responsible for ensuring mandatory legal representation at tribunal hearings and for commissioning an independent medical opinion from a consultant psychiatrist (MHC, 2008: 31). The independent medical report partially addresses consumer concerns about the validity of the original medical (but not necessarily psychiatric) report founding admission, though perhaps less satisfactorily than the second opinion system in England and Wales, or under an expansive *tribunal* review of treatment (Donnelly, 2010 forthcoming). The Commission has wide-ranging statutory monitoring, reporting and educative functions not fully replicated in Australia, which experiences deficiencies in areas including complaints handling, auditing of conditions, clinical leadership and clinical monitoring (Gardner, 2009: 61-64, 67-72).

Australian legislation by comparison with Ireland (and elsewhere) fares unfavourably on rights compliance grounds (Carney and Beaupert, 2008) such as

¹⁰ Victoria recently replaced its Intellectual Disability Review Panel (legal 'merits' review) with three new bodies: a Disability Services Commissioner, a Senior Practitioner, and reviews by the Victorian Civil and Administrative Tribunal: (DoHServices, 2006).

access to second opinions,¹¹ insistence on timeliness of reviews,¹² sufficient time for hearings, or adequate legal representation (particularly the highly prevalent CTOs). Patterns of provision of legal aid, community legal centre or other lay advocacy supports for MHT cases differ greatly between Australian jurisdictions, and often do not extend beyond inpatient admissions to include CTOs (further, Carney, Beaupert, Perry and Tait, 2008; Williams, 2009). From our research, it is clear that some level of advocacy makes a difference to consumers' willingness to

¹¹ In Australia second medical opinions generally are either not explicitly guaranteed by law, or are stated as formal rights (rather than entitlements): E.g. *Mental Health Act 1986* (Vic) (subsequently 'Vic MHA') s. 18(1)(a), *Mental Health (Care and Treatment) Act 1994* (ACT) (subsequently 'ACT MHA'), s 50(1)(b)(i). WA confers a right to a second opinion in respect to any ITO or CTO extensions, and to an interview and examination by another psychiatrist: *Mental Health Act 1996* (WA) (subsequently 'WA MHA') ss 111, 76 and 164 respectively. Tasmania confers a right to a second opinion where admission is *refused*: *Mental Health Act 1996* (Tas) (subsequently 'Tas MHA') s 21. The Queensland MHT is directed to *consider* obtaining second opinions for inpatient orders (which no longer require medical re-certification) which have subsisted for more than 6 months, but it rarely does so: *Mental Health Act 2000* (Qld) (subsequently 'Qld MHA') s 190. Fewer than 10 orders are made each year: *personal communication*, Executive officer Qld MHRT, 14 August 2009.

In practice Victoria advises consumers of a right to a second opinion without cost, but it is available only from within the same service, unlike the case in the UK, and is hard to operationalise: *Mental Health Regulations 2008* (SR111/2008) r 9 and Schedule 7. The equivalent 'Statement of Rights' in NSW is silent about rights to be advised about or entitlement to second opinions: *Mental Health Act 2007* (NSW) (subsequently 'NSW MHA') s 74, Schedule 3. ¹² In the Victorian Charter case of *Kracke v Mental Health Review Board & Ors (General)* [2009] VCAT 646 (23 April 2009), Bell J issued a declaration that the MHRB had breached Mr Kracke's right to a fair hearing under section 24 of the Victorian *Charter* by 'unreasonably' delaying the routine review of involuntary treatment (scheduled to take place every 12 months) and CTOs (scheduled for review within 8 weeks of any extension). Although Mr Kracke contributed by requesting adjournments and a second opinion, the delay was found to be excessive, and the Board was held responsible for 'driving' compliance with the statutory timeframes: see paras [700] to [702], esp. at [702]. Subsequently, community treatment orders were reconfirmed: *Kracke v Mental Health Review Board and Anor (No 2) (General)* [2009] VCAT 1548 (13 August 2009).

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attend hearings, especially inpatients facing their first review hearing, those on CTOs, and those on orders for long periods.

3. Best interests or legal rectitude?

Ireland has had to grapple with the philosophy of the new mental health law without much legislative guidance beyond enunciation of a 'best interests' principle. As Kris Gledhill explained in his recent 'External commentary' report

What is stated is that decisions under the Act should have as their "principal consideration" the "best interests" of the person (section 4(1)). This is not defined further. However, it is provided that "due regard" shall be given to the interests of other persons who may be at the risk of serious harm if a decision is not made (section 4(1)) and also to the need to respect the "dignity, bodily integrity, privacy and autonomy" of the person (Gledhill printed in MHC, 2008: 18).

Because 'best interests' on its own is little more than an 'empty vessel into which adult perceptions and prejudices are poured' this is no real guidance; other perhaps than in recognising that this is a 'health' jurisdiction, as found in Peay's study for England and Wales (Peay, 1989: 205).¹³

Best interests implies detached, paternalist, third-party decision-making, where an external view is formed of what is 'best' for the person, irrespective of the person's own present or past opinions. By contrast with such 'hard' paternalism, others argue that the external view should conform to prior preferences found either in 'advance directives' or derived from the known values of the person (substituted judgment). The 'soft' paternalism justification for this approach rests on the likelihood of retrospective approval on recovery (the so-called 'thank-you' theory), while an autonomy-based analysis points to realisation of the 'authentic' will of the person prior to illness onset. This

¹³ Thus Peay (1989: 209) found that 'the tribunals invariably endorsed the recommendations made to them'. Decisions were found to frequently be made on the basis of considerations which were not part of the legal tests, and that procedural fairness rules were frequently bypassed as the factors most pertinent to tribunal decision-making were often broached for the first time when patients were not present, such as during the deliberation phase (Peay, 2005: 217-218).

approach is finding favour in Australia; thus the Victorian Government's response to its Review Panel (Gardner, 2009) supported a

[S]hift away from a substitute decision-making model. This shift is designed to ensure that people with mental illness are supported to make their own decisions wherever possible (GovernmentResponse, 2009: 2).¹⁴

Other commentators go further. Both Amita Dhanda and Tina Minkowitz argue that, properly interpreted, the *Convention on the Rights of Persons with Disabilities 2006* ('CRPD')¹⁵ permits neither coercion into mental health treatment¹⁶ nor interventions based on assumed loss of 'competence'.¹⁷ This is not warranted in my view, in respect of mentally ill persons,¹⁸ and Australian reforms have not favoured it. Instead the aim of reform is to maximise the numbers able to be dealt with under a voluntary or substituted judgement model, such as by requiring that advance directives or consumer wishes be given presumptive or enhanced weight in decisionmaking and treatment planning (Gardner, 2009: 43-45; GovernmentResponse, 2009: 5).

¹⁴ Advance directives, a presumption of capacity to make decisions, and a focus on participatory planning are among the reforms proposed (Gardner, 2009: 39-45).

¹⁵ For a recent overview, see Kämpf (2008).

¹⁶ One argument is based on the *silence* of the CRPD regarding coercion (neither authorising nor banning its use), while Article 12(4) ambiguously uses both language consistent with competence-based substitute-decisionmaking (adult guardianship) and language espousing 'supported-decisionmaking' (Dhanda and Narayan, 2007: 1198; Dhanda, 2008). See also Minkowitz (2010, forthcoming). While arguably charting the rhetorical direction for reform of mental health laws (such as greater use of enduring powers of attorney or advance directives), neither silence nor ambiguous drafting displaces *prior explicit* language in previous international instruments (Weller, 2008: 87-90). Moreover, Australia expressly reserved its right to retain, 'subject to safeguards' and as a 'last resort', coercion within mental health and retention of adult guardianship laws when ratifying the Convention on 17 July 2008: see <<http://www.un.org/disabilities/default.asp?id=475>> at 19 June 2009. The Convention came into force on 3 May 2008.

¹⁷ Autonomy/capacity-based legislation rather short-changes mental health patients in practice, however (Donnelly, 2008: esp 49-51).

¹⁸ The argument that Article 17 of the CRPD [respect for physical *and* mental integrity] precludes involuntary treatment, lacks support from the history of negotiation of the CRPD and regional human rights jurisprudence, though it can be read as limiting resort to unbeneficial and overly intrusive treatment, including physical restraint or seclusion (McSherry, 2008: esp 120-123).

Debate about philosophical and other considerations regarding whether paternalism warrants incursions into the individual autonomy of mental health consumers extends beyond the shape of the legislation into a host of practice settings. For example, while universal legal representation may satisfy human rights lawyers, the real issue is whether lawyers ‘take instructions’ or form their own views (see section D below), and their approach to making representations or becoming involved in dialogue with the tribunal: should it be ‘adversarial’ or ‘conversational’? In terms of dignity and participation of consumers at MHT hearings, it involves whether or not they are the central figure, and whether and how their views are sought or respected. It also turns on how extensively MHTs engage clinical and social issues (e.g. housing and community support) which are central for many consumers.

From the standpoint of ensuring legal rectitude, one traditional way of injecting content beyond best interests was to apply the ‘least restrictive alternative principle’ drawn from international mental health principles, as is almost universal in Australia.¹⁹ This principle essentially states that effective care and treatment be provided in the manner least restrictive of freedom.²⁰ The overall intent of mental health legislation and the few judicial decisions dealing with the principle suggest, however, that provision of *effective care*, rather than denial of access, tips the balance,²¹ even though decision-makers should always

¹⁹ See NSW MHA, ss 12(1)(b) (general restrictions on detention), 38(1) (in Tribunal hearings that no other care is appropriate and available); Vic MHA, ss 4(2) (statutory objectives) and 8(1)(e) (criteria for involuntary treatment); ACT MHA, ss 7(d) [statutory objectives], 28(d) and 38(e) [in Tribunal hearings]; Qld MHA, s 9. The SA MHA 1993 contains this principle in the objectives of the Act, but does not expressly incorporate it as a final criterion for compulsory treatment: ss 12-13.

²⁰ See UN General Assembly *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991) (‘MI Principles’), Principle 9.

²¹ See *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315, per Mahoney JA at 334 (‘Harry v MHRT’): ‘But the possibility of abuse should not lead to the legislation being so restrictively construed that, where treatment is needed, it cannot be given The court should

consider whether there is an appropriately less restrictive form of care. Where consistent with effective care, this suggests preferring voluntary treatment over involuntary treatment,²² and keeping restrictions of liberty to the minimum necessary for those on orders.²³ But this is easier to contemplate in theory than in practice. For, as Saleem Shah pointed out long ago, the ‘notion does *not* translate readily into mental health procedures and programs’ (Shah, 1981: 254 [emphasis in original]).

So this principle does not advance matters very far. If MHTs are principally dealing with clinical perspectives within a ‘health’ context, however, surely the more important issue is whether treatment concerns are adequately canvassed, and how flexible, engaging and participatory are the hearings?

B. TREATMENT ISSUES LIE AT THE HEART OF ‘BEST INTERESTS’ TRIBUNAL HEARINGS?

In a tacit way, clinical treatment and best interests are often conflated in a preference for acting on psychiatric evidence and opinion. Thus Perkins found that it was common for consumers’ evidence to be disbelieved at hearings, while psychiatrists were viewed as having the patient’s best interests at heart (Perkins, 2003b: 127).²⁴ This confirmed Jill Peay’s earlier findings (1989: 215) that the *source* rather than the *content* of evidence guided MHT reasoning. MHTs also adopted clinical ‘proxies’ for legal tests—such as ‘symptoms’; ‘insight’; ‘compliance’; and ‘risk’ (Perkins, 2003b: 126), as too in Australia (Freckelton, 2010).

give a beneficial and purpose construction to them; it should not give them a restricted construction merely because they may infringe her personal liberty.’

²² See *Harry v MHRT*, *ibid*, per Kirby P at 325; NSW MHA, s 3(c); ACT MHA, s 7(b).

²³ Vic MHA, s 4(2); ACT MHA, s 7(d).

²⁴ The then dual role of the medical member (as fact-finder based on a prior clinical review; and decision-maker) was considered especially problematic. Perkins found that the medical member often provided an interpretative framework within which the other members would assess the patient’s evidence which ‘served to discount what the patient would subsequently say in the hearing’ (Perkins, 2003b: 46).

By contrast with this preference for best interests data as the basis for affirming orders, our research found that the specific details of treatment choices were not addressed by MHTs because they (and those around them) do not perceive this to be their role.

1. Treatment planning and Australian tribunals

This view is largely reflected in the legislation, though the Victorian and NSW MHTs (in the case of CTOs) do have limited functions of reviewing or approving treatment plans.

Since 2003 in Victoria, authorised psychiatrists must prepare individualised treatment plans for involuntary patients.²⁵ The Victorian Board must review whether these plans were prepared in accordance with legislative requirements²⁶—including taking account of consumer’s wishes and those of carers, and any beneficial alternative treatments. The NSW MHT is to *consider* the treatment plan and ensure that there is one, in making CTOs.²⁷ The ACT MHT when making orders must take into account, among other things, the alternative treatments, programs and other services available, including: (i) their purposes; (ii) the benefits likely to be derived by the person; and (iii) the distress, discomfort, risks, side effects or other disadvantages associated with them.²⁸ However the tribunal ‘must not order the administration of a particular

²⁵ Vic MHA, s 19A.

²⁶ Vict MHA ss 19A, 35A. Under s19A the psychiatrist making the plan must take into account: ‘(a) the wishes of the patient, as far as they can be ascertained; (b) unless the patient objects, the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient; (c) whether the treatment to be carried out is only to promote and maintain the patient’s health or well-being; (d) any beneficial alternative treatments available; (e) the nature and degree of any significant risks associated with the treatment or any alternative treatment; and (f) any prescribed matters’.

²⁷ This is because one prerequisite to the making of a CTO is that the supervising health care agency has prepared a treatment plan that is capable of implementation: NSW MHA ss53(2)(a) and 53(3)(b).

²⁸ ACT MHA s 26(k).

drug or make an order about the way a particular clinical procedure is to be carried out'.²⁹ Most recently, the 2009 South Australian legislation empowers the MHT to 'order that the treatment and care plan applying to the person be reviewed'.³⁰

For many consumers interviewed in our study, it came as a surprise and a disappointment that treatment issues were not addressed. This is not an unreasonable reaction in Australia. It is not clear where else consumers, supporters or advocates presently can go, given the absence of strong grievance or quality assurance machinery such as a mental health commission or wide roles for agencies such as an office of chief psychiatrist. Many Australian consumers appear to lack input into their treatment plans (and in some jurisdictions do not always have a plan). Issues of general health, objections to particular medications and side-effects, and desires for psycho-social counselling or treatment, appear not to often be canvassed by or included in treatment plans.

In practice MHTs' consideration of treatment plans seems very limited. In our observations there was little beyond asking consumers whether they had 'seen' the plan, with little investigation of whether their wishes had been canvassed, or beneficial alternative treatments explored. There were a small number of reports of the tribunal insisting on counselling or other care, but even these limited interventions were resisted by some health practitioners.

Yes they're more interventionist with ECT but I think they're more interventionist with everything. Their poking into the detail of patient management is completely out of control. That's why things take so long (NSW health professional, 2006)

For their part, as previously reported (Carney, Tait and Beaupert, 2008), MHT members were often quick to point out that treatment was not in their

²⁹ ACT MHA s 27.

³⁰ SA MHA 2009, s 80(2)(d).

purview, although *informally* many were prepared to make suggestions about care.

I don't see that under the legislation, it is the Tribunal's role to be concerned with, to the point of making Orders, and monitoring and ensuring that certain other things are done. We do it informally now because we care about the person and we can in that informal way, but it's not for us to make an Order that this person get this treatment, that he have his house cleaned five days a week, that somebody can see him regularly and there is somebody there. That should be the responsibility of somebody else, not of the Tribunal but it should be of mental health services, of the Department... of whoever (ACT Member, focus group, 2008)

On the other hand a few health professionals appreciated the enhanced accountability associated with ensuring that treatment plans were in place.

But at least you can have a discussion about that and I've always found the Tribunal's been very good about that like saying to someone, "Are you aware of this right that you have?" I think that's really important that there's an external body that can come and remind the hospital they have to be transparent in their care and to justify what they're doing. It's not just, "We are the treating team therefore...", you know. If you don't have that dialogue with someone in the hospital then they're not going to be compliant when they go home (NSW health professional, 2006)

The Victorian Chief Psychiatrist guardedly favoured MHT review of treatment plans but without being able to order specific treatments: 'For us the psychiatrist is the responsible doctor for the treatment given and the authorised psychiatrist should be able to intervene in that' (2004).

2. Concerns about the choice of medication or treatment

The issue of most concern for consumers in our study, however, was the side effects of medication. These included excessive weight gain, diabetes, liver damage, heart damage, memory loss, confusion, fatigue, blurred vision, tremors, nausea, sleeplessness, oversleeping, thirst, constipation, impotence, agitation and anxiety, and so on.

The major tranquilisers... you could get everything to rigidity to 'electric fleas', you can't keep still for more than a few minutes, you got to get up and walk around and you have got dry mouth, your whole system dries out, you don't go to the toilet for about two weeks and all sorts of things (Victorian consumer, focus group, 2004)

A closely related issue was any CTO requirements for regular clinic attendance for depot injections. Daily oral medication is seen by clinicians as harder to monitor and requiring more extensive (and expensive) supervision. However consumers perceived depot injections as more intrusive or carrying worse side effects.

A community treatment order basically is giving the person medication whether they want it or not. Very often it's depot medication, which is a fortnightly injection, because they don't trust the person to take oral medication. Even though the depot medication they give them is one of a number of old style psychiatric drugs which have the risk of extra pyramidal effects, shaking and so on, some of which can be permanent... (ACT carer, 2006)

Such side effects increase consumers' reluctance to comply.

I don't think people are non-compliant because they feel they've been healthy. They might be, as in one girl who was placed on a CTO when she was given particular mood stabilisers and Lithium combination, started lactating and became incontinent and she's 18 years old. So I wouldn't be compliant either! (Victorian consumer advocate, 2004)

a. Consumer perspectives

Some consumers reported complaining about the effects of medication but not being listened to by the treating team.

I told him: "Doctor please today is my day. For long time you treat me wrong way. You give me the wrong medication. I suffer so much but please today listen to me. I want to speak. You listen until I finish please." He goes: "No, no, you don't have the right to speak. You have a mental health problem" (NSW consumer, 2007)

I just was so distressed because no-one was really listening to me, no-one was hearing what I was trying to say about my feelings, they might have been more interested in your actions, okay you take your medication, but they don't know how it feels to have to suffer side effects. I was trying to explain that and I don't think I felt really heard so I was bawling my eyes out, so was my mum and we just both had to leave the room you know (Victorian consumer, focus group, 2004)

These examples might be read as indicating that consumers believe there is a lack of communication with treating teams to enable them to discuss medication and reasons for compliance failures.

Where consumers were able to discuss their medication and side effects with the treating doctor and be heard it was regarded as a positive (but unusual) thing.

[T]his is the first time ever in all the admissions and all the drama that I've had ... that they've actually sat down and explained... the side effects. He said: "If you're not comfortable with this we will not give it to you." That is the first time ever that I've had the experience of being equal and at least having a brain. And that was a positive thing (NSW consumer, 2007)

b. Carers

Carers also reported not being kept adequately informed about medication and its side effects.

I know speaking to a lot of other parents, a lot of their sons and daughters won't allow them to know what medication they're on because they're told not to tell them. That is wrong, because it's important. I would say 90% of the time a son or daughter relapses is when they stop taking their medication (Victorian carer, 2008)

One carer reported that she had tried to negotiate with the treating doctor over her son's medication but was silenced: 'I just felt like every time I spoke up, I said black he did white and vice versa' (Victorian carer, 2004).

c Access to psycho-social treatments

Carers and others also saw the importance of psycho-social treatments as an alternative or more often as an adjunct to medication:

But the problem is that this community treatment order seems itself to be restricted to medication ... if you were looking up best practice for psychiatric treatment it doesn't restrict itself to psychiatric drugs. It's psycho-social rehabilitation, psychology. My daughter has always complained that psychiatrists don't listen to her, that's why she has her day in court' (ACT carer, 2006).

Some professionals supported this more holistic approach to treatment.

Well the Tribunal I think is a very good idea. It's just that I think they're got to start applying best practice. I really do. I don't think medication is enough. They have to be looking at the whole thing. What is the situation with this person's accommodation, with their quality of life? Is there anything else they can do? (Victorian carer/psychiatrist, 2008)

But others appeared to display some hostility towards psychological practitioners, '[R]eally in life you must know who you ask opinions from. If you ask an opinion for a difficult schizophrenic patient from a psychotherapist then you are an idiot' (NSW Health professional, 2006).

d. Participatory treatment planning

A related issue in our fieldwork was the need to involve consumers, and perhaps carers, in a collaborative approach to treatment. This has been endorsed by the Victorian Mental Health Legislation Review Panel as promoting more holistic and more widely accepted plans (Gardner, 2009: 46-48).

[P]eople, once they started interacting with the doctors and psychiatrists with their own treatment, they feel more positive, you feel more in control of your own destiny and life, you feel like you are doing something for yourself and you are not just being told what to do (Victorian consumer, focus group, 2004)

I think that sometimes consumers may feel that they don't know what's going on in their care, and unless someone directly tells them you just can't make assumptions that they know. Or even if you have told them sometimes you need to just remind them. (NSW Health professional, 2006)

3. Summary; implications for tribunal practice

Australian MHTs were found to vary in the extent to which they allowed consumers to express views about their treatment or lack of treatment, in the degree to which such views are taken into account, or whether the function of the medication, its side effects, and alternative treatments (medical or otherwise) had been discussed with consumers. A Victorian board member commented that consumer involvement in treatment decisions was rare:

But they could have sat down and said "Look we really reckon you will be on this medication for a while and this is the reason we are thinking this. These are your options..." I think it is a rare psychiatrist or case manager that will sit down and do all of that (Victorian Board member, 2004).

Given that MHTs are intended to operate in a more informal manner and inquisitorially, they could however play an important role in encouraging

treating staff to engage more openly with consumers and their families in deciding what treatments are appropriate, as some already do.

So what you want to make sure is that the patient's complaint should be heard, looked into seriously and then see what could be done. Any alternative treatment can be tried or something can be given to counteract the side effects. So we have to make sure that the right things are done. So we listen to the patient's complaints, their general complaints and we have to make sure that the clinicians also have listened and have done something (Victorian psychiatrist member, 2007)

Such issues of medication, alternative/complementary treatments, general care issues and the involvement of consumers and carers in treatment plans are at the heart of involuntary treatment orders. The severity of reported side effects are clearly matters to be taken seriously in treatment planning and hearings. Although decisions about treatment were generally seen by both health professionals and tribunal members as being outside the province of the tribunals, recent legislative amendments requiring some tribunals to have regard to treatment plans are a step in the right direction. As explained in more detail later, MHTs are in a good position to consider treatment plans, provide supportive spaces for their discussion, and ongoing monitoring and dialogue where consumers remain on orders. Advocates can also facilitate this (Beaupert, 2009: 101-102).

But if treatment adequacy and its conditions lie at the heart of any best interests or clinical view of this central 'health' domain in the work of MHTs, how participatory or otherwise are their hearings?

C. ARE HEARINGS AN ADVERSARIAL ADJUDICATION OF LEGAL RECTITUDE OR A 'RELATIONAL SPACE' FOR ADVANCING BEST INTERESTS?

1. Consumer perspectives on hearings

The Australian fieldwork revealed that MHTs hearings can sometimes appear and feel like a trial. A presentation of a diagnosis followed by examples to demonstrate the accuracy of this diagnosis reinforces a particular picture of the consumer—a view some consumers have described as 'one-dimensional' and

misrepresenting their character and their experiences.³¹ Such perceptions are not at all unique (eg for Northern Ireland, Campbell, 2008: 226-27) but are difficult to reconcile with best interests, fair process, 'dignitary' (ie respectful) or any other aspirations for MHTs.

This view can be perpetuated by a number of aspects: by the seating arrangement, by the manner of address used by tribunal members, the way questions are asked, the order and turn-taking of the procedure, and how issues are raised and allowed to be discussed. Each can heighten imbalances of power relations between tribunal members and consumers as well as between consumers and their clinical teams. The setting of hearings within a hospital or clinic for instance can fuel perceptions that MHTs have stronger relationships with the clinical sector, with consumers being somewhat 'outside' the circle of influence or lacking a clear sense of their place within the process. Many consumers and carers said that although consumers were given the opportunity to speak, they did not feel that MHTs took account of their evidence. Expectations of the hearing were not, by and large, positive.

Some consumers expressed high levels of anxiety about the way they would be treated, or about whether they would be discharged. This particularly applied to the first experience of a hearing. Many felt unprepared. Those who had been to more than one hearing were more knowledgeable and less fearful.

a. Anxious and fatalistic:

Many clients were anxious and took a somewhat fatalistic approach.

What were you expecting when you went in?

³¹ Making a case against consumers is of course implicit in providing the basis for satisfaction of the legislative criteria for involuntary orders. But in the absence of another document reporting the consumer's situation or history, the clinical presentation tends to define what is discussed by MHTs and the language used, especially if the consumer has no legal representation or other support.

Not much really. I was just expecting them to try to, not belittle me, but make me feel a little uneasy. Said how all these things, about how they have all the notes about me and that and they expect me to behave a certain way, or something like that (NSW consumer, 2007)

I was a little apprehensive, I didn't know what was going to be said or happen. I didn't know what they would say to me and if I was to tell another person about that I would tell them that it's not anything which they should worry about so that the next person who goes in there they should know it's not something that will hurt you or get upset about or worry about (Victorian consumer, 2004)

You know, there's a high expectation by all the patients that when the Tribunal hearing comes round, you're gonna be discharged... I remember the anticipation of seeing the Tribunal, that at last there was going to be an objective, informed, opinion and decision based on the facts and that I'd be discharged. You know, I always felt confident that that would happen. And that was common to all the other patients (NSW consumer, 2006)

b. Setting and power:

Consumers varied on their sense of the setting being intimidating, too formal, or not formal enough. Several informants mentioned the symbolism of the setting.

One Victorian consumer described the hearing space as a 'big officious looking room ... very overpowering' (2004). Another concentrated more on the seating arrangements than the room itself, saying:

[T]hey were sitting in very authoritarian positions ... I didn't feel as if it was a meeting where I could discuss openly, it was almost sort of like a court room environment rather than being a place where I was going to present them with evidence and they were going to research and find out whether my claims were true or not. So it was more like an adversary system rather than inquisitorial (Victorian consumer, 2004)

An ACT carer by contrast commented favourably on the 'fairly informal roundtable' layout (2006); a very different perception to that of a Victorian consumer objecting to the 'big board table' and the seating of consumers and any support people 'on the corner, not opposite [the tribunal]' – something that the interviewee felt doctors do 'all the time these days', and as being 'just a power thing' (Victorian consumer, 2004). Such perceived barriers associated with what another consumer termed the 'aesthetics of space and language and body language' are compounded by psychosis.

However, the sense of power imbalance is not necessarily resolved by more comfortable informal settings. Particularly those without advocates or family present reported that the numbers of people in the hearing, including tribunal members and health professionals, was intimidating or disempowering.

Even the hearing is just the shape of power. Different sort of power (NSW consumer 2007)

I felt very nervous and intimidated in both set-ups because I had no one with me that was on my side. No family, nobody. It was just me there against all of them. So I just felt very, very scared (Victorian consumer, 2004)

This supports Swain's hypothesis that 'distress' or 'powerlessness' is a significant factor in consumer dispositions at hearings (Swain, 2000).

As observed by the research team during hearings, however, much depends on the size of the room as to how imposing or restrictive the set up of the table and seating arrangement can be, especially in terms of movement. Properly structured, with sensitivity to the physical, emotional and procedural landscape, hearings can be well received.

My daughter has always complained that psychiatrists don't listen to her, that's why she has her day in court. She likes it. They always say, "Do you have anything to say?" She takes the floor like an old trouper. She tells them all about the angel Gabriel and how god talks to her and everything. And the magistrate [sic] sort of listens very politely. The psychiatrist's mouth drops open. She's as mad as a rabbit (ACT carer 2006)

In some hospital settings witnessed during fieldwork, the rooms are small and the table takes up most of the space. In these situations, there may be little room between the wall and the chairs, and to actually get to a seat may require that others get up to make room to walk through. It can be a tight squeeze and somewhat restrictive. Other rooms may have a greater distance between the wall and the table, allowing consumers and others to sit back from the table and position chairs at a more comfortable angle or distance. In most hearings, apart from single member hearings, tribunal members sit alongside each other facing the door and opposite the other parties, who also sit side by side. Again

depending on the room, in single member hearings, the seating arrangements may be more informal, with lounge chairs and a small coffee table between the tribunal member and others. Some rooms may have natural lighting, others do not, most times the window and door have blinds or curtains drawn, although not always.

An advocate described how these features combine to determine the demeanour of consumers and the quality of the hearing experience

Some people are very agitated before and they'll do their bundle like you wouldn't believe and then they'll get in there and then, because of the pressure and the stress, they'll swear at everybody and walk out. And you can see why it happens. One reason is the set up. Everything seems to be set up against the consumer, just in the order of the way the people speak. And they feel that they're on trial and their whole life is on trial and every misdemeanour that they've ever done is going to be raised (NSW advocate 2007)

So the question is what are the 'good practice' ways of overcoming this sense that everything is 'set up against' the consumer?

c. Introduction and explanation

Hearing procedures varied in the Australian study. Generally tribunal members introduced themselves³² and explained the purpose of the hearing, but others did not:

The first question I always ask... is, "Do you know what this is all about?" "We have an application put in by such and such dated and have you seen that?"... Some of them are very seriously unwell people and they don't really understand what's happening, especially dual disability people (ACT member, focus group, 2008).

One consumer graphically described what happened when introductions were not made:

³² In MHT hearings, members sometimes had name plates with their full name, or had surnames only, or were without any name plates. It is not clear whether name plates aid communication or add to symbolic distancing (esp the formality of title and surname only).

[T]hey started having discussions, you know addressing [the advocate] and I said ..."Listen do you mind if you at least give me your names?", as they didn't introduce themselves and they didn't state their functions and [the advocate] picked up on that point as soon as I mentioned it to her. ... And one of the members there took offence to that and said that she wasn't going to tell me... that wasn't necessary, yeah, ... – it went on for about 5 or 6 minutes. And in the end they did introduce themselves and they did tell me what their functions were (Victorian consumer, 2004)

Some members noted that a balance was required between provision of a full explanation and the consumers' capacity to understand due to the severity of their illness or their anxiety.

Do you think often that people just leave a hearing not knowing at all what happened though?

People can. If they go and they're nervous and they don't really know, first time in there. Legal process. Never been into any sort of legal process before. They would get some description of what's going on but they don't hear it. They're too frightened. They do try and engage them though (ACT nurse, 2007)³³

Although the function of the tribunal may be outlined, in terms of addressing the criteria, the actual *mechanics* of hearings were not generally explained at hearings we observed: such as the sequence of events, how long it will take, whether a break is possible, or explanation that members may require time to deliberate. Informing parties at the beginning and throughout the hearing about what was happening or why, was not a regular technique of tribunal chairs. What happened depended on the particular MHT members rather than being part of a standard protocol.

2. Tribunals learning to communicate?

Language was another important issue. Consumers and carers both found the use of technical medical terms difficult throughout the mental health system.

³³ Consumers who had previously appeared, and those with good legal assistance, were more aware of the process. When well informed prior to hearings, explanations were easier to comprehend.

This was exacerbated in some cases by poor education and lack of English language proficiency.

a. Empathetic communication

MHT members were aware of the need for plain English, and tailoring language to suit consumers. Some consumers and advocates reported that MHTs communicated clearly and encouraged health professionals to use plainer language.

What I try to do is to get some sense of the person I'm talking to and how they would normally interact with other people and then work on those sorts of levels. We certainly are in an environment where there is lots of jargon around, so trying to de-jargonise, particularly medical matters, is really important. Making sure people really do understand as best they can what's going on is important. And that varies enormously (Victorian member, 2004)

Carers and consumers mentioned anxiety, mental illness and medication as affecting consumers' ability to understand. This reduced their ability to participate and increased their sense of powerlessness.

Two things here, you are talking to families who are in states of such anxiety that they can't hear what you are saying anyway, let alone understand the words you are using. If you have ever tried to explain things as a clinician to families, you would know the families feel that they should understand it, but they know that they don't and they are too frightened to go back and ask for clarification. And the nature of the system is such that it doesn't really put out the sort of invitation to ask questions, so they go away feeling disempowered (Victorian carer, 2008)

Language difficulties went both ways: some consumers for whom English was not their first language had difficulty making themselves understood to health professionals and the tribunal. Some found that health professionals who were not Australian-born were difficult to communicate with, both in terms of language and because of cultural differences.

Language was also a problem in the sense that negative language, cold language or the medicalisation of a consumer's behaviour was off-putting. This was mentioned more often with regard to treating teams than MHTs. Our fieldwork suggests that such presentations and language inadvertently contributes to hearings being experienced as a 'trial,' rather than the flexible inquisitorial enquiry envisaged. With the general absence of a consumer's report

or comprehensive outline of what has been going on for them, clinical representations tend to be the documents that define what is discussed and the language style. This is exacerbated when consumers lack legal representation or other forms of support to be able to contribute another dimension or view to their behaviour and experiences.

b. Order of speaking

The order of speaking varied. Some legal members believed that the consultant psychiatrist, as applicant, should be questioned first. Others thought that the consumer should speak first, to increase the sense of inclusion.

A NSW community member thought it was better to question the consumer first, as is now the general approach in Victoria:

What do you perceive that [the consumer's] role in the hearing is from your perspective sitting on the other side of the table?

Don't know the role but I really think they should be heard first. ...It's one of those things that is often neglected. I think it's very intimidating for people to be hearing all sorts of things about themselves ... using large words to describe them. And not only the psychiatric terminology but things like violence and aggression and all of those nasties which seem to intimidate people to the stage where they go into a shell and may not be able to talk adequately about themselves... I think though even apart from it being about them if you hear from them first it's a much more effective hearing.... because you straight away know where they're sitting with whatever it is. And that can then determine how the thing flows (NSW member, 2006)

A Victorian legal advocate (2004) raised the issue of consumers having the right to reply to the case put by the treating team.

I think though they are better off responding to things that are raised because they can speak first. But the doctor can then come in afterwards and say "Oh well, they mentioned this and this is my opinion of this". They don't get a right of response to that. I almost think it's better for the doctor to give their evidence and for clients to be able to respond to that, because it's much easier for a Board to pass judgement on someone when they speak initially without the evidence of the doctor or lawyer.

Other cases were more conversational, with consumers able to comment on the treating team's case. One consumer thought he should speak first, followed by his wife:

I've got me wife sitting there that I've been with for 20 years, married with her for 20 years, I live with her and the judge's made a decision without asking me wife, which is very wrong because I don't live with the doctor, I live with me wife. So me wife's got a better idea how I am and I find it that the judge should speak to me first then me wife to verify what I'm saying is right. And then ok listen to the doctor (NSW consumer, 2007)

However, some family members may not wish to say anything or be questioned.

Some consumers were unable to answer after hearing the treating team's case.

I felt really intimidated by them. I felt intimidated, they sort of sat there and asked questions. Actually I was not asked a lot of questions. They said "Did I have anything to say" after the doctor had spoken, after the nurses had spoken, I think my friend spoke as well, I think they said would you like to say. I don't think I was able to utter anything, I think I just said "No, I don't know what to say" (Victorian consumer, 2004)

You usually get asked at the end is there any questions ..., by that time all the lingo goes around and around and you haven't really understood it and "Have you got any questions" and you are totally bamboozled at the end, so of course you are going to say "No" (Victorian consumer, 2004)

A consumer perceived being questioned first as 'merely a nicety', with her comments subsequently ignored.

The client is given the opportunity to speak first. Her or her advocate is given the opportunity to speak first. That should be gone over thoroughly. Not just listened to and forgotten about (Victorian consumer, 2004)

c. Styles or rituals of communication

For consumers, communication is not merely about the 'order' but also the 'style' of discussion, such as whether more fluid exchanges convey a sense that consumers are being 'excluded', rather than promoting informality and inclusion. There were comments that, instead of communication being restricted to rather mechanical questioning, usually through the legal member, there could be more interaction or discussion between other MHT members and consumers, or between treating teams and consumers. While obviously desirable, care needs to be taken to keep the focus on the consumer.

As one advocate observed, the 'ritual' is important

The doctor doesn't talk to the client, the doctor talks to the Board members. The lawyer talks to the Board members. The client talks to the Board members. So there's no actual interaction between the doctor and the client. Or the lawyer and the client. And I think that makes a difference. ... In terms of ritual, I think that thing about the psychiatrist member and community member also interacting with the client is quite important (Victorian advocate, 2007)

It is vital that consumers not perceive that they are being 'talked about' more than being *engaged in* the discussion.

Exactly, it just doesn't feel very good because everyone's left out of the picture and it's like everyone is just talking about the patient, what's going to be best for them without them feeling like they have any voice within that (Victorian advocates, focus group, 2006)

Now that's another thing, this is where they tended to ignore [the consumer]. It must have been awful for her. "All these people are talking about me and yet not acknowledging me. I could be like a leg on the chair." That's how she was treated. They talked about her (NSW carer, 2006)

However, other consumers, carers and advocates reported that communication between the tribunal and consumer was positive, clear and helpful and that consumers were able to raise issues and have them heard.

3. Tribunal manner towards consumers

Most of the consumers and carers reported that MHT members were polite and courteous.

We're lucky here, we do have some very empathetic magistrates in their communications and just the way they speak to the person. I think that S just feels that they are there to help her. And the fact that they defer to her: "What do you think about that?" (ACT carer, 2006)

So how do you feel you were treated at the hearing?

Fairly. In terms of the interpersonal stuff fairly. In terms of the overall decision I felt that there was something lacking. But in terms of how they treated you with respect and ...they gave you opportunities to speak...and that sort of thing...it seemed quite genuine, quite genuine (Victorian consumer, 2007)

Well I think they treated me alright. They let me soldier on. I said, "Can I soldier on?" and they said yes (NSW consumer, 2007)

This was backed up by health professionals and most advocates.

Haven't had a problem with the actual members personally and they are very sweet too. Like on one occasion, "I can see you're upset, would you like to have a five minute break to compose yourself" or that sort of stuff and "Thank you for coming today", because you don't have to come of course to a Tribunal. So they are very nice about it.

And often you can see the members try to put the consumers at ease and it's very quickly actually, it happens very quickly, just makes them feel a bit more comfortable, introducing themselves. Just their tone of voice and the manner in which they're doing things and the consumer will often then make chit chat with the panel members so obviously they've done their work very well in trying to put them at ease, initially (NSW advocate, 2007)

Some consumers commented that MHT members were cold.

I didn't feel any warmth from any Board Member. Not interested, just here to do a job, not concerned about your future (Victorian consumer, 2004)

It is very impersonal, you're just the next person, you are not sympathetic or empathetically listened to (Victorian consumer, focus group, 2004)

An ACT member said that this differed among tribunals.

Different attitudes in different places. In Sydney quite often the hearings will be pretty impersonal. You wouldn't know the people involved and it would be done very much according to the book, and there wasn't much connection in a human way during it; so that in some ways they tended to be legalistic (ACT member, focus group, 2008)

Many consumers and carers said that although consumers were given the opportunity to speak, they did not feel that MHTs took account of their evidence.

I also felt, and still feel, that they don't put a lot of stock in your own opinion. I think, well I don't know what they think, but I just get the feeling that, you know, who is going to listen to a mad woman. There is all that stuff about, you know, I'm the one that is ill so what do I know. Has she got insight? Has she got something real to say about her own situation? Would she know about what she has been experiencing? (Victorian consumer, 2007)

But they didn't seem to take very much notice of what I said.

What made you think that?

It was just their attitude. I wasn't very happy at all. I felt I wasn't allowed to talk. If I did talk it was just that they were just listening and that was all.

They weren't hearing what you were saying. Is that what you mean?

Yes.

Was that something to do with their body language?

It was just the way that he kept saying “yes, yes, yes, yes” to me. Sort of interrupting me when I was speaking. Yes we’ve heard that before from the person who advocated for me. Yet they asked me to speak (Victorian consumer, 2007)

As this fieldwork reveals, there are many and often subtle constituents or characteristics of a good participatory hearing space. For operational purposes, these need to be reduced to some rubrics or action-oriented advice.

Some interviewees noted that, in handing down decisions, tribunals sometimes spoke positively and encouragingly.

I do think it works to give positive feedback, while giving a decision about what the person is about, that the person has come a long way since they first came into hospital and particularly where they are getting good care, that the doctor has performed well in the hearing, the doctor has said these sorts of things, I hope they will happen, wish you well, it is those sorts of things that are best, surround the disappointment, I think they can. (Victorian legal member 2004)

At other times the tribunal, in attempting to emphasise the importance of complying with treatment, was perceived as ‘lecturing’.

I've actually taken a couple of my panel members, one lawyer, and again he is a very good lawyer, and he proceeded to give a lecture on schizophrenia. I said ‘Bob, this person has lived for 18 years with that illness. They don't need your lecture on how it is to live with schizophrenia, what they've got to do’. (NSW community member, 2007)

When people are discharged it usually ends with a lecture about if they don't follow their treatment, or if they don't continue to engage, it's just going to have these dire consequences. There is usually a lecture after someone is discharged, rather than a ‘Congratulations, you deserve it’. I don't think I've heard any member ever say that. (Victorian legal advocate, 2004)

4. Good practice/Best interests conclusions on hearings

Some important ‘good practice’ behaviours and levels of support observed during the research as ones MHTs can provide to consumers (further, Carney and Vernon, 2009: 25-26) include:

- Thank people for attending and participating in the course of the hearing;
- Introduce everyone in the room;
- Consider one’s tone of voice and manner and encourage questions to the members so that a more relaxed and inviting atmosphere is created,

- including making ‘chit chat’ so that people can feel more at ease, especially at the beginning;
- Not be too legalistic in approach but balance questions about legal considerations with other presenting issues;
 - Ask a person what they think about issues raised and acknowledge where there are differences and similarities;
 - Acknowledge when a person is upset or concerned and try to address these emotions as well as ask what a person may require, whether it be a break, a glass of water, or some other support;
 - Show how what the consumer has said is being taken into account, rather than leave them feeling that not much notice is taken of their views. This involves demonstrating how the tribunal took into account their views and evidence;
 - Ask questions not only about the consumer’s actions, in particular as to whether they have taken their medication, but also in how they ‘feel’ about taking it and how they may have to suffer side effects and what this means for them;
 - Ensure everyone present has an opportunity to speak;
 - Explain terms so that everyone in the hearing clearly understands the discussion;
 - Provide summaries so that an incident or issue is captured with the various experiences and explanations identified;
 - Identify what other issues may warrant attention and seek information as to how and who could help with these issues from those present;
 - Be encouraging, empathetic and respectful.

A number of consumers, carers (and MHT members with family experience of mental illness) suggested that MHT members often do not understand the viewpoint of consumers and that greater training could be beneficial.

Of course a participatory tribunal space or process, sufficiently focussed on the health domain, does not tell us how advocacy fits in.

D. ADVOCACY AND BEST INTERESTS

One of the distinctive features of Australian MHTs— with some exceptions such as near universal representation in the NT—are the low rates of legal

representation other than for ‘detention’ cases (Carney and Beaupert, 2008; Beaupert, 2009; Williams, 2009).³⁴ This is an artefact of scarce legal aid funding (and policies), and contrasts unfavourably with New Zealand,³⁵ or with Ireland’s mandatory representation.

Australian MHTs process very large volumes of cases in very short periods of time, on extraordinarily small budgets by comparison with say Ireland.³⁶ This operational feature, where NSW and Victorian MHTs dispatch cases in an *average* of under 20 minutes per case³⁷ is quite distinctive compared to overseas experience of much longer average hearings,³⁸ or by reference to human rights standards (Carney, Beaupert, Perry and Tait, 2008). But there are other more important issues, such as what ‘role’ lawyers adopt between taking instructions or presenting ‘best interests’ perspectives, and their style

³⁴ In 2002 Victorian representation was put at 9.6 per cent (Pearson, 2004: 176).

³⁵ New Zealand reports representation on 69 per cent of appeals (O’Brien, Mellisop, McDonald and Ruthe, 1995).

³⁶ In 2007-08 the Victorian MHRB calculated the direct and indirect cost per ‘hearing’ as AUD459 and per ‘case’ (not all of which come to hearing) as AUD339 (MHRB, 2008 Appendix F at 68). By comparison, the Irish Tribunal costs for calendar year 2007 were €3,103 per ‘case’ (AUD5,387) and €4,753 (AUD8,250) per hearing (MHC, 2008: 58). This is a ratio of nearly 16:1 on cases, or 18:1 on completed hearings. In the 2007-08 *Annual Report*, the Queensland tribunal put the cost ‘per matter’ as AUD289, *down* from AUD342 in 2003-4 (at pp 5, 28), but given its much larger budget than that for Victoria, its calculations cannot be accepted at face value (and may reflect the ‘additional cost’ of hearings).

³⁷ Swain’s (2000) study of 25 Victorian Board hearings in 1997-1998, found that one third of hearings took less than 10 minutes, nearly two thirds less than 15 minutes with only 4 per cent lasting longer than 30 minutes (Swain, 2000: 83). Information on hearing duration was missing from NSW file records on the 299 consumers sampled in respect of 70.9% of all 1,083 ‘hearings’ or 72.6% of the 960 ‘real’ hearings (excluding adjournments and ‘change of health region’ up-dates), so the data needs to be treated with caution.

³⁸ The majority MHT hearings studied in England and Wales in the late 1990s took more than 60 minutes, although *deliberations* accounted for less than 15 minutes in over two thirds of proceedings (Perkins, 2003b: 126). More recent research found hearings in the Cambridge region in 2003 averaged two hours and forty minutes (Dibben, Wong and Hunt, 2005).

(adversarial or conversational) within hearings.³⁹ We found opinion quite divided on these matters.

Legal advocates traditionally act adversarially in accordance with ‘competent’ client instructions; but this potentially rubs up against any ‘best interests’ considerations, raises issues about the legitimacy and stability of instructions, and may conflict with expectations of what is an inquisitorial tribunal. Maria Bisogni (2002: 74) criticised ‘some’ (inexperienced) NSW lawyers for taking what she characterised as an ‘overly adversarial stance and approaching hearings as a strictly adversarial contest’, while also criticising lawyers adopting an extreme ‘best interests’ approach. Instead she commended the middle ground—so-called, ‘delicate balance’ test—enunciated by Mahoney JA in *Harry v MHRT and anor*⁴⁰:

It is proper that these things be monitored [to] ensure that the statutory requirements are satisfied. But that does not mean that the duty ... [is] ‘to get his client off’. The duty ... has always been a delicate one ... [to] ensure that the law is observed and that the protections provided ... are available But to negate the application of beneficial powers for mere technical deficiencies may do damage to the client (p.335).

Views differ about this however. Jan Brakel (2007), of American Bar Association disability fame, criticised the excesses of adversarial lawyering, while Victorian mental health advocacy protocols for their part favour adherence to consumers ‘instructions’. The ACT Public Advocate formerly frequently provided an alternative source of ‘best interests’ and welfare-oriented advocacy, but a regular representative now no longer appears.

Because the focus of MHT hearings will often be on assessing the client’s behaviour and other material for evidence of mental illness, rather than listening

³⁹ These issues have been canvassed for Ireland in the recent paper by Maria Dillon (2009).

⁴⁰ [1994] 33 NSWLR 315.

closely to the content of an argument that appears to be at odds with the picture they discern, advocates face a dilemma:

There is a tension there because you are instructed by the person. There's a presumption that the person can instruct within the legislation, so you act on that person's instructions on the basis of how you explain what it is the hospital wants, and then they tell you what they want. Clearly for some people, it's not in their best interest to be discharged, but if they say that they want to be discharged then it's your role to articulate that (NSW Advocate, 2007)

Numbers of advocates deal with this complex issue by making their instructions explicit to the tribunal, but this can be akin to a 'wink and a nod' that those instructions are problematic.⁴¹ While the lawyer's voice carries more weight than that of the consumer their submissions will also be ignored if they lack credibility. Consequently a major role for lawyers may lie in negotiating outcomes or checking facts, as in one example from our data of a psychotic consumer unable to give instructions due to a belief that he was a vampire:

All he kept on saying was, "Tell them I'm not a vampire, tell them I'm not a vampire" and "I can look after myself". So he wasn't able to give really full instructions, but he wanted me to look at his file. I looked at his file. I'd ascertained that he'd been in institutions for some 5 years. So I represented him, not on the basis that I ever expected to get him out but to push the hospital into looking at the next step, into looking for rehabilitation, to just say, "Look, hey, you can't keep a 19 year old locked up forever and today". The Board agreed with that and they gave the hospital four months, five months, I can't remember, for an early review. (Victorian advocate, 2007)

The issue of legal advocacy before MHTs, then, is a vexed one. Neither best interests nor acting on instructions attracts universal support, while the 'hybrid' of the two raises personal and operational difficulties for advocates. From a procedural justice context, research suggests that the quality of legal

⁴¹ As one respondent commented 'When legal aid does attend, legal aid representatives aren't stupid and generally... If someone's blatantly unwell and needs treatment then the legal aid reps usually say, well my client has asked me to say, or has instructed me to tell you...(ACT Health Professional, 2007). Or as an advocate observed 'My favourite case is this woman who was her first time before the Board and her instructions to me were she was the Virgin Mary and so as I said the Board, "My instructions are that my client is the Virgin Mary. If you believe this we do not have a mental illness" ' (Victorian advocate, 2006).

processes depends mostly on perceptions of whether processes are fair and decision-makers are trustworthy, and whether people feel they are able to participate (Tyler, 1996). More tangible consequences and outcomes, such as the decision, delays and the costs involved were found to have a comparatively small influence on satisfaction (Lind, 1990: 968-71). Proceedings embodying the procedural justice trio of 'participation', 'dignity' and 'trust', are said to lead to greater participant satisfaction and acceptance of outcomes (Tyler, 1996), and even patient compliance with treatment (Tyler, 1996: 147; Winick, 2005), though this is contestable. Irrespective, procedures which support consumer voice, validate and respect participation, and provide opportunities to air concerns about harmful episodes (and how they may be rectified) may promote greater satisfaction and 'internal commitment' to outcomes (King, 2008: 1116).

Again at the level of practical advice, perhaps the best that may be said is that any training or support to enable advocates to engage treatment issues in a responsible way, and better perform their roles, would seem desirable (Beupert, 2009: 101-102).

E. CONCLUSION

The data very selectively reported here tends to confirm rather than contradict hypotheses drawn from previous Australian and overseas studies. The health context is dominant. Little time is available in which to check the legal fidelity of the admission, or the clinical evidence on which it is founded; information about the social or family context is rare, and few clients are legally represented or informally assisted by the presence of family or friends. The bulk of the clientele are seriously ill, and are 'repeat' players (with chronic, relapsing conditions).

Commentators have long been searching for ways of understanding legal models or 'types' of engagement with administrative issues such as those engaged in mental health reviews. The work of Jerry Mashaw (1985) with his three 'models' of bureaucratic ('accurate and efficient reflections of

parliamentary will'), professional ('appropriate support or therapy from the perspective of relevant professional cultures') and 'moral' accountability (fairly arrived at when assessed in the light of traditional processes...') has been the starting point for most. His insights into the essence of 'bureaucratic rationality' is best known, while his characterisation of professional treatment (eg medicine) and moral judgment (eg legal conflict resolution and multi-stakeholder issues such as planning) are less so. Roy Sainsbury (2008: 325), neatly summarised the professional treatment model as entailing

[D]ecisions are made by the application of a body of professional knowledge to someone's individual circumstances. Medical practitioners are an exemplar here ... The idea of 'accurate' decisions is replaced by the notion of 'appropriate' decisions, i.e. decisions are not predetermined by a set of rules but made from a range of possible options based on what is best for the recipient of a decision.

Sainsbury saw merit in Adler's ([1999]) re-working of (and additions to) the models; in associating particular remedies with each model (with second opinions characteristic of the professional model, and merits review with the bureaucratic-rationality model, Sainsbury, 2008: 326); and in postulating discretion as essentially *unproblematic* under the professional regime (ibid, 328).

The cultural analysis developed by Simon Halliday and Colin Scott (2009 forthcoming: MS 19) contends that Mashaw's 'professional treatment' and 'bureaucratic rationality' models 'both fall within a hierarchist ideal type of administrative justice'.

Within the hierarchist bias, government is trusted to act on behalf of the collective. Citizens are not expected to participate in decision-making processes. Public officials, rather, are expected to exercise their skill and judgement for the public benefit, and citizens are content to be passive objects of this official discretion – such is their station. Decision-making processes within hierarchism should support the exercise of expert judgement and/or the accurate and efficient implementation of higher orders (ibid, 12).

On these bases, by confining MHTs to ensuring 'legal rectitude', clinical managerial discretions and the prerogatives of professional judgment are preserved under such a hierarchist professional trust model. Confidence in

clinical judgment instead is secured through professional standards and internal quality control processes (e.g, McMillen, Zayas, Books and Lee, 2008) and peer review; and—in relating to mental health consumers—specifically the traditional device of a ‘second opinion’. ‘Best interests’ on the clinical front, then, is here equated with ‘best practice’ promoted (and policed) *within* health systems and health professions. External accountability, if any, engages professional or service modalities, as with the SOAD, or health commissioners, for example.

Certainly by no means all accountability tasks are ‘law jobs’, so confining mental health law to the ‘outer shell’ of legal rectitude cannot be dismissed out of hand. As Mashaw observed, there are various governance frameworks, including regulatory, market, and social systems of accountability, able to be compared in terms of ‘who’ is accountable to ‘whom’, for ‘what’, through ‘what process’, by reference to ‘what standards’ and with what ‘effect’ or results (Mashaw, 2006: 118). Of course in itself this in no way rules out a wider role for tribunal review since as Richardson and Genn pointed out, tribunals can be constituted and calibrated to perform virtually everything, from liberty protection to allocative tasks such as access to special education services (Richardson and Genn, [2007]). Indeed on one view tribunals and courts may be the preferred choice due to their ability to render ‘administration simultaneously managerially effective and politically responsive’ (Mashaw, 2010 forthcoming).

As previously argued (Carney, 2010 forthcoming), considerable potential exists for adopting a ‘case conference’ *model* of MHT review (cf, Wood, 1998); one which *combines* consideration of legal rectitude with adequate consideration of issues lying in the medical and social domains (Carney and Beaupert, 2008). This would include canvassing concerns about misdiagnosis, adequacy of treatment (including access to psycho-social support), choice (and side effects) of medication, and discharge planning (Carney, 2009), or what John Wood (1999: 134) termed a ‘general review’. As he argued earlier, ‘[a] patient’s rights,

however that concept is interpreted, are best protected by periodic constructive review, so that needs can be identified and pressure exerted to meet them' (Wood, 1995: 420). Timings, styles of hearings and other features might also be left open to some degree to promote flexible engagement with the differing needs of differing *sub-groups* of MHT customers (Wood, 1999: 134-35),⁴² or apply conciliation/mediation processes (as under NSW adult guardianship provisions for presumptive conciliation of initial applications for orders),⁴³ as some of our fieldwork respondents suggested:

In these situations, we should be negotiating or mediating between the person with the mental illness and the family or service so a mediated solution or a negotiated solution is worked out. Somehow or other we should get away from the adversarial atmosphere, and introduce one of negotiation. Of course there are going to be occasions where negotiation will not work, things have broken down in the family or whatever, and you are going to need a legal process, no question. But my feeling is that if we have this other sort of system in place, a mental health service that includes family, and legal processes that mediate or negotiate in cases where that was possible, then we would have different outcomes (Victorian carer, 2008)

MHTs potentially could also potentially assume a general complaints role,⁴⁴ along with these case-planning and treatment review functions.⁴⁵

⁴² For instance our data suggests that there are at least seven possible 'strands' (1) Those 'continuously on CTO' for 2, 3, 4 (maybe 5) years with no evidence of inpatient admission; (2) 'Continuously on involuntary orders' for 2, 3, 4 years, mostly CTOs, but including more than one apparent inpatient re-admission; (3) 'Continuously on involuntary inpatient orders' for 6, 12, 18, 24 months; (4) 'Intermittent histories (revolving door)', with apparent breaks without an involuntary order, then re-admission and CTOs; (5) 'Occasional consumers' – people who go for substantial periods of time with no apparent order, then re-appear in the system; (6) 'One-off inpatients' – those who have one inpatient order, then do not appear on the system within 2 years; (7) 'One-off involuntary community patients' – those who have a single CTO and do not appear again on the system within 2 years.

⁴³ Section 66 provides that (1) The Tribunal shall not make a decision in respect of an application made to it until it has brought, or used its best endeavours to bring, the parties to a settlement. Subsection (1A) provided a dispensation where 'the Tribunal considers that it is not possible, or appropriate, to attempt to bring the parties to a settlement.'

⁴⁴ In jurisdictions such as WA there is already a role for MHTs to deal with complaints. The WA power is a flexible one (able to be internally delegated to a member or the registrar), and covers complaints about failure to honour legislative rights of involuntary patients or 'any other matter to do with the administration' of the legislation: WA MHA, s 146(1).⁴⁵ Another possible source of support and discharge of some such functions may be the community visitors

Wider roles for MHTs are strongly resisted by some, on various grounds, such as cost, lack of real competence in clinical matters, or simply as involving wrong-headed thinking that law has any role to play in medicine or social work. However, studies certainly suggest that mere 'legal rectitude' (or procedural fairness, Carney, Tait, Chappell and Beaupert, 2007), does not overcome the tendency to 'still often defer[] to psychiatric opinion even when the preponderance of evidence showed it to be unsubstantiated' (Hiday, 1977: 665). This is of concern both to mental health consumers and detached observers of the quality of justice. Therapeutic Jurisprudence ('TJ'),⁴⁶ points in the same direction in seeking out a more constructive therapeutic role for MHTs, but it has proved both insufficiently clear about what constitutes the 'therapeutic good', and is too narrowly focussed only on the 'medical' to the neglect of the social or informal civil dimensions of life (Slobogin, 1995; Brakel, 2007).

Whether there should be, or is in fact, either a 'best interests', a 'rights regarding' or some other 'guiding lode star' at work in MHTs is, however, harder to say. Rather than a choice between 'best interests' and 'legal rectitude' it may, as Jerry Mashaw observed, depend more on 'who' is accountable to

and the coordination offered by the Victorian Office of Public Advocate (OPA). OPA's submission to the Victorian review urged establishment of a paid 'independent support person' scheme (OPA, 2009: 9, 43-44). The Review supported this model on grounds of information provision, participation, advocacy and support (Gardner, 2009: esp 53, 57-58, 68), though the Government response was more equivocal (further, see: Carney and Vernon, 2009, unpublished; GovernmentResponse, 2009).

⁴⁵ Another possible source of support and discharge of some such functions may be the community visitors and the coordination offered by the Victorian Office of Public Advocate (OPA). OPA's submission to the Victorian review urged establishment of a paid 'independent support person' scheme (OPA, 2009: 9, 43-44). The Review supported this model on grounds of information provision, participation, advocacy and support (Gardner, 2009: esp 53, 57-58, 68), though the Government response was more equivocal (further, see: Carney and Vernon, 2009, unpublished; GovernmentResponse, 2009).

⁴⁶ Therapeutic jurisprudence ('TJ') aims to craft laws and procedures which maximise therapeutic gains and minimise avoidable harms (Wexler, 1992; Kapp, 1994; Winick, 1994; Slobogin, 1995).

'whom', for 'what', through 'what process', by reference to 'what standards' and with what 'effect' or results (Mashaw, 2006: 118).

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